



# **The diffusion, modularization, and institutionalisation of Direct Social Actions in healthcare.**

The Greek Healthcare Arena: 1983-2019.

**Ph.D. thesis**

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06/06/2022

## **Abstract**

This thesis is the product of my political and scholarly engagement with healthcare activism in Greece during the past decade and, more specifically, with the Social Clinics-Pharmacies' movement that emerged in the country over the course of the most recent cycle of anti-austerity contention. The Social Clinics-Pharmacies' movement was composed of grassroots clinics and/or pharmacies that provided free healthcare services and pharmaceuticals and engaged in protest tactics for reform in the Greek National Healthcare System. In just two years the movement became prominent and affected opportunities for itself. As such, and upon the closure of the cycle of contention and the rise of its ally-party SYRIZA into power in 2015, representatives of the movement were invited to participate in the drafting of healthcare reform around two of the most pressing and unresolved issues of the Greek National Healthcare System since its establishment in 1983. These pertained to the extension of coverage and the development of a comprehensive Primary Care level. I argue that this involvement of the movement into policymaking is an instance of movement institutionalization that reinforced convergence around tactics of healthcare provision from below as well as divergence in their strategic employment. By 2016 the movement had dissolved while individual clinics and/or pharmacies continued their operations.

Departing from this case study, this thesis contributes to the existing social movement scholarship in at least three directions. First, it enriches analyses on repertoire innovation by providing a contextual and strategic perspective to the appropriation of tactics of healthcare provision by different actors. The expansion of Direct Social Action tactics (henceforth DSAs) has received attention over the past years and has been interpreted as reflecting a double deficit in democratic and welfare politics. I argue that healthcare DSAs compel us to study the configuration of strategies against fluctuating socio-economic and political environments and within particular institutional arrangements that advance as central for the domain of healthcare.

In addition, this thesis advances the recent literature on DSAs by introducing a relational, dynamic and longitudinal perspective to their employment. This is achieved through the close investigation of healthcare DSA tactics from (i) the first instances of their utilisation after the establishment of the Greek National Healthcare System, (ii) their diffusion and modularization in the years following the 2010 crisis and the cycle of anti-austerity contention, as well as (iii) their solidification following movement institutionalization. Those three periods highlight the contextual and dynamic, interactive and strategic dimensions of the employment of healthcare DSAs.

Last, this thesis embellishes accounts on movement institutionalization. More specifically the longitudinal investigation of the Social Clinics-Pharmacies allows us to approach institutionalization as at once a process and an outcome of the diffusion of healthcare DSAs in the Greek healthcare arena.

As I hope to show the healthcare arena molded the profile of the movement as particularly institutionally oriented, and prone in assisting in and negotiating over progressive healthcare reform. This led to the swift institutionalisation of the movement at the peak of the Social Clinics-Pharmacies' paradigm. Institutionalization, therefore, was a process composed of the various interactions between all those actors animating the Greek healthcare arena in the direction of repertoire innovation and healthcare reform. Institutionalization was also an outcome of collective action, with direct implications onto healthcare policy and indirect, unintended effects for the movement. Following movement institutionalisation, movement dissolution and the advent of reform, I observe the carving of different trajectories to and fro the same tactics of healthcare provision configured around the different interpretations of the reform and, relatedly, distinct strategic uses of healthcare DSAs.

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## List of Abbreviations

- ADEDY: Civil Servants' Confederation. (ΑΔΕΔΥ: Ανώτατη Διοίκηση Ενώσεων Δημοσίων Υπαλλήλων)
- ADYE: Self-organised Health Structure in Exarchia. (ΑΔΥΕ: Αυτοοργανωμένη Δομή Υγείας στα Εξάρχεια)
- ANEL: Independent Greeks. (ΑΝΕΛ: Ανεξάρτητοι Έλληνες)
- ANTARSYA: Anti-capitalist Left Cooperation for the Overthrow. (ΑΝΤΑΡΣΥΑ: Αντικαπιταλιστική Αριστερή Συνεργασία για την Ανατροπή)
- ASOEE: Higher School of Economic and Commercial Sciences. (ΑΣΟΕΕ: Ανώτατη Σχολή Οικονομικών και Εμπορικών Επιστημών)
- DYPE: Health Region Administration. (ΔΥΠΕ: Διοίκηση Υγειονομικής Περιφέρειας)
- EAM: National Liberation Front. (ΕΑΜ: Εθνικό Απελευθερωτικό Μέτωπο)
- EC: European Commission.
- ECB: European Central Bank.
- EEK: Workers Revolutionary Party. (ΕΕΚ: Εργατικό Επαναστατικό Κόμμα)
- ELAS: National Liberation Army. (ΕΛΑΣ: Εθνικός Απελευθερωτικός Στρατός)
- ELSTAT: Hellenic Statistical Authority. (ΕΝΣΤΑΤ: Ελληνική Στατιστική Αρχή)
- EINAP: Union of Hospital Doctors in Athens and Piraeus. (ΕΙΝΑΠ: Ένωση Ιατρών Νοσοκομείων Αθήνας και Πειραιά)
- EODY: National Health Organisation. (ΕΟΔΥ: Εθνικός Οργανισμός Υγείας)
- EOPYY: National Organisation for the Provision of Healthcare Services. (ΕΟΠΥΥ: Εθνικός Οργανισμός Παροχής Υπηρεσιών Υγείας)
- ESY: National Healthcare System. (ΕΣΥ: Εθνικό Σύστημα Υγείας)
- GP: General Practitioner.
- GSEE: General Confederation of Greek Workers. (ΓΣΕΕ: Γενική Συνομοσπονδία Εργατών Ελλάδας)
- IKA: Institute of Social Insurance. (ΙΚΑ: Ίδρυμα Κοινωνικών Ασφαλίσεων)
- IMF: International Monetary Fund.
- ISA: Athens Medical Society. (ΙΣΑ: Ιατρικός Σύλλογος Αθηνών)
- KEELPNO: Centre for Disease Control and Prevention. (ΚΕΕΛΠΝΟ: Κέντρο Ελέγχου και Πρόληψης Νοσημάτων)
- KESY: Central Healthcare Council. (ΚΕΣΥ: Κεντρικό Συμβούλιο Υγείας)
- KIA: Social Clinic of Solidarity. (ΚΙΑ: Κοινωνικό Ιατρείο Αλληλεγγύης)

- KIFA: Social Clinic-Pharmacy in Athens. (ΚΙΦΑ: Κοινωνικό Ιατρείο-Φαρμακείο Αθήνας)
- MdM: Médecins du Monde.
- MKIE: Metropolitan Social Clinic in Elliniko. (ΜΚΙΕ: Μητροπολιτικό Κοινωνικό Ιατρείο Ελληνικού)
- M-L KKE: Marxist-Leninist Communist Party of Greece. (Μ-Λ ΚΚΕ: Μαρξιστικό-Λενινιστικό Κομμουνιστικό Κόμμα Ελλάδος)
- MoU: Memorandum of Understanding.
- MSF: Médecins Sans Frontières.
- ND: New Democracy. (ΝΔ: Νέα Δημοκρατία)
- NGO: Non-Governmental Organisation.
- NHS: National Health Service.
- NSRF: National Strategic Reference Frameworks.
- ODIPY: Organization for the Management of Health Resources. (ΟΔΙΠΥ: Οργανισμός Διασφάλισης της Ποιότητας στην Υγεία)
- OECD: Organisation of Economic Co-operation and Development.
- OGA: Organisation of Agricultural Insurance. (ΟΓΑ: Οργανισμός Γεωργικών Ασφαλίσεων)
- OENGE: Federation of Unions of Hospital Doctors of Greece. (ΟΕΝΓΕ: Ομοσπονδία Ενώσεων Νοσοκομειακών Γιατρών Ελλάδος)
- PASOK: Panhellenic Socialist Movement. (ΠΑΣΟΚ: Πανελλήνιο Σοσιαλιστικό Κίνημα)
- PEDY: National Primary Care Network. (ΠΕΔΥ: Πρωτοβάθμιο Εθνικό Δίκτυο Υγείας)
- PeSY: Regional Health Systems. (ΠεΣΥ: Περιφερειακά Συστήματα Υγείας)
- PeSYP: Regional Health and Welfare Systems. (ΠεΣΥΠ: Περιφερειακά Συστήματα Υγείας και Πρόνοιας)
- PFI: Primary Health Care. (ΠΦΥ: Πρωτοβάθμια Φροντίδα Υγείας)
- PI: Private insurance.
- PIKPA: Patriotic Foundation of Social Welfare and Culture. (ΠΙΚΠΑ: Πατριωτικό Ίδρυμα Πρόνοιας και Αντιλήψεως)
- PIS: Panhellenic Medical Society. (ΠΙΣ: Πανελλήνιος Ιατρικός Σύλλογος)
- POEDIN: Panhellenic Federation of Public Hospital Employees. (ΠΟΕΔΗΝ: Πανελλήνια Ομοσπονδία Εργαζομένων Δημόσιων Νοσοκομείων)
- SHI: Social Health Insurance.
- SMO: Social Movement Organisation.
- SSH: Social Space for Health. (ΚΚΧ: Κοινωνικός Χώρος για την Υγεία)
- SYRIZA: Coalition of the Radical Left. (ΣΥΡΙΖΑ: Συνασπισμός Ριζοσπαστικής Αριστεράς)

- ToMY: Local Health Unit. (ToMY: Τοπική Μονάδα Υγείας)
- UNICEF: United Nations International Children Emergency Fund.
- VIO.ME: Industrial Mining. (BIO.ME: Βιομηχανική Μεταλλευτική)
- WHO: World Health Organisation.

## Acknowledgements

When enrolling in a PhD program people warn you against it. They say that it is a long, difficult, and lonely endeavor. Upon reaching the end, I need to correct some of these assumptions. Writing this thesis has indeed been long. Too long. It has been difficult but in a way that was both challenging and rewarding. But it has not been lonely. This work is very much the product of extensive conversations and debates, formal, semi-formal and informal with colleagues, friends, and comrades.

First, I would like to thank my supervisors. Donatella della Porta who took interest in this project and has sensibly and sensitively guided me along the way. Lorenzo Bosi who was only later assigned to me, and, despite our initial agreement on partial supervision, accommodated six years of work into three. Donatella and Lorenzo have been precious advisors in this period; they have been assertive but always mindful and I consider myself lucky to have gone through this process with their help.

I would like to thank my department at the Scuola Normale Superiore and the Centre on Social Movement Studies for taking me into their family and hosting me through these years. Finding myself among such kind and brilliant colleagues is yet another reason for thanking my lucky stars. These, of course, include my fellow Cyclists with whom we came of age together. I would especially like to thank my friends Francesca and Linus for their uninterrupted support, emotional and intellectual, and for their affection. I would like to thank Rosa for joining me later and for sharing some of her light with me.

Being part of the Laboratory on Contentious Politics of the Panteion University of Social and Political Sciences in Athens was among the highlights of my journey and I am grateful to Seraphim Seferiades for setting it up and for welcoming me. Our Thursday meetings have been formative for me and defining for this project. I would also like to thank Nikos Serdedakis and his team -and Myrsini particular- for sharing their excellent work with me.

Looking back, I realise I would not find myself in Florence (or in political sociology) if it were not for my dearest EUI veterans, Arturo and Giorgos. I wish our theses were more synchronized, but this would imply some “historical revisions” that are usually ill-advised. But they compensated with bringing Christina into my life (and house). I would like to thank Christina for being the inspiring friend that she is. And for introducing me to Margarita and Elisavet who cared for me like few people have.

This thesis would not have been possible if it were not for my interlocutors and all those people that believe in and fight for a better world for everyone. In healthcare and in general. This list is potentially endless but I will confine myself to thanking receptionists Eleni, Petros and Lena and doctors Alexis

Benos, Katerina Matsa and Theodoros Megalooikonomou for sharing their insights and thoughts with me.

Last, but not least, I would like to thank my family. My sister Myrto for her stubborn determination. My sister Nina for her uncompromising integrity. I would like to thank my father, Dimitris, for giving me the tools to address and analyse complexity. I would like to thank my mother, Valia, for her inexhaustible empathy and optimism. This thesis is dedicated to her.

“Declare the past, diagnose the present, foretell the future.”

Hippocrates

## 1. Introduction

This thesis is the product of my long, affective, political and scholarly engagement with healthcare activism in Greece during the past decade and, more specifically, with the Social Clinics-Pharmacies' movement that emerged in the country over the course of the most recent cycle of anti-austerity contention. As such, empirical observations, challenges and puzzles preceded the research questions addressed in this work. From the sum of my observations -inferred through the triangulation of my participant observation, forty-four semi-structured, in-depth interviews with relevant actors, and the collection of material covering four decades- my bibliographical overview and subsequent analysis, I argue that the case of the clinics-pharmacies can provide important insights in at least three directions that have advanced as relevant for and pressing in social movement studies in the recent years.

More specifically, the case of the Social Clinics-Pharmacies movement allows us to enrich existing understandings of the dynamics of repertoire innovation, especially with regards to the development of those tactics of welfare and healthcare provision from below. To be sure, these tactical forms, by now associated with anti-austerity contention, at least in Europe, have attracted scholarly attention in the past years and are widely discussed in both scholarly and political milieus. Tactics of welfare provision, as we will see, proliferate in particular socio-economic and political environments and, as such, prompt us to shift our focus (back) to the conditions affecting their strategic employment. For the purposes of this thesis, I utilise Bosi and Zamponi's (2015, 2019, 2020) definition of these tactical forms as Direct Social Actions (henceforth DSAs), meaning those "forms of action that focus upon directly transforming some specific aspects of society by means of the *very action itself*, instead of claiming something from the state or other power holders" (ibid, 2015: 367; emphasis added).

However, scholarship is yet to investigate DSAs longitudinally and/or upon the institutionalisation of those contentious actors appropriating and utilising them. This has thus far resulted in the accumulation of static, fixed, and often decontextualized, accounts of welfare provision tactics. Stemming from these observations, this thesis opts to advance existing scholarship on DSA tactics, through the elaboration and consolidation of a dynamic and longitudinal approach to their diffusion, modularisation and institutionalisation.

Finally, this thesis attempts to address some of the shortcomings of the literature on movement institutionalisation. Movement institutionalisation has largely been approached through the study of protest movements, and contentious politics' approaches have overlooked DSAs, which offer a great opportunity to delve into and explore movement institutionalisation. As such, I hope to embellish existing perspectives on movement institutionalisation through the close analysis of the institutionalisation of actors involved in the provision of healthcare from below. I argue that

healthcare DSAs are particularly fitting for studying institutionalisation as a process and an outcome of collective action.

This thesis wishes to provide a relational, dynamic and longitudinal perspective to the employment of DSAs by contentious actors in healthcare. This is achieved through thick descriptions and critical analytical accounts of the employment of those tactics before, during and after the cycle of anti-austerity contention- that is over four decades. This case also allows us to investigate the processual dynamics involved in and the transformative potential of institutionalisation. In looking at the institutionalisation of the Social Clinics-Pharmacies' movement, I hope to bring attention to the complementarity of the accounts of institutionalisation as at once a process and an outcome of collective action and study its effects on DSAs, the actors employing them, and their context. I, therefore, would like to contribute to the relatively scarce and sparse literature on movement institutionalisation with the elaboration of a more strategic and interactive framework for its investigation.

### **1.1. The Social Clinics-Pharmacies Movement: iterations of data and theory**

The Social Clinics-Pharmacies' movement emerged at the apex of the Greek austerity crisis, with the intention of intervening onto the politics of healthcare as well as ameliorating the negative effects of the crisis onto population health. The movement was comprised of a number of grassroots clinics and/or pharmacies organising on the national level and operating on the basis of two interrelated principles. On the one hand, they organised and were involved in contentious activities, including demonstrations, protests and pickets resisting austerity in healthcare, advocating for healthcare reform and/or proposing an alternative healthcare system. On the other, they offered free (primary) healthcare services and/or free pharmaceuticals to the ever-increasing part of the population left uninsured and/or impoverished by the crisis. This combination of indirect tactics of contention targeting the state and its officials with healthcare DSAs was rooted in the clinics-pharmacies' overall support and favour for the public healthcare system. As such, the individual clinics-pharmacies that participated in the movement actively resisted and refused substituting the Greek National Healthcare System (henceforth ESY) and pressed for the satisfaction of their appeals for reform as a prerequisite for their dissolution.

Albeit seemingly contradictory, the combination of these tactics allowed the movement to affect opportunities for itself. To be sure, the mushrooming of the Social Clinics-Pharmacies over this period is interesting and worth studying in and of itself. As I hope to show, their tactics of direct mediation into the growing health and care needs of the population quickly became popular, diffused and modular. Moreover, together with other movements and grassroots initiatives, they constituted the wide-ranging Solidarity movement. The Solidarity movement intervened in alleviating economic and

social pressures resulting from the crisis and dynamically transformed the political landscape in Greece. DSAs, especially in the domain of health and care, stood at the core of the repertoire of anti-austerity contention in the country and have become emblematic for it, invigorating visions for social and political change, healthcare and medical reform.

The first problem formulated already in the initial steps of this research was the seeming “unexpectedness” of such tactics in the Greek context. Greek civil society has traditionally been described as “weak” due to the “partitocracy” prevailing over the associational sphere, the paternalistic role of the state and the multitude of clientelistic networks undermining it (Mouzelis, 1995; Huliaras, 2015; Simiti 2017). This picture is complemented by the frequently cited low levels of social trust towards institutions as well as fellow citizens (Sotiropoulos, 2007), in turn used to explain why Greece persistently scores among the countries with the lowest number of volunteers in the EU<sup>123</sup>. The predominant bibliography, thus, paints a picture of a “cachectic, atrophic or fragile” (Hadjiyanni, 2010:20) civil society, characterized by a general lack of “volunteering mentality” and “civic culture” (Clarke, 2015: 69).

The few voices countering this thesis argue that Greek civil society is largely informal and non-institutional, therefore untraceable by European Social Surveys and Barometers (see Sotiropoulos, 2004; Rozakou, 2016). This debate is not of central importance to this thesis; what is important is the “strange” flourishing of civil society over the crisis’ years that most of the aforementioned scholars appear to agree upon. Interestingly, Sotiropoulos and Bourikos (2014) argue that the official volunteer force active in the country did not grow in size, but rather that those voluntary groups involved in social protection against the consequences of the austerity policies expanded their interventions. More specifically, they suggest that “[w]ithout covering the large social protection gap, left over after the welfare state had receded, both formal and informal groups contributed to the rise of social solidarity in Greece” (ibid: 34). This proliferation of social solidarity from below is explained on the basis of (1) the expansion of deprivation to wider social strata, (2) the curbing of state funding for NGOs, and (3) the political projects attached to those informal and grassroots initiatives engaged in solidarity from below. Namely,

“informal organisations do not want to act in a fashion complementing state-driven social protection.

They reject the state and charity activities of the business sector, they want to treat the beneficiaries of

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<sup>1</sup> European Social Survey (2002).

<sup>2</sup> European Commission (2007). Special Eurobarometer 273/ Wave 66.3. European Social Reality [online] Brussels: European Commission.

<sup>3</sup> European Commission (2010). Volunteering in the European Union. Final Report Submitted by GHK. [online] Brussels: European Commission, Educational, Audiovisual & Culture Executive Agency.

their activities as participants in the collective production and distribution of social assistance, and view social solidarity in the context of the economic crisis as part of a wider political movement to construct alternative forms of social and economic life (ibid: 52)".

This gap "between official versions of reality and the facts on the ground" (Marx, 1997: 113) was the very first puzzle of this thesis. Leaving behind conceptualizations of an atrophic or largely extra-institutional civil society, one can reformulate the last point made by Sotiropoulos and Bourikos as a case of repertoire innovation, on the one hand -as informal (here contentious) collective actors increasingly engaged with DSAs in the domain of welfare- and substitution on the other -as informal civil society took on the task(s) previously assigned to formal civil society actors. Instead of pondering over whether and how civil society rejuvenated or expanded over the crisis years, therefore, I approach the puzzle through a social movements' perspective and focus on why and how did tactics of social protection attached to wider political strategies and projects diffuse over the crisis' years. And more specifically, for this case study;

*Why and how did tactics of healthcare and pharmaceutical provision diffuse and modularize among contentious collective actors over the course of the cycle of contention?*

Echoing Bosi and Zamponi's (2015, 2019, 2020) observations about contentious actors employing DSAs in the Italian context, the overwhelming majority of the clinics-pharmacies' stated goal was to mediate and politicize needs, in order to push for health reform that would deem them redundant. That is, the clinics-pharmacies, at least while operating as a movement, wanted their demands for reform to be met, after which they would dissolve and interrupt their operations.

This sets the basis for the second puzzle stirring the direction of this research. Over the course of the contentious cycle, the bipartisan system that prevailed in the country for over forty years disintegrated. As the hegemonic social-democratic party of PASOK (Panhellenic Socialist Movement) was displaced, SYRIZA (Coalition of the Radical Left) saw an unprecedented growth from a marginal to the leading left-wing party in just six years. SYRIZA had numerous members inside solidarity initiatives and was quick to acknowledge the political potential of the movement, and the role of the Social Clinics-Pharmacies therein.

Despite the party's phenomenal growth, SYRIZA did not reach a majority and in 2015 it formed a coalition with the minoritarian nationalist party of AN.EL. (Independent Greeks), on the basis of their shared anti-austerity and anti-memorandum agendas. The accession of the coalition coincides with, if not compels, the closure of the cycle of contention. Once in power, the coalition announced its intentions to design and implement Healthcare Reform, not least in the direction indicated by the Social Clinics-Pharmacies' movement.

As such, SYRIZA invited representatives of the movement -a great share of which already members of the party- to participate as unpaid advisors to the reform effort. A number of volunteers offered their help and in 2016 and 2017 SYRIZA announced two interrelated healthcare reforms that were meant to tackle two chronic problems of the ESY, which, and upon the experience of the crisis, the movement had identified as its main weaknesses. These pertained to the revisiting of admission criteria for coverage by the ESY and the (re)structuring of the feeble Primary Care level in the country. Upon the announcement of the reforms, SYRIZA appointed an ex-activist doctor of the clinics, Andreas Xanthos, as the new Health Minister, responsible for planning and overseeing their implementation. I argue that the involvement of the movement into the reform effort, the resultant reforms, and the appointment of Xanthos into office make up for at least three forms of movement institutionalisation as conceptualised by Ruzza (1997) and Meyer (2007).

Healthcare reform was largely welcomed by participants in the movement; although not everyone saw it as a direct product of their efforts, the majority considered it “a step in the right direction”. It was then that the question of the redundancy of the clinics-pharmacies advanced as central, triggering an intense political debate within the Social Clinics-Pharmacies movement, the Solidarity movement and SYRIZA itself. This period presented movement milieus with dilemmas concerning their strategies and the alignment of DSA tactics therein, paving the way for different trajectories of action in the realm of health and care. Indeed, individual clinics and/ or pharmacies continued their interventions in the provision of healthcare from below but shifted their organizational characteristics and strategic orientations in doing so. This initiated two simultaneous processes; that of movement dissolution and that of the strategic solidification around DSAs.

Upon the announcement of Healthcare Reform in 2016 the Panhellenic Network of the Social Clinics-Pharmacies dissolved, effectively halting the emergence of a Health Social Movement (Brown and Zavestoski, 2004) that could challenge the mainstream medical paradigm propagated by the ESY. What remained constant and, therefore, perplexing is the clinics-pharmacies’ renewed commitment to those tactics of direct provision of care and pharmaceuticals, despite the external and internal shifts they underwent since movement institutionalisation. As we will see, the processes leading up and following movement institutionalisation as well as its products were different for each clinic-pharmacy. For the purposes of this thesis, I attempt to reconstruct what I call those distinct trajectories to and fro healthcare DSAs. These trajectories can be understood as contingent upon the context of austerity and dynamics of anti-austerity contention. At the same time, and as I hope to show, they are informed by strategic interactions in the field of contention. I showcase those trajectories through the exposition of ideal typical cases of clinics-pharmacies. I argue that the various trajectories help highlight the different

pathways to the same form of action, the various negotiations of institutionalisation and, relatedly, the distinct strategic configurations of the same tactics.

To untangle this “paradox of participation”, therefore, I ask;

*What was the impact of institutionalisation on (1) DSA tactics, (2) their place within larger strategies, (3) the collective actors themselves, and (4) their environment?*

## **1.2. Austerity crises, anti-austerity contention**

The relational, dynamic and longitudinal approach proposed in this work opts to contextualize transformations in the realm of (contentious) collective action. As such, the diffusion, proliferation and persistence of healthcare DSAs cannot be understood outside of the socio-economic and political transformations induced by austerity in Greece. For the purposes of this thesis, I consider the context to comprise of the socio-economic environment in the country over the course of the crisis years, the impact of austerity onto healthcare and population health and the political environment affected by the initiation of the cycle of anti-austerity contention. Changes in the repertoire of anti-austerity contention, then, are in direct link and affinity to structural changes.

As scholars before me have argued, anti-austerity mobilisations not only gave social movement studies a new and fresh object of study- they challenged a number of its theoretical and methodological tools developed and established prior to them. As austerity policies and the politics of austerity as a whole gained centre stage in contentious politics in the past decade, the materiality of the economic collapse and concomitant social relations of production had to be brought back onto what was considered either a post-material or post-democratic landscape (Inglehart, 1977, 1990; Crouch, 2000). Della Porta adds that research conducted prior to the crisis historically corresponds to the perceived conciliation of the class cleavage that “risked ‘freezing’ the image of new social movements as new middle-class phenomena” (ibid, 2015). On a more suspicious note, Peterson, Wahlstorm and Wennerhag (2015) find it plausible that it was social movement studies, not Europe, that turned a blind eye on issues of class and socio-economic justice. “Whatever the case” they conclude, “we can no longer neglect the materialist focus of contemporary protest” (ibid: 1).

This break, thus, is empirical as it is theoretical and has overt political implications; as New Social Movement theorisations and concomitant tools borne out of the “end of history” (Fukuyama, 1992) envisioning “social movement societies” that mobilise on the basis of “post-materialist” values, ideas and goals (Inglehart 1977, 1990) seem to be thoroughly outdated, if not blatantly wrong (see also Tejerina, Perugorria, Benski, and Langman 2013; Giugni and Grasso 2016).

In addition, this spark in social movement activity amplified concerns over the discipline's tendency to become inward-looking and movement-centric. Building on existing criticisms over the uneven focus on movements vis-à-vis their environment (McAdam, Tarrow and Tilly, 2001: 42, McAdam and Boudet, 2012:22), McAdam and Tarrow reiterate that although the field developed in interaction with wider audiences, situated in broader disciplines in the 1970s and 1980s, it “quickly grew sufficiently large as to serve as its own primary audience, allowing it to become increasingly insular and self-referential in the process” (McAdam and Tarrow, 2018:32). The authors stress that while research in this direction has yielded very insightful theories concerning collective and contentious action, successfully demarcating a territory for itself, the mobilisations in the aftermath of the 2007 financial crisis beg for opening up the scope of the analysis as well as for contextualising it within broader political, economic and social environments that shape and inform it.

The collapse of the financial system in the US in 2007 triggered a global economic crisis, with massive effects onto national economies and democratic systems and with direct impact onto people's lives. Reaching Europe and its institutions, the financial crisis fed into the sovereign debt crisis of the European South, as international pressures for economic stability imposed internal devaluation in combination with a series of austerity measures. During this period, the Southern European countries saw a grave relaxation in labour relations, growing unemployment, accumulation of debt, mass privatisations, and shrinking GDPs, accompanied by sharp cuts in welfare provisions for their ever-growing vulnerable populations (Armingeon & Baccaro, 2012; Stuckler & Basu, 2013; Kentikelenis, 2017). The unwillingness of the International Monetary Fund (IMF), the European Central Bank (ECB) and the European Union (EU) to change their agenda created a vicious cycle of austerity and depression, restricting policy options for national governments, and challenging the democratic legitimacy of national governments, transnational and international institutions in the maelstrom of the crisis.

In response to these transformations in the European periphery, a wave of contention arose in Southern Europe, challenging national and transnational authorities, the financial system, destabilising existing political systems and threatening the integrity of the European Union. Greece was perhaps the country that attracted the most attention, scholarly and political, during this period. The crisis in Greece, or the Greek crisis, or the crisis of Greece; the recession, or the debt crisis; the European crisis, the crisis of capitalism, or the crisis of neoliberal policies, were all used to describe the same phenomenon but through different lenses, diagnostic and prognostic frames, sets of perpetrators and victims.

Amidst this economic and political climate, Greece entered into a long period of debt relief, in the form of Memoranda of Understanding (henceforth MoU), provided with conditionalities from the European

patrons. These Memoranda prescribed policies aiming to reduce public debt and regain market confidence in the country through measures of internal devaluation and harsh austerity. To be sure, during this period Greece saw the grave deregulation of its labour market and the restructuring and depletion of its welfare and healthcare systems. The combination of these debt servicing policies drove the country in a vicious cycle of debt-deflation depression. This term, coined by Fisher (1933) in his analysis of the Great Depression, led to a “great paradox” whereby “the more the debtors pay, the more they owe” (ibid: 334).

All of the above stirred great political upheaval in the country, which, as in other settings following the recent financial crisis, saw the initiation of a long and eventful cycle of anti-austerity contention. As I wish to illustrate in this work, the successive waves of contention affected repertoire innovation in the direction of DSAs. This innovation was triggered by the return to collective claims for citizenship and social rights (della Porta, 2017) and can be traced back to the decentralization of contentious collective action from central squares to neighbourhoods, its specialization into particular affected domains, and an overall shift towards service and goods’ provision tactics to mitigate the effect(s) of the crisis.

The dismantlement of the ESY, as we will see in this thesis, provided the opportunity and the threat for mobilisation in the healthcare arena. To be sure, the growing demand for healthcare services and coverage led to the collective specialization around issues of health and care, and in 2012 we see the establishment of numerous clinics-pharmacies around the country, operating in the name of solidarity and fighting against healthcare austerity whilst advocating against the combined impact of austerity onto health. I argue that this case provides a great opportunity for studying both the concrete effects of austerity onto the social, political and biological bodies, as well as a prism for understanding the diffusion and modularization of mediation tactics in the twilight of the welfare state.

### **1.3. Anti-austerity DSAs**

In investigating the relationship between contention and context, tactical choices have advanced as particularly relevant. More specifically, and building on Tilly’s (2004) critique of social movement studies, della Porta (2015) has urged scholars to return to his contribution on the repertoire and study its evolution as a means of remedying tendencies to dehistoricise contention.

Tilly (1986) abstracts from the various repertoires of contention to a more general repertoire incorporating all the different tools available to the population for the purposes of claim-making. This generalisation serves to highlight the relationship between what people do, that is what is expressed and mobilised in collective contentious action, what they know to do and what society expects them to do. As such, the repertoire is a relatively hard convention made up of tools at the disposal of contesters to make claims. The tools, their appropriateness and effectiveness are structured and *structured* historically,

and movement actors are called upon to choose among those most likely to advance their goals and cause. The repertoire is, thus, a “set of performances available to any given actor within a regime” (Tilly, 2003: 45) configured through the interaction between the contours of the said regime and its tactical employment on the ground.

To reiterate, Tilly’s work on the emergence and development of the modern repertoire of Great Britain (1993) and France (1986) serves to show how larger socio-economic transformations, such as the advent of the industrial revolution, the solidification of the state and the consolidation of national markets impacted on patterns of socio-political organisation, giving way to new claims, negotiated between and articulated by emergent collective actors. These transformations, naturally, birthed new tactical forms alongside their collective vehicles, that is social movements, which are historically specific to the development of the nation-state and modern capitalism.

The repertoire can, thus, be studied as a lens for unearthing broad patterns of power and conflict without losing sight of its interactive and relational dimension, as its very definition involves negotiations among actors in its utilisation and enactment (performance). The evolutionary and transformative dimensions of the repertoire are also inherent in the concept and, as such, it can only be studied by giving the same amount of analytical emphasis on the (historical) context in which it emerges as much as on its (co)production and innovation on the meso- and micro-levels. The repertoire can, therefore, be thought of as evolving through time and space.

As mentioned above, this thesis was inspired by the observed shift in collective action forms from indirect to direct tactics. Although not replacing indirect forms of action, such as strikes or the demonstrations, the Greek anti-austerity cycle of contention saw the diffusion and modularisation of DSA tactics to ameliorate the effects of the economic crisis, so much from social movement actors, as well as alternative communities, solidarity collectives, resilience groups and NGOs.

These observations have led to a growth in the literature around such direct tactics, understood as “alternative”, “solidarity” and “resilience” tactics that result from deficits, either in the realm of welfare and/or democratic politics. Ultimately, scholars working on those tactics expect them to replace protest waves (Forno and Graziano 2014; D’Alisa, Forno and Maurano, 2015; Kousis and Paschou, 2017). These accounts are very valuable, especially in mapping the field of these initiatives and rooting them into the austerity context. I argue, however, that they suffer from a lack of sufficient operationalisation of those tactics and of proper systematisation of those actors employing them; weaknesses that ultimately limit their analytical potential.

It is for this reason that I utilise Bosi and Zamponi’s (2015) conceptualisation of DSAs, which I consider to represent the most analytically sensitive approach to the tactics investigated in this thesis.

More specifically, and according to the authors, DSAs constitute an inclusive category that captures those tactics aimed at unmediated social change, that is, tactics that wish to bring about change by means of their mere intervention. They, then, clarify between those tactics and indirect claims-making tactics which imply the mediation of change by the state and/or other authorities and powerholders. I argue that this sets the ground for observing the potential strategic combination and/or political complementarity between these two sets of tactics. In addition, it allows scholars to analyse those instances where one tactical set is preferred over the other and to distinguish between the different levels of their employment, that is between instances of repertoire innovation, on the meso-level and repertoire transformation, on the macro-level.

As we will see later in this work, Bosi and Zamponi's definition of DSAs paves the way to a number of findings relevant to this work. First, it allows them to make a case over the historical affinity of DSAs to the context under investigation, that is contemporary Italy. This, in turn, sets the ground for analysing their proliferation, at least in terms of visibility, in times of economic crises. Moreover, their concrete differentiation between the collective actors engaged in DSAs allows the authors to identify the areas of intervention each actor is involved in, and thus infer the principal role of contentious actors in welfare provision. The authors then demonstrate that DSAs have the potential to travel over time and across sets of actors and, as such, to be reappropriated and refashioned. We understand, therefore, that a clear conceptualisation of DSAs goes beyond their understanding as resilience tactics dictated by relative deprivation. On the contrary, their analysis highlights the strategic dimension of the employment of DSAs that mediates structural and tactical changes.

In a later work Zamponi (2019) and Bosi and Zamponi (2019, 2020) focus their inquiry onto those contentious actors that prevail in the scene of welfare provision, to reconstruct the reasons for their tactical utilisation of DSAs and account for the latter's place within larger political strategies. In brief, these tactics are explained as responses to the economic crisis, the retrenchment of the welfare state, as well as the observed decline in political participation. The strategic motivations of the actors are therefore coming to the surface, and it becomes apparent that actors that have perceived a relative failure to mobilise and/or extend their constituencies during the crisis years' -which for them should otherwise constitute an opportunity-, change their strategy as witnessed by their change in tactics. In this way we can consider DSAs as resulting from political strategies that aim at mediating the "politicisation of the need" and the "social" in an environment where neither is implied.

Finally, in undertaking this reconstruction the authors unearth the inherent tensions, if not contradictions, in the employment of welfare DSAs by contentious milieus. To be sure, these collective actors are critical and cautious of the use of DSAs as those could potentially work as substitutes of the

collapsing welfare state. The politicisation potential of DSAs is thus understood as at once a strategic goal and the “antidote” to the peril of substitution inherent in these tactical forms.

This thesis lends the definition of DSAs and analytical approach put forward Bosi and Zamponi, to zoom into those tactics of direct healthcare and/or pharmaceutical provision in the Greek context. In so doing, I aspire to complement their work in three directions. First, this thesis hopes to enrich existing accounts on DSAs through the elaboration of their utilisation in the domain of healthcare. The healthcare arena is markedly distinct from that of welfare, and as such offers a particular environment for the employment and strategic utilisation of DSAs. In addition, and similarly to Bosi and Zamponi (2015), this thesis broadens the temporal scope of the analysis to identify those precursors of contemporary healthcare DSAs. This allows to uncover the genealogy of this particular tactical set as originating in marginal, extra-institutional and informal collective actors, to trace its diffusion and various re-appropriations during the cycle of contention. Last, this thesis follows those tactics outside of the cycle of contention, and upon the institutionalisation of the Social Clinics-Pharmacies’ movement. This shall complement accounts on DSA tactics through an elaboration on the impact of institutionalisation onto them, the collective actors employing them and the healthcare arena. This perspective shall provide a more holistic account of the evolution of the repertoire and constitutive tactics therein, and shall inform and enrich existing scholarship around institutionalisation.

#### **1.4. Healthcare arena**

Notwithstanding their close affinity and various overlaps, welfare and healthcare systems are distinct and should not be conflated (Moran, 2000). This bears implications for those tactics that mitigate their retrenchment by mediating their provision. In what follows, I attempt to sketch the healthcare arena, to decipher the possibilities offered by and limitations posed in the use of healthcare DSAs by contentious actors.

Healthcare systems necessitate and absorb greater resources, material and human, than most domains of welfare provision. This invites a wide range of powerful actors and their vested interests into the healthcare arena, making it a heated ground for competition. On the one hand, the state is strongly incentivised to intervene in matters of health, care and illness, primarily to minimise the political costs of inequality and the economic costs of sickness. The state is responsible for overseeing health and care, it has monopoly over the licensing of healthcare professionals and the regulation of (bio)medical and pharmaceutical products and practices.

Medical professionals are also central in health policy and more generally, according to sociologists of professions, among the most powerful professional groups writ large. Building on Freidson (1970), scholars agree that doctors have historically established their “dominance” over other healthcare professions and have acquired “clinical autonomy” from other health workers, their constituencies and the state. This autonomy has clinical, economic and political implications, that include the acquired right of medical professionals to regulate and oversee medical practice, to decide on their compensations and to affect healthcare policy as experts (Elston, 1991). More recently, scholars have raised our attention over the decline in the relative status of doctors, as resulting from the “deprofessionalisation, proletarianisation, corporatisation and bureaucratisation” of their professional group (Calnan, 2015: 293). Despite these observations, scholars agree that doctors’ expertise and, therefore, indispensability for healthcare systems, whether public or private, still grants them a place at the centre of the healthcare arena.

Another important player is the market. As noted in the relevant literature, the scientific, (bio)medical and pharmaceutical market(s) have an increasing role in health politics. Healthcare professionals and scientific experts often have double affiliations with the state and the market and can operate either as gatekeepers of the state or mediators of biomedical and/or pharmaceutical corporations (Carpenter, 2012: 299). The healthcare market also exhibits some idiosyncrasies. Scholars contend that healthcare goods are at once consumption goods and investments as their purchase and allocation is mediated by physicians, an arrangement that is inherently distorted by information asymmetries. In addition, in most healthcare systems, healthcare goods are compensated for by third parties, that is insurance funds, while co-payments on the side of the consumer usually involve only a share of the total price of the product (Foland et al, 2016; D’Cruz and Kini, 2007). Last, some note that the healthcare market rests on a distinct premise, as the consumer purchases healthcare which is a “surrogate need”, not the “direct need” that is their health (Sorato et al., 2020).

Civil society and, in particular, social movements also participate in and affect the healthcare arena. Although having received relatively little scholarly attention, Health Social Movements (henceforth HSMs), understood as “collective challenges to medical policy, public health policy and politics, belief systems, research and practice which include an array of formal and informal organisations, supporters, networks of co-operation and media” (Brown and Zavestoski, 2004: 679) have great transformative potential for the healthcare arena. In summarising the relevant literature, I argue that HSMs have historically affected healthcare systems, medical policy and practice, they have devised potent equality claims and justice frames that later informed wider struggles, and have constructed and/or disrupted existing identities, cleavages and common assumptions on health, illness and their causal links (Satre,

1982; Shakespeare, 1993 ; Epstein 1996; Hamlin, 1998; Brown and Zavestoski, 2005; Crossley, 2006; Banaszak-Holl et al. 2010; Brown et al. 2012; Taylor and Zald, 2013; Bracke, 2014).

Having deciphered the main actors, their asymmetries and co-dependencies, we can begin to shed light onto the potential of DSAs in the healthcare arena. As I hope to show in this thesis, healthcare DSAs affect opportunities for contentious actors while, at the same time, make them particularly susceptible to institutionalisation, in ways that may not affect their welfare counterparts. This is in line with the relevant literature that looks at the institutionalisation of the Hospice movement in the US during the 1970s and 1980s, and the Women's' movement in 1970s Italy.

Briefly, these movements were counter-institutional and had forged their own system of healthcare provision from below. The Hospice movement did so by creating its own hospices, which consisted of interdisciplinary teams that cared for the terminally ill. These initiatives were inspired by the “counter-institutions” of the 1960s and aspired to advance compassionate care and challenge the sovereignty of physicians at least in the management of care for the incurables (Abel, 1986). Similarly in Italy, and over the course of the intense debate concerning the legalisation of abortion, the Women's' movement alongside other sympathetic groups established their own clinics, known as *Consultori Autogestiti*, that offered services of reproductive health, including contraception and abortion (Bracke, 2017). Despite their differences, both movements challenged the medical establishment and prefigured an alternative to the healthcare model. However, both movements and their practices, were absorbed by the respective healthcare systems at the peak of the diffusion of their propagated paradigm. More specifically, hospices were incorporated into Medicare to soon expand as for-profit enterprises, while the *Consultori* were absorbed by the Italian National Health Service which transformed them into Family Clinics.

In synthesising the aforementioned case studies with my own, I argue that, unlike welfare DSAs, healthcare DSAs are guided by medical humanitarianism. This corresponds to a particular hierarchisation of strategic goals, that centre around the provision of medical services and related products with the intention to preserve and better life. As issues of “life and death” come to the fore, healthcare and medical reform follow as secondary and tertiary priorities of collective action. This medical (-pharmaceutical) focus, moreover, restricts tactical choices for contentious actors to options that imply high costs. To be sure, and reflecting the very systems in which they intervene, healthcare DSAs are more “expensive” than those of welfare, both in terms of material and human resources and related “costs”.

Healthcare DSAs, at least in the case of the Social Clinics-Pharmacies, take the form of the provision of healthcare services by licensed doctors, and the distribution of regulated products by licensed

pharmacists. State-issued licensure is, therefore, central to the legitimisation of those tactics both in the eyes of the state and in the eyes of the recipients of healthcare DSAs. The more legitimate these initiatives are, however, the less flexible they become, and the more susceptible to activists' "burn-out" at the impossibility of replacement and rotation. In addition, the employment of such tactics often relies on expensive infrastructure and technologies, which, no matter how advanced, can never "compete" with a coordinated and fully integrated healthcare system, that offers comprehensive care and can guarantee its safety and continuity.

A last characteristic of healthcare DSAs pertains to the constituencies it targets. As we will see in this thesis, the Social Clinics-Pharmacies' intention to politicise health, care and austerity, and in some cases, even the mainstream medical paradigm, proved difficult when addressing people who carry the double burdens of illness and poverty. In many cases, recipients were physically incapable of actively participating in the movement, thus multiplying the costs of collective action and leading to frustration on the side of the activists.

Departing from Bosi and Zamponi's remarks on the risks implied in the utilisation of welfare DSAs by contentious actors, this thesis wishes to unpack the tensions inherent in healthcare DSAs. These tensions and contradictions mirror the opportunities offered to and limitations encountered by contentious actors who employ healthcare DSAs and intervene in the healthcare arena, *pace* Jasper (2004). This will allow for the reconstruction and analysis of the strategic dilemmas those collective actors faced, their subsequent decision to institutionalise as well as the seemingly paradoxical outcomes of this institutionalisation onto those collective actors, their tactics and strategies. I expect that the focus onto the healthcare arena will bring important analytical insights so much in the direction of institutionalisation, as well as advance the relevant literature on healthcare activism.

## **1.5. Thesis structure**

Chapter Two, introduces the most important theoretical tools employed in this study through an overview of the relevant literature and concomitant debates in contentious politics. More specifically, the chapter begins with a presentation and discussion of the scholarship around tactics, to showcase the empirical and theoretical potential offered in the study of DSAs. In addition, the chapter introduces James Jasper's concept of the "players and arenas" (2015) which prologues this study's theoretical approach and proposes a method for proceeding it. In so doing, I chapter presents some of the limitations of Jasper's strategic interactionist framework and suggest some improvements. Last, the chapter introduces the concept of movement institutionalisation. After scrutinising the available research, the chapter closes with a suggestion of a relational, dynamic and longitudinal perspective to

the institutionalisation of the Social Clinics-Pharmacies' movement, and its contribution to social movement scholarship.

Chapter Three provides a critical account of the methodology employed for the completion of this research. This includes a presentation of the research design and research questions, a presentation, justification and operationalisation of the case(s) studied and the methods used. The chapter opts to provide a clear and honest account of the long and iterative development of this work and bring attention to the benefits reaped from and weaknesses of this endeavour. It closes with a non-exhaustive discussion on the ethics and the politics inherent in this work and some reflections on my approach to this research.

Chapter Four approaches the healthcare arena through a historical institutionalist perspective. More specifically, it wishes to provide a picture of the Southern welfare and healthcare systems, and account for their developmental and institutional characteristics. Zooming into healthcare, the chapter presents the key characteristics shared among the different Southern European systems, to then move on with a longer and more detailed bibliographical overview of the development and evolution of the Greek National Healthcare System. This chapter wishes to set the scene for the institutional characteristics and shortcomings of the healthcare system in Greece prior to the crisis, and offer a better understanding of those rupture points within the system and the collective stakes articulated over the crisis years by collective actors intervening in the healthcare arena.

Chapter Five is the first empirical, analytical chapter and it is a historical reconstruction of the healthcare arena as an arena of political contestation since the development of the ESY in 1983 and until the crisis in 2010. This long, but relative to the cycle of contention, quiescent, period serves to identify the key actors that form the political arena around healthcare, and informed collective claims and demands on healthcare delivery and practice in the country. To be sure, this period is overwhelmingly dominated by the vested interests of the medical professional group. In addition, this chapter tracks and traces other relevant actors, including the various sickness funds, state bureaucrats and the broader trades union movement that also made claims and interventions in the arena, in the direction of path-dependency. The main novelty of this chapter is the discussion of those marginal actors intervening in the arena using innovative tactics, including healthcare DSAs. The discussion of the arena prior to the crisis serves to set the scene for its transformations during the years of the crisis.

Chapter Six is dedicated to the period of the crisis and the cycle of contention, stretching between 2010-2015. In this chapter, I provide an overview of the austerity-induced crisis and its impact on health. The sum of the data provided in this chapter wish to conclude to the counter-cyclical effects of austerity onto population health and public healthcare. In addition, the cycle of contention and its three

constitutive waves is also presented in this chapter, exemplified through the thick description of five ideal-typical clinics(-pharmacies) that were established in this period. As such, it brings together the economic and institutional context of the ESY, with broader dynamics of contention, to present and animate those actors involved in healthcare provision from below. This chapter focuses on the explication of those processes leading to the diffusion and modularisation of DSA tactics in the healthcare arena and the repertoire of anti-austerity contention. The idea of trajectories for each ideal-type is also introduced in this chapter, to further help illustrate strategic divergences following the closure of the cycle of contention and the institutionalisation of the Social Clinics-Pharmacies' movement.

Chapter Seven follows these actors between the period of 2015-2019, that is after the movement-ally party of SYRIZA has come to power, a transformation that acted as a catalyst for movement institutionalisation. This chapter wishes to explicate movement institutionalisation as at once a product and a process of strategic interaction among a plethora of actors animating the healthcare arena. In addition, the chapter unpacks the seeming paradoxical decision of the various clinics-pharmacies to continue with their healthcare DSAs upon movement institutionalisation, movement dissolution and the announcement of Healthcare Reform. As we will see, the trajectories already carved during the cycle of contention are concretised over this period. In this way, we see tactical convergence between the different collective actors, but strategic divergence, as the same tactics shape and inform different strategies depending on the collective actors' (1) ideological origin, (2) interaction with the state and (3) interpretation of the crisis. As I hope to show, the combination of these characteristics serve as predictors for each clinics' interpretation of the Healthcare Reform and configure each clinics-pharmacy's strategic employment of healthcare DSAs after the Social Clinics-Pharmacies movement has dissolved.

Chapter Eight is the concluding chapter, which brings together the concluding remarks of this research. In so doing, it reflects on the consequences of neoliberalism onto health and care, as well as the role of DSA tactics and the third sector in mitigating and/or enabling healthcare system retrenchment. The chapter also offers a direction for enhancing the findings and arguments of this work. Last, the chapter presents some reflections on the implications of the COVID-19 pandemic and the relevance of healthcare activism today.

## 2. Theoretical departures

### 2.1. Introduction

This thesis represents an attempt to advance social movement scholarship in at least three directions. First, it wishes to enrich existing scholarship on the repertoire of collective action and the dynamics of its innovation by considering and firmly embedding Direct Social Action tactics therein. As we will see, DSAs offer a unique opportunity to study tactical negotiation, appropriation, diffusion and modularisation, as they represent a set of understudied tactics that focus upon affecting direct and immediate social change.

In addition, and in so doing, this thesis opts to embellish recent accounts on welfare DSAs by adding a longitudinal and dynamic approach to their employment, and an additional focus on those DSAs focusing on healthcare. To do this, I propose a perspective that considers tactical choices and strategic dilemmas as consequential for the tactics employed, for the collective actors employing them, and for the context in which they intervene. In so doing, I identify and trace those contentious actors employing healthcare DSAs to decipher their interactions before, during and after the cycle of anti-austerity contention. This perspective should account for transformations in the patterns of collective action over time, thus setting the scene for investigating the institutionalisation of the Social Clinics-Pharmacies' Movement.

The institutionalisation of the case studied here is understood as the outcome of the popular and, indeed, successful utilisation of healthcare DSAs during the cycle of contention. At the same time, institutionalisation cannot be understood as anything less than a process animated by collective action and consisting of the strategic interactions between the different actors employing DSA tactics, the state as well as broader constituencies within the healthcare arena. In approaching institutionalisation as at once a process and an outcome of collective action, this thesis wishes to unravel those successive steps in the transformation of the healthcare arena and its players as well as unpack the impact of institutionalisation onto those sets of tactics, the actors employing them and their environment. Last, and through my investigation of the institutionalisation of a movement that oriented itself to the provision of healthcare from below, I wish to contribute to the literature on movement institutionalisation.

In what follows I present the main theoretical tools employed in this study. As we will see, these tools are configured through the triangulation of three lines of literature namely but not exclusively pertaining to tactics, strategy, and institutionalisation. This chapter begins with a discussion on the most important theoretical innovations regarding the repertoire of contention and its constitutive tactics, to

introduce those concepts relevant for the subsequent analysis. As explained below, this overview is organised in a way of highlighting the analytical potential offered in rooting DSA tactics within the repertoire of contention. I argue that more so than any other tactics DSAs are employed by a plethora of collective actors, while their contentious employment is highly contingent and often presents tensions for those actors employing them, if not paradoxes for those strategies including them. In order to identify the relevant actors, uncover the tensions and analyse their employment, I utilise Jasper's (Jasper and Duyvendak 2015) approach of players and arenas. Last, this chapter provides a critical overview of the perspectives on movement institutionalisation. Existing scholarship is divided between those approaching institutionalisation as a process and those approaching it as an outcome of (successful) mobilisation. My proposed approach wishes to bring to light the complementarity of those perspectives, to conclude with a proposition of a relational and dynamic perspective on movement institutionalisation.

## **2.2. Tactics**

The repertoire of contention and/or collective action is among the most potent analytical tools developed by social movement studies. Rooted in the political process approach, the repertoire has been used to decipher the links between shifts in the politico-economic environment and the forms that (contentious) collective action takes over time and across settings. As such, the repertoire offers researchers a unique opportunity to study the dynamics of collective action as those unfold in particular contexts, without losing sight of their strategic employment on the side of those actors choosing to enact them.

More specifically, the repertoire represents an abstraction of the various tactical forms chosen by collective actors to a broad toolkit a population has at its disposal for the purposes of mobilising and affecting change. In summarising and synthesising the relevant literature, I decipher two broad approaches to the repertoire; one that focuses on tactics of social change (here strategy-oriented tactics) and one that looks at tactics of personal change (here identity-oriented tactics).

### **2.2.1. Strategy-oriented tactics**

#### *2.2.1.1. Dynamics of Repertoire Transformation*

As already mentioned in the introduction of this thesis, Tilly (1978) first conceptualised the repertoire as “consist[ing] of the various forms of activities that are used by challenging groups in a given historical period” (ibid, 366). Through his analysis of the transformation of contentious politics in Britain (1995), Tilly shows the gradual transition from direct to indirect action tactics over the course of

the eighteenth and nineteenth centuries, to conclude in the overall predominance of the latter in what we today consider the modern repertoire of contention. Tilly's historical analysis allows him to link the transformation of tactical forms, and subsequent modularisation of indirect tactics, to macro-level transformations that include the development of capitalism and the concomitant consolidation of nation-states as prime targets of contention. To understand how the repertoire becomes innovated, the author contends;

“Repertoires are learned cultural creations, but they do not descent from abstract philosophy or take shape as a result of political propaganda; they emerge from struggle. People learn to break windows in a protest, attack pilloried prisoners, tear down dishonored houses, stage public marches, petition, hold formal meetings, organise special-interest associations. In any particular point in history, however, they learn one a rather small number of alternative ways to act collectively” (ibid: 42)

#### *2.2.1.2. Dynamics of Repertoire Innovation*

Building on Tilly (1986) and in trying to account for the transformations of the repertoire through time, Tarrow (1993) speaks of moments of heightened contention that initiate cycles of protest and can, potentially, contribute to the evolution of the repertoire. More specifically, in lending Zolberg's (1972) concept of “moments of madness” that the latter developed to explain the processual transformation of discourse among and through movements, Tarrow applies it to the repertoire as a broader cultural toolkit of political intervention and social interaction. He concludes that moments of madness have the same impact on the repertoire as they do on discourse, that is they provide it with an opportunity to become modular, diffused and (to an extent) socially absorbed as mediated by changes in public policy. Tarrow's contribution links Tilly's macro-perspective on the transformation of the repertoire, with the exposition of those meso-level dynamics contributing to its innovation.

To be sure, and to reiterate Tilly (1995), innovations in the repertoire, that is in the particular forms of action taken by contentious actors, happen very rarely and when they do, they result from processes stretching over long and protracted periods of time. Once initiated, protest cycles and their internal dynamics play a significant role in modularising a form of action. That is because cycles of protest constitute “laboratories” for the repertoire's application, experimentation and assessment (ibid: 284; see also, Wada, 2012). What is more, Tarrow defines those cycles by this transformative attribute. More specifically he argues that;

“[a] final characteristic of protest cycles is perhaps their most distinctive trait: they are crucibles within which new weapons of social protest are fashioned. [...] The most successful and the most transferable become part of the future repertoire of collective action even during quieter times. In a number of cases, forms of collective action are not merely the instrumental means that people use to demand new rights

and privileges; rather, they themselves express the rights and privileges that protesters are demanding and are diffused as general expressions of their claims and similar ones” (Tarrow, 1993:286).

#### 2.2.1.3. *Dynamics of Repertoire Diffusion*

This perspective was later complemented with accounts of the repertoire’s capacity to diffuse across space and time and therefore acquire its durability. Space, understood as both literal (geographical) and metaphorical (across actors), and time provide crucial analytical tools onto the study of the repertoire as they highlight its structural, cultural and interactive properties. More specifically, the very capacity of the repertoire to “travel” invites us to follow its journey and subsequent transformations across institutional and political settings. In addition, its diffusion urges us to consider wider sets of actors in its animation, legitimation and delegitimation, either through instances of tactical diffusion across movements, across different actors, or objection and obstruction by challengers. In summarising Tilly’s contribution, Doherty and Hayes (2018) highlight that “tactics are the result of an interaction: the repertoire does not belong to any one set of actors, but is produced through the encounter between different sets of actors (ibid: 274).”

#### 2.2.1.3. *Dynamics of Repertoire Preservation*

Meyer and Whittier (1994) build on Tarrow’s cyclical approach to contention and propose the concept of the “social movement spillover” as a (political) processual approach to the continuity between movements and their effects. Meyer and Whittier focus on tactical repertoires to look at how interactions between movements as well as between movements and the state, alter the field of threats and opportunities for present and future movements. In this way, we can see collective action as organic, alive and consequential, as “[c]lusters of movements [...] flourish and decline in cycles as states respond to movement challenges and alter opportunities available to contemporary and subsequent movements (ibid: 279; see also Meyer, 1993; Tarrow, 1991)”. Building on the interactive nature of the repertoire, these accounts, thus, prove Tarrow’s (1993) hypothesis and empirically showcase its transformative potential for the very tactics chosen, the actors utilising them as well as their environment, thus linking meso- with macro-level shifts.

As such, we see that the political process approach has concentrated around these protest tactics employed by social movement actors to address the state. These tactics reflect configurations of power, they are innovated in the context of protest cycles which allow for their testing, diffusion and subsequent modularisation and ultimately alter the socio-political context in which contention takes place, feeding back subsequent transformations in tactical forms (Brockett, 1995; Tarrow, 1998). Despite the relevance of these contributions, and albeit Tilly’s (2004, 2008) warranted caution,

subsequent scholarship on the repertoire as a strategic toolkit to affect social change placed an uneven emphasis onto those visible and indirect contentious forms over other tactics, examined mostly during times of generalised upheaval and restricted its focus on the dialectics between social movements and the state, over other relevant actors and interactions.

## 2.2.2. Identity-oriented tactics

### 2.2.2.1. *Dynamics of Repertoire Transformation*

These shortcomings were to a large extent addressed, albeit implicitly, by the New Social Movements (henceforth NSMs) of the 1960s. Much like the anti-austerity movements discussed in the introduction of this thesis, NSMs empirically challenged existing theorisations of contentious collective action, thus prompting the development of new theories that could best address and analyse them. Alberto Melucci (1985, 1993, Melucci, Keane, and Mier, 1989) was among the most notable scholars of NSMs. To be sure, if Tilly's account of the emergence of the modern repertoire was rooted in an ontology of the macro-historical transformations brought about by capitalism, including the rise of social movements as vehicles and expressions of contention, Melucci's contribution raises awareness over the "paradoxes of post-industrial democracy" and calls for the development of new and more adequate conceptual and analytical tools to study contention in late capitalism.

For Melucci, NSMs mirror the political transformations brought about by modern societies' transition to service industries. These transformations pertain to the corrosion of the affirmed unity and homogeneity of both the state and civil society, which served as a prerequisite to the legitimacy of representative democracy. More specifically, and in his words;

"this distinction between the state and civil society, upon which the political experience of capitalism was based, is fading. As a unitary agent of intervention and action, the state has dissolved. [...] Even civil society, at least as it was defined by the early modern tradition, appears to have lost its substance (Melucci, 1993: 187)".

The disintegration of both spheres of the state and civil society, in turn, sets into motion two competing forces; on the one hand political institutions prod for citizen integration and participation, on the other social groups strive for their autonomy from state paternalism. This resistance is best captured in NSMs' efforts to demarcate their collective identities vis-à-vis political institutions, and their mobilisation to resist the integrative pressures of the state (Melucci, Keane, and Mier, 1989). These observations led Melucci to denounce the term "social movement" as belonging to a "semantic and conceptual framework" of a different era, and propose the concept of the "submerged networks" as a temporary correction and adjustment anticipating more effective conceptual tools.

#### 2.2.2.2. (*Latent*) *Dynamics of Repertoire Diffusion*

Melucci's "submerged networks" historically correspond to "a morphological shift in the structure of collective action (ibid, 1985: 800)", a shift that consists of multiple and parallel memberships of short-term militantism coupled with life-long affective commitment and solidarity to particular cultures and ways of being in the world. This morphological shift, naturally, impacts the dynamics of contention. As such, "moments of madness" that foster contentious action and prompt the evolution of contentious tactics, lose their centrality to periods of latency, which represent the habitus of the submerged networks. More specifically,

"[actors] become visible only where a field of public conflict arises; otherwise they remain in a state of latency. Latency does not mean inactivity. Rather, the potential for resistance or opposition is sewn into the very fabric of daily life. It is located in the molecular experience of the individuals or groups who practice the alternative meanings of everyday life" (Melucci, Keane, and Mier, 1989: 71).

Periods of visibility, then, are dialectically linked to periods of latency. More specifically;

"[l]atency allows visibility in that it feeds the former with solidarity resources and with a cultural framework for mobilisation. Visibility reinforces submerged networks. It provides energies to renew solidarity, facilitates the creation of new groups and recruitment of new militants attracted by public mobilisation who then flow into the submerged network" (Melucci, 1985: 801).

To be sure, this emphasis on latency not only compensates for the uneven scholarly focus around protest cycles and tactics. NSM accounts of collective action shed light onto new organisational and tactical forms, reflecting broader socio-political transformations. New Social Movements are products of "multipolar action systems", configured around the orientation of the relations towards the "ends" of collective action, its means and its environment. From this perspective, Melucci's theory is harmonious with the existing political process model in that the repertoire is "the concrete link between orientations and systemic opportunities/ constraints" (Melucci, 1985: 620). NSM theory's (or theories') innovation lies in its (or their) assertion that post-industrial society posits new stakes in domains that fall outside -or are irrespective of- the existing political institutions. As such, the message brought forward by the said movement is the movement itself, deeming its repertoire "self-referential" of -if not tautological to- the movement (Vahabzadeh, 2001).

At this point, it is important to reiterate the epistemological break represented by the aforementioned scholars. The contentious politics approach, best exemplified by Tilly, approaches contentious politics as deriving from a historical shift from direct to indirect forms of action, corresponding to the advent of capitalism and its impact on social and political relations. As such, indirect tactics -in the form of the repertoire- are by definition visible responses to the web of political opportunities and threats,

intending to exert pressure on the state, recognised as the primary agent of social representation and responsible for advancing movements' demands.

On the other hand, Melucci's concept of New Social Movements is borne out of the end of social and political representation, and the displacement of political by cultural struggles. As such, the state is no longer a viable target, and contentious actors need not necessarily make their demands and claims public. Instead, emphasis is given to the cultural cues activist circles deem appropriate and legitimate in affecting change in their own lives and communities; changes produced, reproduced, diffused and strengthened through submerged networks during periods of latency. The sum of the above characteristics of NSMs, then, represent a return to direct forms of action that are inherently identity-oriented. It is in this light that the repertoire can be extended to include all forms of tactics- visible or not- as long as those are conscious and intentional by the actors partaking them.

Partly inspired by Melucci's vision, recent scholarship has attempted to bridge the structuralist-institutionalist approaches to contentious politics with what was seen to be the New Social Movements' preoccupation with challenging cultural hegemony to better clarify "the type of relations existing between cultural and political processes in movements, and those between movements and wider society (Yates, 2015: 4)" as the one is seen to be collapsing into the other- even if partially (see also Taylor 1989; Melucci 1996; Staggenborg 1998; Staggenborg and Taylor 2005).

#### 2.2.2.3. *(Latent) Dynamics of Repertoire Preservation*

Such studies have advanced understandings of the continuity of the repertoire and movements through "abeyance structures" in periods of movement "decline and equilibrium (Taylor, 1989), or through "movement communities" brought together by "movement culture" and capable of "maintaining movements during the 'doldrums'" (Staggenborg, 1998: 181; see also Rupp & Taylor, 1987). More recent attempts to account for the interplay between structure and culture in movement continuity can be traced back to Polletta's operationalisation of "free spaces" as "repositories of cultural materials" for future generations of movements (McAdam, 1994, in Polletta, 1999). These include analytical accounts of those micropolitics of movements, that is those every day and routine tactics that create and sustain collective action through the development of collective identities, alternative cultures, and practices (Futrell and Simi, 2004; Glass, 2010; Yates, 2014).

#### 2.2.3. Intervention-oriented tactics

The demarcation made above between the "strategic-oriented" and "identity-oriented" schools of tactics is more heuristic than absolute and clear-cut. Instead, this organisation of the literature on tactics

is used to present and contextualise my main analytical tools and, upon so doing, highlight the theoretical and analytical potential offered in the study of DSAs.

Indeed, scholarship has already stressed the coexistence and complementarity of both tactical orientations in any given set of tactics employed by contentious collective actors (Steinberg, 1995; Bernstein, 1997; Goodwin and Jasper, 1999; Buechler 2000). What is more, and more recently, Ring-Ramirez, Reynolds-Stenson, Earl (2014) invite us to think of the repertoire not as “grab bag of available tactics, or an unstructured arsenal awaiting strategic actors” (ibid: 406), but as a structured cultural space where sets of tactics are given meaning and are attributed roles, in turn, informing and shaping the co-deployment of particular component forms. They, therefore, urge us to adopt a “thicker” perspective to the repertoire that includes the set of tactics available at a given time, the roles assigned to different tactical forms, their configurations and combinations (ibid: 407).

I believe that DSAs offer an opportunity to proceed in this direction. In considering DSAs as structurally integral to the modern repertoire of contention (Bosi and Zamponi, 2015), we can shed light onto those tactics oriented at direct, unmediated social change, which, in turn, can enrich existing understandings of the strategic use of tactical forms in their various combinations, and their dynamic diffusion, modularisation and transformation, as well as preservation in periods of latency. Building on Ring-Ramirez, Reynolds-Stenson, Earl (2014), therefore, DSAs can be strategically employed by collective actors opting for direct change, they can be complementary to larger contentious strategies and/or help advance collective identities and foster solidarities of counter-cultural communities.

Zooming in and in considering healthcare DSAs as a component of the repertoire of the anti-austerity contention, we can begin to analyse and contextualise their modularisation as resulting from the combination of socio-economic shifts, and political strategies. This can be captured in their gradual displacement from non-contentious to contentious collective actors, their diffusion among contentious milieus and the concomitant appropriations to their employment.

As already mentioned above, these tactics are not inherently contentious or political. This presents two challenges to the researcher that sets out to study them. First, and due to their widespread use by different milieus, DSAs make the demarcation of those contentious actors employing them difficult, especially when employed periodically and over the course of their diffusion among and across groups and sectors. In addition, the use of DSAs by contentious groups is subject to tactical debates and tensions, that vary in salience over shifting political backgrounds and can often lead to strategic paradoxes. These tensions become particularly apparent when DSAs and their actors are studied diachronically and longitudinally to discern their configuration within larger sets of strategies, their

impact onto those collective actors utilising them, and onto the arena they are employed to intervene in and affect.

In what follows, I hope to show how Jasper's (Jasper and Duyvendak, 2015) strategic interactionist perspective to collective action is particularly fitting for studying (healthcare) DSAs and for advancing the analytical potential offered by this set of tactics. As I hope to show in this thesis, this approach allows us to identify and categorise the various collective actors employing DSAs, trace their interactions and follow them over time. In addition, it provides the analytical ground to assess the impact of those tactics onto those actors employing them, their strategies and their environment.

### **2.3. Strategy**

Social movement scholars stress that DSAs have recently proliferated due to the intersectional pressures of democratic and welfare deficits (Forno and Graziano, 2014; D'Alisa, Forno and Maurano, 2015; Bosi and Zamponi, 2015, 2019, 2020; Kousis and Paschou, 2017; Loukakis, 2018; Papadaki and Kalogeraki, 2018). These same studies, however, and with the exception of Bosi and Zamponi, lack a clear categorisation between and among those collective actors employing DSAs, often conflating contentious with non-contentious groups, informal with formal collective actors and solidarity tactics with practices of resilience. That is partly because DSAs have not been typically associated with contention in social movement literature and as such have been "overlooked and treated like something "new" every time they resurface" (Bosi and Zamponi, 2015: 367). In addition, I argue that this conflation demonstrates the wide employment of DSAs but conceals the heterogeneity of those actors employing them, and distorts their strategic utilisations across actors and settings.

To mitigate this challenge, I make a conceptual step back from analyses and theorisations of the repertoire through the lens of social movements, to propose a more dynamic and relational approach that considers those movements, if and when those exist, as collective actors within broader arenas of conflict. This is an attempt to at once situate and contextualise collective action, infer contention, and blur the arbitrary line drawn between movements and their environment.

#### **2.3.1. Players and Arenas**

Among the pioneers in this direction are Jasper and Duyvendak (2015), and their work on "Players and Arenas". In this book, Jasper proposes the mutually dependent concepts of "players" and their "arenas" in an attempt to advance and operationalise Bourdieu's (1989, 1990) field theory for the purposes of empirical social science research. He specifies that, notwithstanding the apparent similarities between fields and arenas, the latter represent better conceptual and analytical tools to study

social interaction as they consider institutional structures with defining norms and characteristics that can be pinned down. Moreover, he argues that whereas in fields competition is taken for granted, usually resulting in a zero-sum game - see for example Fligstein and McAdam's (2012) elaboration of Bourdieusian fields- a conceptualisation of socio-political life as consisting of arenas gives space to other forms of social interaction, including that of cooperation which is very frequently encountered. On a more methodological note, Jasper points out that fields are largely metaphorical and cannot be observed, drawn or sketched through one's data. He, thus, argues that whereas "[f]ields are constructed by social scientists; arenas are built by the strategic players themselves (in Jasper and Duyvendak, 2015: 19)". As such, he prompts us to follow an inductive approach to the study of collective action as composed by a series of strategic interactions shaped within institutional environments.

More specifically, Jasper defines an arena as "a bundle of rules and resources that allow or encourage certain kinds of interactions to proceed, with something at stake" (ibid: 14). As such, an arena shares similar attributes to institutions while capturing most characteristics of structure, such as physical and literal structures, alongside norms, rules, and expectations. We understand that, and in line with the introduction of this thesis, the concept of the arena is particularly fitting for studying political conflict in healthcare, as it helps unearth the opportunities it offers and the limitations it poses for collective action. In addition, it allows us to contour those relationships, co-dependencies and interactions between all the relevant actors, it captures those resources (material and human) necessary for intervention within it and it considers the medical humanitarian commitments that, at least in principle, animate it.

What is more, Jasper argues that arenas represent a silver bullet for two interrelated problems in the existing literature. First, in contrast to Bourdieusian approaches, arenas can locate and trace power dynamics as those exist within them, instead of outsourcing them to the overly abstract and elusive "field of power". Moreover, and in the absence of any structural logic or institutional characteristics, fields run the risk of representing social but not institutional structures.

At the same time, however, he raises caution for approaches that are strictly institutional. Jasper therefore attacks (neo)institutionalist approaches as having imposed limitations on social interaction through their heightened emphasis on constraints, which informs research around stability and at the expense of strategic actors' agentic potential. In his words;

"Social facts, structures, networks, institutional norms or logics all emphasise constraints. Various kinds of habits and routines are introduced to explain the stability of interactions, most recently in the guise of habitus, an internalised set of dispositions for reacting in predictable ways even while improvising slightly within the set (ibid: 20)".

Central to those arenas are the players who inhabit and shape it. The conceptualisation of actors as players, already hints in the direction of strategy- if not game theory. Players can be individual or compound, such as in the case of a social movement, although they are never fully unified. They are “necessary fictions” constantly subject to individual and compound shifts including aggregation, disaggregation, splits and dormant periods. (Jasper and Duyvendak, 2015: 10-11). Echoing Fligstein and McAdam’s (2012) “Theory of Fields”, players within these arenas “work constantly to strengthen their positions (ibid: 22)”. This interaction also pushes them to constantly (re)define themselves against their environment.

Players also allow us to break from strict conceptualisations of movements as the main objects of inquiry and, as such, overcome some the challenge presented in the study of DSA tactics outlined above. More specifically, and according to Jasper;

“Talking about players allows us to avoid the term ‘social movements’, which many scholars think is simply too vague (although it is perhaps another necessary fiction, useful as a popular label or collective identity). Researchers have also given too much attention to explaining the rise and fall of movements, as opposed to the many other dynamics inside and outside of them (McAdam et al., 2001, McAdam and Tarrow, 2010). Once we break both the movement and its environment down to their component players and arenas, we can judge when there is enough coherence to these players to warrant them the term ‘social movement’ (in Jasper and Duyvendak, 2015: 14)”.

He, thus, prompts us to adopt an inductive approach that would better inform our conceptual tools as well as overcome the strict differentiation between the actor in question and their environment.

Jasper’s most ambitious contribution, however, lies on the competences he grants to his players. He insists that while players are indeed shaped and informed by their social environment, they are not determined by it, as “behind every ‘structure’ is usually another player at work. [...] A great deal of strategic action is aimed at creating new arenas as well as transforming existing ones (Jasper, 2006: 167-168)”. Players always have choices, even if they fail to acknowledge them (Jasper, 2004: 7). Contrary, thus, to most of the theory that departs from those constrains placed upon social and political actors, including theorisations of the repertoire as a mirror of limitations, Jasper figuratively emancipates players by attributing them the liberty of choice. As such, choices presented in the form of dilemmas can act as a lens through which to decipher instances of creativity, ingenuity, and break from path-dependency.

Jasper’s proposal is at once dialectical, processual and interactionist. As such, the process of the interaction as implied by the arena itself bears impact on individual players, on compound players and their configuration and on the arena itself. These successive “steps” take place over time

“with each succeeding step creating new conditions under which all the people and organisations involved must now negotiate the next step. [...] [This] makes theoretical room for contingency [...] The interactionist emphasis on process stands [...] as corrective to any view that insist that culture or social structure determines what people do (McCall and Becker, 1990: 60; in Jasper and Duyvendak, 2015: 22-23)”.

#### 2.3.1.1. *Critiques*

Duyvendak and Fillieule (2015) are invited to review Jasper’s strategic interactionist model. The authors applaud Jasper’s contribution especially with regards to the broader perspective to social interaction it proposes. They argue that looking at players and arenas, instead of social movements alone, could incorporate neglected, yet very relevant, actors and factors while situating those within broader episodes of contention. In addition, they praise the model’s potential to deconstruct essentialist categories, and highlight the dynamic nature of collective action.

They also make some critical remarks however, two of which are particularly relevant to this case study and subsequent analysis. First, they draw our attention to the patterns of fluidity characterising human interaction and remind Jasper that “[p]layers are not formed overnight, nor do they totally change in the interaction itself (Duyvendak and Fillieule, in Jasper and Duyvendak, 2015: 296)”. This raises caution against focusing on the synchronic at the expense of the diachronic that would ultimately strip the players and their arenas from any context but the web of their interactions. The authors then propose that a “dispositionalist” approach that would take into account the players’ socialisation within a “particular system of disposition” (ibid, 309), i.e., habitus, could be beneficial in mitigating some of the shortcomings of the framework proposed by Jasper.

I would add here that the diachronic is also central to understanding and approaching the “stake” foundation of the arena and the interactions it attracts; if players gather up they do so because of some stake preceding their entrance in the arena. The authors suggest that Jasper tackles this pitfall through his attention to players’ biographies, which operate as an analytical thread of continuity which informs present dilemmas and the choices they ultimately make. I would argue that, although a biographical approach would be important in understanding players’ choices and in “evaluating” their break from what is expected from them, it nonetheless does little to contextualise the arena and its stakes per se. This is related to the authors’ second line of critique which touches upon the issue of contextualisation, albeit on a larger scale. More specifically, the authors warn Jasper of running the risk “of overestimating what people in most situations experience as changeable since strategic interaction is always ‘situated’, that is, historically established (ibid: 299)”.

### 2.3.2. Strategic Dilemmas

Jasper's concept of players and arenas is a culmination of his work on strategic interaction organised around the different dilemmas social life entails (2006). In his earlier book "Getting your way: Strategic dilemmas in the real world", Jasper diffuses the concept of strategy across actors and settings, and stresses how individuals, groups, organisations and entire nations are constantly faced with dilemmas and are called upon to make choices. Perhaps the most interesting point made in the book is the delineation between the different "goals" guiding strategic choices, that can explain not only seeming paradoxes, but also the players' satisfaction with an outcome that falls short of their "basic" goals. On a similar note, Jasper invites us to consider players as "juggl[ing] a number of different projects at the same time" (ibid:60). These observations take us back to our discussion about the configuration of tactics within larger strategies of collective action. That is, the different projects pursued by any one actor, individual or compound, should be reflected in the tactical prioritisation and resultant combinations at each moment in time. In addition, the different "goals" of those actors can come to light by scrutinising the various tactical forms employed and their orientation.

#### 2.3.2.1. *Critiques*

Jasper commits to turning structuralist accounts on their heads and contends that "[s]trategic dilemmas and choices are an important part of freedom and agency [...] Strategic action is not the whole of social life, but it is a big part of it (ibid: 13)". I argue that despite offering a refreshing perspective onto social interaction, Jasper's universalistic project pursued in this work suffers from the same weaknesses pointed out for "Players and Arenas", while lacking an overall framework for studying strategic interaction (for more extensive critique see Schwartz, 2008). In addition, and relevant to our discussion here, Meyer and Staggenborg (2012) also point out that Jasper appears to be overlooking at "how much dilemmas are interrelated and how their solutions are constrained"(ibid: 6). Rossi (2017) further develops these points to conclude that

"[t]he main issue with the concept of 'strategic dilemmas/ trade-offs' is that it suggests the universality of micro short-term tactical decisions. An additional problem with this approach is that although sometimes action seems logical when its effects are retrospectively analysed, the 'social agents have 'strategies' which only rarely have a true strategic intention as a principle' (Bourdieu, 1998: 81). It is thus necessary to trace the history of the strategy/ tactic that is being performed to provide a contextualised meaning of it (Rossi, 2017: 36)".

I strongly agree with the remarks raised by Duyvendak and Fillieule (2015), Meyer and Staggenborg (2012) and Rossi (2017) and believe that, although Jasper is showing a bold way to agency, it is not

entirely convincing. This thesis, and in light of the case study and relevant data, shall take tactical choices and strategic dilemmas very seriously as contextualised expressions of (inter)actions within the healthcare arena. As such, and through the close analysis of the Social Clinics-Pharmacies movement and healthcare DSAs therein, this work wishes to advance both DSA scholarship as well as Jasper's attempt to operationalise Bourdieu's approach to social interaction.

## **2.4. Institutionalisation**

In accounting for the transformations in collective action and its repertoire over periods of time and across different actors, the aforementioned scholars have paid little -if any- attention to the dynamic effect(s) that institutionalisation as a process and an outcome might have on collective action. Institutionalisation is a key concept in social movement and organisational studies, albeit examined in different light(s) and to different ends. As we shall see, those different perspectives have definitional implications, some explicit but most implicit, as formal definitions of the concept are rarely encountered. This renders institutionalisation an evasive and slippery concept, understood vis-à-vis informal tactics and/or flexible organisational structures, at one extreme, and co-optation, on the other. In what follows, I present a brief overview of the literature on institutionalisation, aspiring to provide a critical reading onto those approaches that emerge.

### 2.4.1. Transformation or outcome? Theoretical implications

In his comprehensive bibliographical overview of the concept, Bosi (2016) showcases the division of the literature on institutionalisation between two main "schools". The first school views institutionalisation as a transformation and it stems from an appreciation of the state as the central and main agent affecting and effecting institutionalisation. Social movements in this light are understood as *a priori* extra-institutional and susceptible to the paternalism and/ or repression of the state, which ultimately restricts their options to either institutionalisation or radicalisation.

Similarly, Seippel (2001) tracing the definition that links institutionalisation to the capacity of "dynamic movements" to turn into "rigid hierarchic organisations" (ibid: 123) also provides an overview of the scholarship around institutionalisation-as-transformation. In so doing, he identifies and historically situates three main approaches to the process, all of which he criticises as "one-dimensional" and in stark contrast to the increasingly refined theories social movement studies are producing (ibid: 124). More specifically, he argues that early social movements' literature viewed institutionalisation as an (inevitable) outcome of (successful) mobilisation. This view was briefly countered by theorisations around New Social Movements which, as we saw above, were considered as new forms of contentious politics, especially in that they were inherently anti-hierarchical and anti-institutional. At first glance, this

idea would imply the relative irrelevance of the state in affecting mobilisation on the part of these movements; an impression that culminated in theories that saw the transposition of the “means” of collective action (tactics) into goals in-and-of themselves (Melucci, 1996). The reluctance of New Social Movements towards institutional politics was, thus, hastily translated into a relative autonomy and independence on their behalf, which would, in turn, deem them indifferent and immune to the pressures of institutionalisation. However, and as those movements began to exhibit characteristics of formal institutionalisation -such as the in the cases of the Women’s and Environmental movements - scholars resorted to the initial unilateral conceptualisation of the relationship between movements and the state, highlighting the institutionalising and, in cases, co-opting tendencies and capacities of the “establishment” affecting movements. We understand, therefore, that these approaches are unevenly focused on the role of the state and strip any agency from social movement actors. In addition, they are totalising as they are simplifying of the two actors involved in the process, disregarding their internal dynamics and the context in which institutionalisation (or co-optation) unfolds.

I argue that scholarship that regards the states as the principle and main agent affecting movement institutionalisation affords a single strategic dilemma to movements; that is, to institutionalise or radicalise. According to this perspective, institutionalisation impinges on the politicisation, radicalisation and flourishing of movements, due to their inherent (organisational) incompatibility with the state (see also, Piven and Cloward, 1977; Tarrow, 1989; Koopmans, 1993; Kriesi et al., 1995). In extending this perspective, de-radicalization, routinisation and decline might also be results of co-optation -itself regarded either as an extreme variant of institutionalisation or a synonymous process- whereby “[t]he government (the co-opting body) embraces a movement in order to sustain its own legitimacy and authority and to aver threats to its stability (Suh, 2011: 444)”. Co-optation, as will be further discussed below, reiterates this view of the unilateral agency of the state vis-à-vis the movement in question, by highlighting the capacity -and indeed single and unified intentionality - of the state to subordinate movements and their demands while diminishing the strategic ground of movement actors to the simple dilemma to “participate or perish (ibid)”.

On the opposite end, the second perspective identified by Bosi (2016) sees institutionalisation as a positive or desirable outcome of mobilisation, intended by the movement in question in order to advance its goal(s), gain legitimacy and expand its platforms by entering into institutions and its constituencies by entering the mainstream. This perspective can be summed up in Suh’s most recent formulation of institutionalisation as “a process of social movements traversing the official terrain of formal politics and engaging with authoritative institutions such as the legislature, the judiciary, the state, and political parties to enhance their collective ability to achieve the movement’s goals (ibid: 443)”.

We understand that this perspective considers social movements as primary agents in this interaction with the state, operating strategically, premeditatedly, and instrumentally towards their target. In that case, de-radicalization and decline are a possibility, not a certainty of institutionalisation (see also Ruzza, 1997; Katzenstein et al, 1998; Giugni, 1998; Raeburn, 2004; Stearns and Almeida, 2004; Meyer, 2007). This perspective also implies a juxtaposition between institutionalisation and co-optation, as the former advances the movement, while the latter hinders it in favour of institutional actors. Castaño (2019) building on Meyer (2007) provides a comprehensive operationalisation of the concept;

“1) policymakers’ consultation with representatives of movements; 2) offering of platforms to express movements’ claims; 3) the creation of agencies devoted to dealing with the claims of movements; 4) funding services provided by social movements; 5) use of the rhetoric of social movements by officials; and 6) inclusion of movement actors within deliberative processes (Meyer, 2007: 126-129, in Castaño, 2019: 172)”.

Castaño (ibid), writing on the impact of the institutionalisation of the Bolivian Movement of Domestic Workers on policy, advances this typology by adding yet another element, proposed by Ruzza (1997) which is the insertion of social movement members into official positions of power (Castaño, 2019: 172). In contrast, he presents the (opposite) process of co-optation as consisting of the following elements;

“1) the government allows the participation of a movement in policy-making, 2) the government unilaterally launches this process to sustain its own legitimacy, 3) the movement drops at least some of its most ambitious demands, and 4) the final policy does not reflect the movement’s demands (ibid: 170)”.

Yet again, the homogeneity of the movement and the state leading to either their clash or cooperation is foundational and goes uncontested. This simplification also extends to the process and outcome of the interaction between the two parties, which sees no possibility of combining elements favouring the movement with those favouring the position of the state. These shortcomings are so foundational to the literature on institutionalisation that efforts to advance it with more relational and dynamic perspectives go unacknowledged.

One such example is Castaño who, although inspired by Suh in his formulation of co-optation, fails to put forward his strategic interactive perspective, which constitutes the novelty of his work. In his paper on the Korean Women’s Movement, Suh (2011) approaches institutionalisation as a strategic choice with open-ended and context-based results for the movement. To this end, he defines institutionalisation as the “consequence of concurrent strategic choices and strategic alignment by both parties- an *engagement* approach by social movements coupled with an *integration* policy by the state (ibid: 446; emphasis added)”. This definition gives choices to both actors, which are mindful of their structural positions as well as the context in which the interaction takes place.

What is more, existing studies of institutionalisation approach the repertoire as an affirmation of the “radicalisation” vs. “institutionalisation” thesis. That is, movements that decide to radicalise, employ “street based” tactics, whereas movements which institutionalise undergo organisational and tactical transformation towards more moderate, routine and bureaucratic tactics that result from “the burdens of institutional maintenance” (Coglianese, 2001: 25) and ultimately inhibit their contentious characteristics. I argue, however, that these are normative approaches to tactics, and that the repertoire, together with processes that account for its transformation deserve more nuanced approaches to understand the strategic goals and means of political (inter)action. In this way, we can begin to identify and examine the dialectical relationship between the repertoire and institutionalisation, not only for contentious actors but for the whole of the arena in question.

#### 2.4.2. Merging Polar Opposites

This approach resonates with Bosi’s (2016) conclusion who, upon reviewing the two approaches, and instead of denouncing them as irreconcilable, attests to the -partial- usefulness of each through the points of their complementarity. He, thus, attempts to analyse the process of institutionalisation of the Northern Ireland Civil Rights movement through a combination of the two approaches, under a “strategic- relational perspective” capable of attributing the benefit of agency to both the movement and the state (Bosi, 2016: 343). The strength of this approach consists of three important elements that will advance as central to this work. First, it considers both the state and the movement as heterogenous actors, further enriching the analytical potential of studying their interaction, dynamics, and goals in their complexity. This has been a persistent weakness in the literature on institutionalisation as we have seen above, and an uncharacteristic one for social movement studies. Secondly, it considers third-party actors, such as counter-movements and movement allies, as capable of mediating and affecting the interaction in certain moments in time, widening the scope of investigation beyond the movement-state duo. Thirdly and through Bosi’s longitudinal perspective to the “long process of institutionalisation” spanning over thirty years, the analysis does not lose sight of the historical context in which these interactions unfold.

Bosi (2016) concludes that

“[...] institutionalisation is a process driven, to a significant extent, by dynamics located within the process itself, in patterns of interactions involving multiple actors within the relational field formed by the political conflict. Therefore, any reading of how and when social movements institutionalise needs to pay attention to the shifting and mutually influencing interactions between social movements and the state over an extended period of time that is not limited to a single protest wave, but takes into consideration different types of contention that are strongly interrelated (Maney, 2007; Bosi and Malthaner 2012; in *ibid*: 355)”.

## **2.5. Relational, dynamic approach to institutionalisation: the case of the Social Clinics-Pharmacies' Movement**

This idea of the relational fields created through the interaction of various actors involved in a political conflict brings us back to our discussion over players and arenas, albeit implicitly. Bosi's dynamic and relational approach to institutionalisation as composing of a sequence of contingent social mechanisms and sub-mechanisms is very similar to Jasper's understanding of the co-production of arenas, players, their strategic interactions and tactical means (in Jasper and Duyvendak, 2015: 22-23)<sup>4</sup>.

More specifically, collective actors can be conceptualised as players, compound and individual, to include the state and the "movement" in all their heterogeneous expressions, in addition to "third-party" actors who acquire relevance by means of their relationship and interactions with those actors. In applying Jasper's approach this thesis traces those contentious actors using DSAs to follow their tactical appropriation and diffusion and explain DSAs' eventual modularisation within the repertoire of anti-austerity contention in Greece. As we will see, the healthcare arena is radically transformed in the context of the cycle of contention, as resulting from its mass infiltration by new contentious actors themselves, to a large extent, constituted by their tactical convergence around healthcare DSAs.

The modularisation of DSAs in the healthcare arena gives incentives for the cooperation of and coordination between those contentious actors employing the same tactics, thus, promoting their constitution into a Health Social Movement that draws from different traditions, legacies and visions for change. The formation of the clinics-pharmacies into a movement helps advance the contentious characteristics of all the actors involved, and integrates polymorphous claims that range from the end of austerity in healthcare, healthcare reform, to revolutionising the medical paradigm. These new (or new-to-DSAs) contentious actors displace previously hegemonic collective actors and, therefore, advance the political role and mobilising potential of such tactics and the claims and grievances they are employed to address.

At the same time, the creation of a movement advances the position of our actors in the healthcare arena, and affects opportunities for them in the realm of formal politics. As we will see, the cooperation between and proliferation of the clinics-pharmacies are mediated and assisted by third-party actors, and more specifically the Social Movement Organisation Solidarity4All that SYRIZA established during the

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<sup>4</sup> At this stage, it is important to note the definitional differences between Jasper (2015) and Bosi (2016)'s approaches to social interaction. Albeit similar in their perspective, the two authors derive from different traditions and speak to different audiences. As such Jasper presents his approach as "strategic" and "interactionist", to highlight the agentic potential of his players, while Bosi refers to his as "strategic-relational" with the intention of shedding light onto those contextual and processual characteristics of institutionalisation. As both approaches are foundational in this work, I try to reduce the possible cacophony of the various definitions through the presentation of my own approach which attempts to capture both.

contentious cycle. The interactions between those actors in the healthcare arena during the cycle, then, set the ground for movement institutionalisation.

Upon the closure of the cycle of contention and the election of the movement-ally party of SYRIZA into government, a victory no less affected by the cycle of contention and the broad appeal of the DSA-oriented Solidarity movement, these opportunities are translated into the prioritisation of strategies to affect reform in the National Healthcare System, thus reinforcing the process of strategic interaction between the movement and SYRIZA. Ultimately, the traversing of social movement actors in the arena of institutional politics affects Healthcare Reform and, as such, reconfigures the healthcare arena both structurally and institutionally. This transformation comprises of successive and consequential steps that alter the arena and as such present new strategic dilemmas to contentious actors employing healthcare DSAs.

Viewed in this light, movement institutionalisation is a contingent process and an outcome of strategic interaction in the healthcare arena. The dilemmas that emerge after movement institutionalisation culminate in the dissolution of the movement and the splintering of the various clinics(-pharmacies). As we will see, this dissolution is prompted by the clinics-pharmacies' tactical convergence yet strategic divergence in the employment of healthcare DSAs. My approach to the movement as a compound player formed to gain advantage in the healthcare arena, then, allows for a contextualised yet agentic account of those strategic interactions leading to and following movement institutionalisation.

In doing so, this thesis proceeds with the reconstruction of the different trajectories to DSAs on the side of different clinics-pharmacies. These trajectories are deeply rooted in the dynamics of contentious collective action, and the healthcare arena. Following movement institutionalisation, these trajectories become reinforced, as deciphered through the various strategic alignments of DSA tactics by the dispersed parts of the movement. The relational and dynamic reconstruction of those trajectories, then, allows us to disentangle the seeming paradox of movement dissolution and the retainment of healthcare DSAs upon movement institutionalisation.

As I hope to show, the trajectories of collective action following the movement's institutionalisation, dissolution and the announcement of the healthcare reform can be traced back to processes preceding the "moment" of the movement's transversal to the institutional arena. More specifically, interactions and characteristics that developed over the course of the contentious cycle shaped each clinic-pharmacy's interpretation of the movement's involvement in institutional politics and, relatedly, the policy outcome of this effort, thus reconfiguring the strategies for each clinic and the role of healthcare DSAs therein.

### **3. Methodological navigation**

#### **3.1. Introduction**

The research for this thesis began with my keen participation in, turning into curious observation of, and eventually puzzlement over the Social Clinics-Pharmacies Movement in Greece. The study adopts an interpretivist approach, whereby the analysis and causal reconstruction derives from the explication of the situated motivations for peoples' actions (della Porta and Keating, 2008: 27). Or, in the worlds of Greenhalgh and Taylor (1997), it sets out to study “things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings that people bring to them” (ibid: 740). As a result, the research design and concomitant questions of this investigation emerged inductively, through my immersion into the field and familiarization with the relevant literature (Merton, 1968). Each successive step of the research further focused and refined the study and methods used. In what follows, I discuss the research design and the methods employed for the purposes this work and pose some methodological and ethical reflections that emerged over the course and upon the completion of my data collection and analysis. I close this section with a short contemplation on the political considerations inherent in the study of social movements.

#### **3.2. Selecting on the case**

A case-study research design is “based on the in-depth empirical investigation of one, or a small number, of phenomena in order to explore the configuration of each case, and to elucidate features of a larger class of (similar) phenomena, by developing and evaluating theoretical explanations (Vennesson, in della Porta and Keating, 2008: 226)”. Despite its widespread use and appeal, case-study designs have been criticized for limited generalizability due to their small scope and, relatedly, for the impossibility of testing their findings. In striving to advance their profile, scholars have attempted to provide guidelines for what is understood to be the most challenging endeavor they present; that is the selection of optimal cases that can attribute representativeness to the case selected (Seawright and Gerring, 2008: 294). Already in my first year in this PhD, Professor Phillippe Schmitter warned us against “selecting on *the* case”, something that he quickly admitted of having done so himself over the course of his own doctoral thesis, for all the wrong, apparently, reasons and to the most successful results. I left the seminar that afternoon with mixed feelings of confidence and angst to make my case work.

In departing from the case of Greece, and through iterations of theory and empirical observations, I only later realized that what was the real challenge for me was deciphering my case between number of overlapping cases I was touching upon, without, however, totally covering. These were mainly the case

of crisis Greece, healthcare activism, healthcare DSAs, the Social Clinics-Pharmacies movement and the social clinics-pharmacies as grassroots initiatives. Seen dynamically, my case consists of all the above, as it represents a contextualized study of the modularization of healthcare DSA tactics, the creation of a movement around them and its subsequent institutionalization. To do so, then, I had to delve into their intersections.

This effort implied continual and consistent work on the conceptualization over and operationalisation of the relevant hermeneutic devices employed in the design of this research, the organisation of the relevant literature, the collection and ordering of its data and, ultimately, their analysis. Among the most crucial such steps pertained to the clarification of what healthcare DSAs are, if they are different from welfare DSAs as defined by Bosi and Zamponi (2015) and if so, in which way. I operationalize healthcare DSAs as this subcategory of DSA tactics which focus *upon directly intervening to cover healthcare needs*, either through immediate *provision* of services and related products, or through *mediation* to secure those, instead of indirectly claiming coverage from the state or relevant actors.

In addition, the Social Clinics-Pharmacies Movement I intended to study had to be clearly defined, especially due to its short-lived trajectory and swift dissolution and in light of the continuation of the autonomous operations on the part of a number of social clinics-pharmacies to date. Interestingly, a number of my interlocutors active in such clinics still referred to themselves as part of a larger movement. As such, it became clear that certain criteria for the utilization of the concept were imperative. This initiated an abductive iterative process of re-operationalising my object of study (Blaikie 2000). In a previous work, Kotronaki and myself (2019) have identified the emergent Social Clinics-Pharmacies' Movement as a network *pave* Diani (1992) of “informal interactions between a plurality of individuals, groups and/or organisations, engaged in political or cultural conflicts on the basis of shared collective identities” (ibid: 1). The most prominent indicator of this was the establishment of the Panhellenic Network of Social Clinics-Pharmacies in 2013 which brought together a number of such initiatives and formulated a Map and Code of Conduct pointing to their shared collective identity and values, consolidating their operations on the basis of fundamental rules and synthesizing their demands. According to this operationalization, the Network was dissolved in 2016 coinciding with the closure of the cycle of contention, SYRIZA's election, the announcement of the Healthcare Reform, and the beginning of this research project.

While in the field, my data collection initially triggered my interest over the retainment of DSAs in the period following the cycle of contention, understood as a period of “movement latency”. My aim, at that stage, was to contribute to the literature on DSAs with a diachronic account of their utilization beyond those “moments of madness” (Tarrow, 1993) and to provide a social movements' perspective onto the production of what Andrea Muehlbach (2012) called “ethical” and Nikolas Rose (2000)

“moral” citizens mediating the collapse of welfarist solidarity. However, the more data I gathered -and simultaneously analysed- the more I came to realise that the process of subjectification (Foucault, in Dreyfus and Rabinow, 1982) was not as linear or homogeneous as initially imagined. Instead, one can observe a dynamic but non-linear process of “substitution” of formal welfare institutions, whether state or voluntary, by contentious collective actors; a process that consists of the interactions among collective actors and between collective actors and the state leading to heterogeneous and open-ended outcomes.

For the case discussed here, these interactions were partly affected by the closure of the cycle of contention, but what also began to appear as relevant was the institutionalization process the movement had undergone upon the closure of the cycle and the election of SYRIZA into office. Drawing from the relevant literature, I understood this process as consisting of (1) SYRIZA’s consultation with representatives of the Social Clinics-Pharmacies’ movement; (2) SYRIZA’s creation of its own Social Movement Organisation, Solidarity4All intending to coordinate and assist solidarity initiatives and publicise the movement’s demands; (3) officials’ increasing appropriation of the rhetoric of the movement; (4) the inclusion of movement representatives within deliberative processes preceding the reform, and, finally, the (5) the appointment of ex-activist Andreas Xanthos as Minister of Health to enact the Healthcare Reform (Ruzza, 1997; Meyer, 2007). Therefore, instead of asking why did some clinics-pharmacies remain in operation after (or despite) the announcement of the Healthcare Reform I started to investigate how did the reform affect those collective actors and their utilization of healthcare DSAs. To do so, I had to zoom into the processual and consequential dialectic of movement institutionalization.

### **3.3. Levelled sampling**

As mentioned above, the emergent movement of the Social Clinics-Pharmacies had dissolved by the time this research started. Since membership in the Network was no longer a viable sampling strategy I decided to induce my relevant actors by virtue of their tactics of intervention and mediation in healthcare. To this end, I use Jasper’s (Jasper and Duyvendak, 2015) conceptualization of arenas and their players to attempt a reconstruction of the dynamic transformations induced in the realm of healthcare collective action over the course of the crisis’ years. Lending some methodological insights from grounded theory, therefore, my “theoretical sampling” (Charmaz, 2006) involved an expansion of my scope both in terms of the actors involved and temporally. This process involved two phases of sampling, each corresponding to a different level of analysis.

My sampling was initially informed by two studies on the Social Clinics-Pharmacies that attempted to map and analyse the phenomenon of the clinics-pharmacies. The first was a study published by the

Institute of Labour of General Confederation of Greek Workers (INE GSEE) in 2015, where the authors Adam and Teloni present 56 solidarity clinics in operation from 2011 to 2014. These include clinics-pharmacies set up by a range of collective actors, from grassroots groups, to parties, to the church [see Table 1]. Among those they distinguish between two types of clinics-pharmacies, between those “movement initiatives” and those “institutional initiatives”. “Movement initiatives”, which are my focus here, are described as more political than their institutional counterparts, with ties and connections to other movement milieus and struggles. Adam and Teloni describe these clinics-pharmacies as active in the broader anti-austerity movement, mitigating the effects of the crisis onto peoples’ health and healthcare, while simultaneously working for their politicization and defense.

In another research paper attempting to map and categorise the Social Clinics-Pharmacies, Evlampidou and Koveginas (2018) identify 92 clinics-pharmacies in operation in 2015 that are “not directly connected and funded by state owned organisations or big NGOs” (ibid: 2). The authors describe the sum of the clinics as “a social movement oriented to the supplementary provision of health care” whose members are usually standing against austerity and its effects on health and healthcare (ibid).

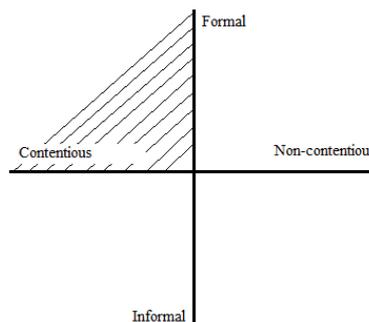
Adam and Teloni (2015): 56 clinics-pharmacies		Evlampidou and Koveginas (2018) 92 clinics-pharmacies	
Movement initiatives	34%	Citizens’ initiatives	39%
Regional authorities	9%		
Third sector	7%		
Doctors’ Trade Union	2%	Municipal authorities	30%
Municipal political party	2%		
Group of health professionals	2%		
Church	2%	Church	11%
Synergies	42%		

**Figure 1: Summary and comparison of findings of Adam and Teloni (2015) and Evlampidou and Koveginas (2018).**

These studies were very useful in getting an idea of the phenomenon of the clinics-pharmacies and the distribution of such initiatives across different groups of collective actors. However, and as these studies focus mostly on mapping the clinics-pharmacies, the categories they employ are too broad and unrefined for the purposes of this study. As such, and upon the first level of my casing, I decided to scrutinize the categories proposed by the authors cited above. To do so, I had to open up my sample to the whole universe of collective actors employing healthcare DSAs in Greece to date, to distinguish

between formal and informal, contentious and non-contentious collective actors. This was a very important decision as the introduction of new actors and tactics in the healthcare arena blurred the boundaries between the aforementioned categories, especially in the period following the Healthcare Reform. It was for this reason that a good operationalization of both axes was essential.

- Formal/ informal collective actors: I consider formal collective actors all those actors that rely on state resources in order to carry out their activities. This dependence on the state implies their condescension by it and diminishes their contentious potential. Such instances were very quickly identified to be predominantly (1) NGOs, (2) municipal authorities and (3) the Greek Orthodox Church involved in healthcare DSAs. The sample of the informal collective actors involved in healthcare DSAs is larger and it has grown over the course of the latest cycle of contention. These actors are (1) social clinics-pharmacies, (2) voluntary clinics and (3) social movement milieus involved in healthcare provision, health promotion and disease prevention.
- Contentious/ non-contentious collective actors: This differentiation was harder to establish, as the alignment of DSAs within broader strategies changed over the timeline examined in this study. Contention was operationalized as the combination of DSA tactics with any other tactic of the contentious repertoire usually with the intention of indirectly intervening in the healthcare arena to raise criticisms and/or make claims. The non-contentious actors employing DSAs are those that exhibit no contentious characteristics and articulate no demands in the healthcare arena, but do mediate for healthcare needs where those exist.



In this way, I resisted the pitfall of viewing those actors as inherently contentious, a mistake I came across in several contemporaneous studies of the Greek cycle of contention. In line with my very initial stated goal, therefore, I made a conscious choice to move away from pre-determined and normative classifications of those collective actors involved in healthcare provision from below, and search anew for those boundaries between formal and informal, contentious and compliant collective actors involved in healthcare provision from below. This provided me with the necessary conceptual tools to

approach and examine those actors, their interactions and interplay in the twilight of the (Greek) National Healthcare System.

This sampling strategy reinforced another decision that was critical for my research design, that is to approach the healthcare arena longitudinally to identify transformations in its composition, organizational capacities, characteristics, stakes and, most importantly, tactics. “The historical approach is particularly relevant for case-oriented research designs that are by definition context-bound. Long-term processes are particularly important for “internal” interpretation (what is usually called *verstehen* rather than *erklären*) (Della Porta, 2008: 217)”. This added a “historical” element to my originally diachronic intention, that included the period since the establishment of the Greek National Healthcare System.

This longitudinal perspective of the healthcare arena allowed me to unearth its historical transformations as well as decipher relevant actors that would not be visible otherwise (Bartolini, 1993). One such instance is the first clinic providing healthcare services for free to uninsured migrants established as early as the 1990s. This clinic was neither reliant on the state nor did it exhibit any contentious characteristics, but it did inform the creation of several clinics-pharmacies during the cycle of contention. Another interesting finding pertained to the anarchist- autonomist traditions regarding healthcare DSAs. These traditions enabled the flourishing of healthcare DSAs among those actors over the course of the cycle of anti-austerity contention as well as reinforced their insulation from the Social Clinics-Pharmacy movement that emerged over the course of the cycle. From this point on, I was capable of assembling lineages of action to formulate trajectories of tactical convergence and, later on, strategic divergence.

The sampling technique followed was a combination of purposive sampling, based on my experience of the case and the relevant key informants for my research, and snowball sampling to enhance my data collection and substantiate my findings (Bryman, 2012: 416-421). For the purposes of this thesis, I focused on a sample of 22 clinics-pharmacies, the overwhelming majority of which (18) still in operation at the time of my fieldwork albeit, most often than not, changed since their establishment. Most of those were located in the Athens metropolitan area, three were in the second largest city of Greece, Thessaloniki, three in the island of Crete and four in other smaller cities in the country (Larisa, Volos and Patra). This sample should not be confused as representative nor exhaustive. There has been no official recording of the total number of grassroots initiatives employing healthcare DSAs over the period covered in this research and neither was I intending to map the field.

In addition, I looked at the cooperation and coordination networks between and behind these clinics-pharmacies, to include the Panhellenic Network of Social Clinics, the Solidarity Network of Social

Clinics, the SMO Solidarity4All, as well as local branches of political groups, neighborhood collectives and/or party branches facilitating the operation of the clinics-pharmacies.

These were complemented by the sampling of the two major NGOs involved in healthcare provision for free to those in need, Médecins du Monde (henceforth MdM) and Médecins Sans Frontières (MSF). These were used as ideal-typical of NGO interventions in the healthcare arena, and illustrative of their interactions with this study's informal and/or contentious collective actors. In addition, I also collected material for those municipalities that set up their own Municipal Clinics and/or Pharmacies, usually in competition with the clinics-pharmacies mentioned above.

Albeit keeping actors employing DSAs at the center of my data collection and analysis, my research did not lose sight of those employing indirect tactics. These were mostly captured by the medical professional trade unions and doctors' associations including the Panhellenic Confederation of Public Hospital Employees (POEDIN), the Medical Association of Athens (ISA), the Panhellenic Medical Association (PIS), the Union of Hospital Doctors in Athens and Piraeus (EINAP), the Confederation of Hospital Doctors (OENGE) as well as the two leading trade unions in the country, the General Confederation of Greek Workers (GSEE) and the Civil Servants' Confederation (ADEDY). Similar to the NGOs, these actors were deemed important in the reconstruction of the healthcare arena and its dynamics over time.

Only when this was achieved at the conceptual level was I able to detect the gradual relocation of DSAs from formal to informal civil society actors and track the beginning of this process historically before the crisis, to be accentuated over the course of the cycle of contention and fostered and consolidated after its closure. The widening of my sample also allowed me to detect the impact of this process on the different collective actors, through shifts in their understanding and strategic appropriation of DSA tactics over time. As I collected and analysed my data, I started organizing my case into ideal-types, to then redesign my research as a within-case comparison.

### 3.3.1. Within-case comparison

Over the course of my data collection and analysis, I decided to add two levels of within-case comparison in my case study research design. These involved a less systematic comparison of the healthcare arena in three moments in time to then zoom in and compare the different collective actors employing healthcare DSAs in the present. Both these comparisons were the product of constant iterations between the case and relevant theory, deeming the comparison through time and among cases to be of research value and personal interest. More specifically, the comparison through time is more implicit and elevated to a higher level of abstraction, paying less attention to shifts on the micro-

level. Rather, my focus lays on the meso-level of dynamic shifts and transformations of the healthcare arena and the various trajectories of its players, understood as embedded within the macro-level transition to “health system neoliberalism” (Gaffney and Muntaner, 2018).

The comparison between the different collective actors engaging in healthcare DSAs was not initially intended but came out from my observations in the field. As I have already mentioned above, what I initially approached as a relatively homogenous movement was, at the time of my fieldwork, split into smaller clusters of collective actors engaging in healthcare DSAs. This compelled me to widen up the scope of my research to operationalize and compare the different relevant actors. What is more, and for those contentious actors in the period under investigation, I reconstructed their trajectories of tactical convergence during the cycle of contention to then identify the reasons for their strategic divergence following institutionalization.

“Comparison in the qualitative tradition thus involves comparing configurations (Ragin, 1987: 3)”. My comparative method between the different trajectories culminated in the establishment of five ideal types of strategic action involving healthcare DSAs. These are presented in the thesis as configurations of tactics within overarching strategies, informed and shaped by each collective actor’s relationship to the state, interpretation of the crisis and framing of the Healthcare Reform. These configurations are brought to light through thick descriptions for each ideal-typical clinic(-pharmacy).

This comparison provided the basis for the carving out of the different trajectories to and fro Direct Social Actions in healthcare. Those trajectories, showcased through the elaboration of my ideal types, opt to provide a holistic and contextualized picture as to the transformations in collective action dynamics over the course of the past four decades and since the establishment of the Greek National Healthcare System. In addition, they help emanate the relevant characteristics explaining differentiation upon movement institutionalization, and interrogate the latter as a dynamic, contingent, strategic and consequential process.

### **3.4. Methods combined**

This research endeavor faced some major challenges. The most important of these was its longitudinal perspective vis-à-vis the relatively recent scholarly attention on DSA tactics as well as healthcare-related contention more broadly. This implied the collection of various primary sources across time and the location of the scarce and sparse secondary sources on those actors induced for the purposes of this thesis. To overcome this difficulty, I utilized a range of methodological tools, the combination of which intending to produce “rich data” (Charmaz, 2006) on collective actors and their practices and shed light on as many facets of the healthcare arena as possible. More specifically those were (participant) observation, in-depth semi-structured interviews and primary and secondary sources. In what follows, I

provide an account of those tools, their respective limitations and their potential mitigation through their triangulation.

#### 3.4.1. (Participant) Observation

This project represents a continuation of my participation in a Social Clinic-Pharmacy in the Athens metropolitan area over the period of 2013-2014 and, subsequently, my MSc dissertation completed in 2015. More precisely, my participation consisted of my training as a receptionist, upon the completion of which, I was volunteering for twelve hours a week, divided into three four-hour shifts per week. In addition, I helped organise and attended various events held by the clinic, including parties and exchange bazaars. To be sure, my active participation in the clinic opened the door for my participant observation of the clinic-pharmacy's everyday operations, general assemblies and regular meetings with other collective actors between 2013 and 2015. This thesis draws from my ethnographic notes taken over this period.

Building on those and upon reflection on my past fieldwork and related experiences as an active participant, I decided to not assume an active role in any of the clinics(-pharmacies) studied for the purposes of this PhD thesis. This was mainly due to time constraints put forward by the breadth of my sample. From active to passive participant observer (Bryman, 2012: 446) at this point, I limited myself to some visitations of the clinics-pharmacies during their opening times. Prior exposure to a number of clinics facilitated my understanding of the level, intensity and orientation of each clinic and/or pharmacy's interventions, as well as comparisons for my within-case research purposes.

In addition, to the clinics, I also (passively) participated in a series of assemblies, meetings and events organized by local or health activist milieus, such as those held by the Workers' Club in Nea Smirni, and the Psy-initiative for Mental Health Reform, as well as Solidarity Hubs and their events in different neighborhoods. In addition, I also attended formal events such as the "Future of Healthcare in Greece" (2019) conference attended by representatives of the World Health Organisation (WHO), the Organisation for Economic Cooperation and Development (OECD), the World Bank as well as Greek health policy experts.

#### 3.4.2. Interviews

Perhaps the most important tool I utilised to collect data for this thesis was the in-depth, semi-structured interviews I conducted over 2014-2015, again for the purposes of my MSc, and 2018-2020, for the purposes of this thesis. My MSc research complemented my ethnography with twelve semi-structured interviews on the coproduction of solidarity practices and subjectivities with volunteers of

the same clinic, which, however, is an entirely different project to the one pursued here. As such, these interviews were only used when appropriate or as supportive material, enriching the findings of the interviews conducted during the period of my data collection for this thesis.

The second round of my fieldwork took place between 2018 and 2020 and was largely retrospective. For the purposes of this thesis, I conducted thirty-two interviews with people in and around the movement, including movement experts, healthcare policy advisors, healthcare syndicalists as well as people in broader social movement milieus. The interviews composed of a number of fixed questions pertaining to the establishment, networks of cooperation and trajectory of each clinic, followed by some open lines of inquiry that emerged over the course of each interview. The interviews lasted a mean of one and a half hours. The different themes picked up and expanded upon by my interlocutors were particularly useful for creating a holistic picture of the individual and collective interpretations of particular forms of action.

#### 3.4.2.1. *Retrospective Interviewing*

Most of these interviews involved some degree of retrospection. Retrospective interviewing deserves some attention and reflection upon, as it offered many possibilities and posed some challenges onto my data collection and analysis. Retrospective methods are employed “to measure and understand change and to include a time dimension to the data that can be used to identify causal factors contributing to any observed change” (de Vaus, 2011: 268). According to de Vaus, the reconstruction of processes, events and, ultimately, causal links is only possible when the researcher manages to adequately put together the past. In this light, retrospective interviews are particularly susceptible to “faulty memory” (ibid: 269).

Over the course of my fieldwork, I came to identify several occasions whereby my interlocutors were either misrecollecting certain issues and events, or were altogether forgetting about them. These memory lapses were particularly prominent in questions pertaining to the period of the cycle of contention. Such incidents included the misordering of events, the partial evocation of issues and practices as well as the fading of the subjective importance of initial values and principles. The interviews were subject to discourse analysis, and upon reflection it became apparent that in many cases those memory lapses were more telling than they were silencing. More specifically, I came to realise that most often than not, these instances denoted either the intensity of the period for the actors in question or shifts in the salience of certain issues, practices and/or events.

### 3.4.2.2. *Active Interviewing*

All interviews combined retrospective with contemporary questions, implying an invitation for reflection on the part of the respondents. It was for this reason that question items concerning more recent strategic decisions and the contemporaneous operation of the clinic and/or pharmacy in question were less structured and formulated over the course of the interview. At this point, I should add that my positionality as once-activist in the Social Clinics-Pharmacies' movement facilitated the conduct of the interview and very quickly allowed me to pose deeper and more complex questions. At the same time, my previous affiliation and participation in a clinic and my current position as a researcher, often triggered questions on the side of the respondents, who took their turn in asking me about my analysis, conclusions and opinion regarding their interventions.

Notwithstanding, therefore, the ethical repercussions of this engagement, deriving by my own positionality, as will be discussed below, this stirred my methodological orientation in the direction of active interviewing. Active interviewing strives for reciprocal engagement between the interviewee and the interviewer, encourages stimulation and provocation on the side of the researcher and expands the scope of the interview to include those “interactional and discursive gestures that shape respondents' answers to questions asked (Hathaway, 2019: 2)”.

Active interviewing was also a way of overcoming some of the pitfalls of my familiarity with the case. From the beginning of my transcription of the first interviews conducted I noticed there were incidents whereby I took certain positions or ideas for granted, when they deserved greater elaboration by my interlocutors. Active interviewing kept me attentive so that I would not end up projecting my own understandings onto them. My acquired but not unproblematic “nativity” inviting implicit conversation, needed to be counterbalanced by assuming a position of an “outsider” researcher persisting on explicit explication where I would ask my interlocutors to repeat, explain and expand on things that they -as well as I- assumed I was familiar with.

### 3.4.3. Discourse Analysis

This mode of interviewing probed data that were then subject to discourse analysis. Of particular methodological attention and scrutiny were those insights that pertained to the layered and evasive concept of solidarity, constantly evoked by my interlocutors. Through my longitudinal observation of the clinics-pharmacies, I came to realise that the concept was continuously stretching, expanding over different and wider collective actors and practices, as it was also shifting in content and salience over time. In a conference in 2015, anthropologist Heath Cabot who also conducted participant observatory research in a solidarity clinic (2016) said that in all the years she has been studying Greece, the case, and

Greek, the language to approach it, she had never come across the term “solidarity” before. She only did so during the crisis years, and it was a challenge as “*αλληλεγγύη*” was as difficult to pronounce as it was omnipresent. Finally, she joked that scholars working on Greece nowadays are exposed to the word before any other advancements in their vocabulary.

Guided by similar observations, anthropologist Theodoros Rakopoulos produced a number of publications in a pursuit to unpack and define the concept of solidarity “a term that has become ubiquitous in the public discourse of contemporary Greece” (Rakopoulos, 2014: 313). One such instance is his attempt to explain solidarity in terms of a “bridge-concept”. More specifically, he argues that

“solidarity [is] a concept that bridges- that is, captures loosely and yet in tension- diverse modes of practice, forms of sociality and mechanisms of envisioning future prospects for people’s lives. It links diverse networks of people and sometimes contradictory meanings in the context of anti-austerity mobilisation. The idea of solidarity as a conceptual bridge in people’s actions and understandings of selfhood in crisis links our common inquiry and lodges it within broader discussions of crisis (ibid, 2016: 142)”.

This inherent complexity and diversity of the concept only reinforced my active interviewing and close discourse analysis to unearth these “interpretive repertoires” *pace* Foucault (ibid 1980, 1982), as composing of different heuristic devices arranged in patterns situated in context, reflecting and affecting broader transformations in the realm of collective action (Willig, 2014).

#### 3.4.3.1. *Analysis of Primary and Secondary Sources*

Albeit very important to this thesis, interviews were not enough to cover for the broad spatial and, above all, temporal scope of this research. It is for this reason that this thesis also relies on those secondary sources covering the period 1990-2013, my personal collection of movement material that started in 2013 as well as other primary sources that I deemed relevant for this work.

More specifically, and echoing Tilly’s (2006) approach to the historical evolution of the repertoire of contention, this thesis sets to reconstruct the healthcare arena through identifying its main animating actors, stakes and tactics. For this reason, it covers a long period of time and its reconstruction invited the utilization of methods frequented in historical inquiries (Bosi and Reiter, 2014).

This was particularly relevant for the period prior to the cycle of contention. Drawing from a handful of health policy research papers available at the time of writing, I collected relevant newspaper articles, documents released by healthcare professional associations and unions as well as parliamentary debates during heated moments in the healthcare arena.

In addition, I created a “discursive database” summarising all the activities published by MSF and Mdm Greece on their official websites. More specifically, both organisations established their Greek branches in 1990 but their online presence only starts in 2005 for MSF and 2010 for Mdm. From those reports and announcements, I created categories of interventions and operations, and divided those into three broad areas of work; 1) children, 2) migrants and refugees and 3) Greek nationals.

In addition, these materials were pivotal for the reconstruction of the arena in more recent times, especially to complement for the limitations of retrospective interviewing briefly discussed above. My collection of relevant material includes documentaries, radio shows, posters, leaflets, books, news articles, Facebook posts and blogpost entries, as well as debates concerning healthcare in the public sphere, especially concentrated in periods of reform and in SYRIZA’s pre-election campaign. All the above were particularly insightful and provided great devices from which to examine changes in those clinics and their interactions, as they remain unaffected by time, my research questions and positionality (Mattoni, 2014: 27). All these data were subject to content analysis to identify the context in which they were written, their orientation and the categories they bring forward. This type of analysis is particularly insightful for studying contentious actors as some come from particular traditions, employing specific hermeneutic schemes which, in some cases may change over time, as we will see in the course of this thesis. Once I had identified the discursive patterns used by actors, I could start comparing and contrasting them, and create lineages of action and tactics within them.

Finally, a great resource for this work was the Protest Event Analysis database compiled by Professor Serdedakis and colleagues at the University of Crete covering the period between 2010 and 2015. Professor Serdedakis was kind enough to share the team’s database with me, from which I extracted data for 1) demonstration, 2) peaceful demonstration, 3) contentious demonstration, 4) strike, 5) stoppage action and 6) occupation pertaining to healthcare. All the above represent the boldest indirect forms of protest over this period, and I used them to confirm my thesis on their gradual, yet partial, substitution by healthcare DSAs.

These sources, alongside with the relevant interviews and the sum of my observations allowed me to conclude to the creation of ideal-typical trajectories to and fro healthcare DSAs. This was mainly achieved through process tracing, “a procedure for identifying steps in a causal process leading to the outcome of a given dependent variable of a particular case in a particular historical context (George and Bennett 2005).” Ultimately, my data collection and subsequent analysis allowed me to provide a “narrative explanation” of the particular outcomes of the diffusion of healthcare DSAs by informal and/or contentious actors onto the healthcare arena, as well as the outcomes of social movement institutionalisation onto tactics, players and their arena. (Vennesson: 235).

### 3.5. Ethical considerations and political reflections

Qualitative studies are particularly susceptible to ethical contestation and preoccupied with ethical reflection (Lincoln and Tierney, 2004). These considerations are even more pronounced in the study of social movements where epistemology, methodology and politics are explicitly linked (Milan, 2014: 446). In what remains, I will try to present the most important ethical concerns affecting the research design and conduct and some personal ethical reflections that stemmed over the course of this research.

From a strictly formal ethical perspective, this research subscribes to and follows the ethical conduct as prescribed by British Sociological Association's "Statement of Ethical Practice" (2017) and to the American Anthropological Association's "Statement on Ethics" (2012). The two documents outline a fundamental code of conduct for social research, focusing mostly on the protection of participants, the transparency of the research and the accessibility of its results. I consider this to be the very basis of ethical research and all of those principles were respected and followed closely.

To be sure, all my research participants were informed about my role, my background and project at the time of the research. Before each interview, all interlocutors were given the option to accept or reject the recording of our conversation, and they were all offered the transcripts of the interview in case they wanted to consult, correct and/or withdraw them altogether. All informants agreed on the recording, although some made "off the record" comments. Of those, one interlocutor asked to review their interview, but that was on the basis of collecting their ideas into writing. People that participated in this research were also given the option of anonymity. Three participants asked to remain anonymous, one participant preferred to be given their movement "nickname" instead of their name. For the purposes of this thesis, I refer to my participants, when given permission, with their first name and use both name and surname only for those public figures that I interviewed. All those that wished to keep their anonymity are not named.

Formal transparency was also respected, although as the data collection and analysis were developing, so was the research project and questions. To this end, I provided each interviewee with a clear idea of what my project was about at the time of the interview at least and the reasons motivating my research. All were informed about my enrollment in a PhD program and my source of funding.

Accessibility is hard to establish at this stage, as I have only published one relevant paper on the topic of the social clinics in an open access journal. I have, however, shared previous work with actors of the social clinics-pharmacies. More specifically, and upon the completion of my MSc, I forwarded my dissertation to the clinic researched which published it on its website. In another occasion, I have invited activist-participants of that same clinic to attend an open conference where I presented my

work. Although informal, in many occasions I was directly asked by participants to share impressions and findings of mine, including personal opinions about the future of the clinics-pharmacies, questions on similar practices in other contexts, as well as particular information about other clinics. All these issues were tackled with naturalism, yet care, to not overshadow or influence my interlocutor's personal opinions or expose members of the research.

Ethical considerations, however, do not stop there. They encompass every step of the research, from its conception, to conduct, to its "completion" by means of the production of a manuscript. Stefania Milan (2014) has outlined some of those issues and reflections commonly encountered in social movement research and invites social movement scholars to be in constant reflection upon their methods and practices in and around their research.

For what concerns the first item necessitating reflection on the side of the researcher, Milan invites us researchers to pay attention and respect both the knowledge produced and politics pursued by our interlocutors, as well as be aware and reflective of those practices that (co-) produced this knowledge and political orientation. She draws our attention to the common disconnections and discontinuities of knowledge production and distribution between the social movement and the academy. It is for this reason that one should reflect on the relevance of their work for the collective actors investigated. In the case of the clinics, this point was paramount since the very conception of this study.

The clinics-pharmacies under investigation in this thesis are all active knowledge producers. As organized, compound players they have advanced critiques and have proposed alternatives to the mainstream medical paradigm as practiced in the country. In this process, they have also learned from each other, as individuals previously excluded from the healthcare arena. Engaging in healthcare DSAs is an instance of self-organisation in a highly closed and institutionalized arena, scientised, certified and legitimated by layers of expertise and authority. My interlocutors have all being exposed to the inner workings of a (primary) clinical setting and/or have participated in an alternative system of pharmaceutical distribution outside the state and the market. In addition, in most cases clinics-pharmacies were created from scratch, meaning that their activists-volunteers needed to device ways of organizing patients' records, of ordering their workflow and of planning, staffing and funding their activities.

These experiences have given them the confidence to demand access to the healthcare arena. DSAs from below bring forward alternative conceptions of health, healthcare and wellbeing, at least to the mainstream healthcare practices and ideas, to include holistic, non-medical approaches that escape the strict medical framework and consider the impact of social structures and inequality onto health and care. To a large extent, all these are products of personal and collective engagement with the social

clinics-pharmacies paradigm. In many occasions participants, both healthcare professionals and “lay” activists, talked to me about issues they had previously not considered, such as the dangers of polypharmacy, the insulation of health policy by technocratic “experts” and the hierarchy implied in doctor-patient relationships and interactions.

This thesis does not delve into the interesting question of knowledge production, but it nonetheless showcases fragments of this collective knowledge produced over the past few years. I would argue that the study obtains its relevance, in Milan’s terms, by its very attempt to provide a meticulous report on the health and healthcare effects of austerity in the country- a concern and goal shared with the actors discussed in the thesis- as well as capture this emergent movement in both its peak and decline. That is, to account for the growth and the dissolution of a health movement that stood against “health system neoliberalism”. I believe that this account, followed by my critical analysis of the macro-level transformations in the healthcare arena upon the dismantlement of the public healthcare system can provide material for thought and reflection on the side of the participants. However, as we can no longer talk of a movement, sharing these findings and observations were limited to private discussions with activists who were curious towards me and my work, and asked of me to complement their perspective with, what they considered, my more extensive observations on health activism.

This point is, of course, related to positionality and, as discussed by Milan, to the tensions inherent in the unbalanced relationship between the researcher and the researched. This study did not subscribe fully to the Participatory Action Research methodological framework, as I have fluctuated between different roles over the past nine years of my exposure to the clinics; from a student in a clinic, to an active participant, to a participant observer, to a student of healthcare DSAs. These fluctuations turned my political enthusiasm with the clinics into political and theoretical puzzlement over them, while my proximity to those actors encouraged active engagement and exchange of ideas and criticisms. Positionality, therefore, does not directly imply the relevance of the research for the research participants, but it does encourage it. Or in the words of Dawson and Sinwell (2012);

“[...] involvement in, and even sympathy for, a movement can enable one to come to grips with the internal contradictions within a movement or the structural limitations with which they are faced. Researchers and movements are more likely to be able to constructively engage each other if they are on the same side. Being involved in the everyday activities of a movement can enable academics to undertake research projects that are valuable to activists (ibid:187)”.

In most cases, I was also confronted with great sympathy by the study’s participants. The interviews conducted were all particularly friendly, as I was feeling that my interlocutors were content to discuss about the clinics, their interventions and ideas, and confident to confide to a person who shares similar experiences, aspirations and, oftentimes, frustrations. On a single occasion I was not allowed access to

a clinic and none of its activists. This was explained on the basis of the collective's suspicion towards academic research and their refusal to speak as individuals representing a collective. In addition, the collective was also hesitant due to my previous participation in a clinic they were particularly hostile towards. All those points were understood and respected, as stemming from political traditions and experiences and I confined my data collection strictly to material produced and made public by the group.

## **4. The Greek National Healthcare System**

### **4.1. Introduction**

This chapter provides the background to the subsequent discussion on the evolution and transformation of the Greek healthcare arena over the past thirty years. To do so, it begins with a brief examination of the Southern welfare and healthcare “families” vis-à-vis their Northern counterparts. In what follows, I outline the developmental and institutional characteristics of Southern welfare systems with the intention of explaining their similarities and particular vulnerabilities. As we will see, Southern welfare regimes share a defining “peculiarity”, that is the establishment of their National Health Systems out of their fragmented and, otherwise corporatist, welfare configuration. This chapter introduces those institutional logics of welfare and healthcare organisation and provision, to then highlight their intersections and breaks. Upon delineating one from the other, this chapter moves on to examine those healthcare systems of the European South and their frailty to political and economic pressures. Last, this chapter provides a historical perspective onto the institutional architecture of the healthcare arena in Greece, that shall preambulate the analysis of the healthcare arena as an arena of political contestation.

### **4.2. Southern Welfare**

Preparations for the Economic and Monetary Union (EMU) as well as the European integration project sparked a fervent scholarly discussion and political debate as to the types and determinants of welfare regimes. In that environment the countries of the European South gained particular attention. Literature around Europeanisation has always considered these countries as democratically and institutionally immature, highlighting the benefits that European integration will have upon their development and consolidation. The lack of democratic traditions was followed, if not preceded, by economic and developmental considerations. To be sure, Italy, Spain, Portugal, and Greece have all been latecomers into the modernisation period, only to clumsily adjust themselves, their economic and social structures onto the post-industrial landscape of the late 1970s and early 1980s.

The debate that we are to follow here starts from the publication and recognition of Esping-Andersen’s book “Three Worlds of Welfare Capitalism” (1990). Drawing evidence from the advanced capitalist countries of the European West, alongside other developed countries, Esping-Andersen identifies three different welfare regimes classified through patterns of welfare provision and coverage as well as through their relationship to the labour market. These are the Liberal, the Conservative and Social Democratic models, ideal types that attain their characteristics from specific welfare and socio-

economic arrangements and configurations of those arrangements as encountered in the developed Western world.

The obvious exclusion of the countries of the European South, however, seemed at odds with the European integration project of the time and the accelerating preparations for the EMU. Scholars of economics, political science and public policy seemed concerned with the heterogeneity exhibited by these states, and the viability of common action and coordination that should benefit all member-states of the Union. Such anxieties led, among other things, to a critical examination of the role of welfare in fostering economic and social stability and enhancing democratic legitimacy, as well as to reflections of its sustainability against changing geopolitical and demographic contexts. These debates culminated in critiques over the appropriateness of the Esping-Andersen typology onto the countries of the European South. More specifically, scholars started emphasising those fundamental differences exhibited by the countries of the South, with the aim of explicating and, eventually, overcoming them within the newly established European community.

Although lending some elements from all three worlds of welfare, Southern welfare regimes exhibit a number of particularities that pushed scholars in the direction of either proclaiming a separate welfare regime, the “Southern Model of Welfare” (Leibfreid, 1992; Ferrera, 1996); or declaring an inherent idiosyncrasy, “the southern syndrome”, that albeit structuring aspects of welfare policy, does not amount to a separate welfare category (Rhodes, 1996; Castles, 1995; Katrougalos 1996).

More specifically, and as pointed out by the aforementioned scholars, the main peculiarities of those southern welfare states can be summarised as follows;

- Southern welfare systems exhibit a high degree of fragmentation and disparity in welfare provisions, especially with regards to cash benefits. This coincides with the existence of privileged and favoured social groups, usually referred to as an extreme case of corporatism that is typically encountered in Conservative welfare states. This exaggerated fragmentation results in a dualistic system of social protection that distinguishes between the hyper- and under-protected employees (Ferrera, 1995).
- Southern welfare systems all moved from a Social Insurance Health system to a National Health System in the early and mid-1980s. This transition has been achieved to varying degrees and with varying levels of success across those Southern European countries. However, the continuities and discontinuities between those two systems are particular to those Southern European countries as they are peculiar in and of themselves, as we will see below.

- This group of countries is characterised by a low degree of state penetration, as attested by the low levels of social spending relative to other European countries. This abnegation in the provision of social security on the part of the state is substituted by the strong presence of the family, as well as the church and charity in some cases.
- Last, the distribution of welfare provisions in these countries appears to be informed, if not dictated, by relationships of clientelism and patronage. This makes Southern welfare systems particularly vulnerable to manipulation and distortion by powerful political groups.

A variety of convincing explanations has been gathered to account for this bricolage of characteristics. In brief, scholars have approached these characteristics through either a developmental (historical, economic, and structural) or an institutional perspective. In what follows, I summarise the most important points made by each. Again, this discussion does not aim at a critical reading of the relevant literature, but rather a collection of those characteristics typical of Southern European welfare and healthcare systems.

**Social Expenditure in the EU countries**  
(as percentage of GDP)

	<b>1980</b>	<b>1986</b>	<b>1992</b>	<b>s (1980-92)</b>
Belgium	28.0	29.4	27.8	-0.2
Denmark	28.7	26.7	31.4	2.7
France	25.4	28.5	29.2	3.8
Germany	28.7	28.1	26.6*	-2.1
Ireland	21.6	24.1	21.6	0.0
Luxembourg	26.5	24.8	28.0	1.5
Netherlands	30.8	30.9	33.0	2.2
United Kingdom	21.5	24.3	27.2	5.7
<b>EU 12</b>	<b>24.4</b>	<b>26.0</b>	<b>27.1</b>	<b>2.7</b>
Greece	12.2	19.4	19.3	7.1
Italy	19.4	22.4	25.6	6.2
Portugal	14.7	16.3	17.6	2.9
Spain	18.1	19.5	22.5	4.4

\* 1991. **Source:** Eurostat, 1993.

**Figure 2: Social Expenditure in the EU countries 1980-1992.**

#### 4.2.1. Developmental Factors

Castles (1995) and Katrougalos (1996) both stress that the Southern European welfare states were established late, by weak and underdeveloped national economies and in direct competition with their

Northern counterparts. Welfare expansion in those settings was complicated by the lack of available resources for social spending. Comprehensive reform in the extension of welfare policy was delayed or even disallowed by these countries' weak economies which faced grave difficulties during the economic recession of the 1980s and additional pressures during the preparations for the European accession.

Moreover, the very development of those systems in the post-1970s period is understood as rapid and spatially-restricted, structuring and deepening inequalities along territorial and class (occupational) lines. As such, modernisation in the region saw the exacerbation of heterogeneity in Mediterranean societies, ultimately leading to the emergence of strong and dynamic middle-classes, capable of manipulating political developments (Petmesidou, 2001). Scholars who focused solely on the economic determinants of those welfare states were generally optimistic as to their advancement and progress. To be sure, they were proponents of the "catching up" hypothesis which was only to be facilitated by these countries' integration into the European Union.

Other scholars moved away from deterministic socio-economic interpretations to more holistic understandings of the development of these welfare systems. More specifically, and in considering the establishment and expansion of the welfare state in those countries as a means of smoothening the democratic transition, scholars have underlined the impact of the respective national legacies of authoritarianism onto these systems' conception and formation (Maravall, 1992; Moreno and Sarasa 1992; Moreno, 2010). When considering authoritarianism as a common denominator in the trajectory of all four Southern European countries, we can see that welfare policy design was structurally and ideologically influenced by it- both in the cases of structural (dis)continuities and ideological breaks.

One example of structural continuity can be found in the cases of Greece and Spain where corporatism, as it was fostered under the respective national dictatorships, was maintained even after the countries' transition to democracy. The legacy of authoritarian rule has also been used to explain the relative weakness, fragmentation and radicalisation of parts of the Left in the Southern European countries, resulting from its prolonged and protracted exclusion from formal politics. This has indirect implications for the development of the welfare states in question. As argued by Rhodes (1996), Social Democracy in the European South found itself in direct competition with the traditionally rooted national Communist Parties, paving the way to a distinctive trajectory away from its Northern branch. Namely, Southern Social Democratic parties became

“the vehicles for the ascendance of a modernising (and sometimes self-promoting and corrupt) bourgeoisie and quite open to appeals of the neoliberal ideas which

[...] became a new international policy paradigm at a critical moment in the ideological development of these parties and in the southern welfare construction” (ibid: 10).

Ideological distancing from the authoritarian past was another inspiration behind the constitution of those welfare states. Viewed in this light, (some) progressive policies were pre-emptively rejected on the basis of their affinity to policies enacted by the authoritarian regimes. One such example is the rejection of family policy in Spain which, according to scholars, was an attempt to avoid affinities with Franco’s pronatalist policies (Valiente, 1996; in Rhodes 1996).

#### 4.2.2. Institutional Factors

Institutional arrangements and particularities help complement the range of factors contributing to those welfare idiosyncrasies. These are here summarised as the division between formal and informal labour markets, formal and informal vehicles of social provisions and support, and the role of party politics in advancing vested interests at the expense of welfare equity.

Scholars of the Southern European countries have directed their critique to Esping-Andersen and his adherents’ outward exclusion of certain economic sectors and corresponding social structures which are fundamental and deeply rooted in the four countries considered here. More specifically, and as pointed out by Pereirinha (1996), their strong emphasis on the formal labour market and concomitant rights and responsibilities of citizens-workers, has contributed to the historical and scholarly undermining of informal labour markets which remain prominent in the South of Europe.

This has significant implications for the conceptualisation of social policy vis-à-vis alternative and/or informal networks of social support which are to be found in Spain, Italy, Portugal and Greece. For this reason, Rhodes, *pace* Pereirinha, puts forward an approach to welfare states that would include not only the relationship between the state and the market, but also civil society and its expressions on both household and public levels.

A number of feminist scholars have since highlighted the centrality of the family in social security in the European South, as a means of both welfare provision and informal employment (see Trifiletti, 1999; Bakker and Silvey, 2008). Although obscure in the minds of public policy scholars, the incorporation of the family into the study of social protection and/or economic organisation is unavoidable in our attempt to comprehend the cases of the aforementioned countries. Departing from a rejection of the

presumed linear evolution and convergence of national markets and their welfare counterparts, scholars like Papadopoulos (2006) have emphasised that amidst economic hardship and supranational competition, both the states and the markets of the South have made attempts to isolate and minimise their responsibility towards social reproduction. More specifically, in appeals to growth and competitiveness, both parties have avoided taking on those obligations found in Northern welfare states. The resultant void in social protection is understood to be taken on by the institution of the family, as both a welfare provider and an economic agent, so much so that some refer to this arrangement as “familistic welfare capitalism, whereby “[t]he self-reliance of families has traditionally been taken for granted by governments in matters of social care and material support” (Moreno, 2006: 75; see also Papadopoulos & Roumpakis, 2013).

To be sure, the family is understood as a “social shock absorber” (Karamessini, 2007: 2) in those contexts as the low-wage labour markets of the European South were never matched with an adequate system of social support (Papadopoulos & Roumpakis, 2013). Southern European welfare states do not provide any benefits schemes for young people prior to their first employment, they provide minimal benefits to non-contributing single parents, and make no provisions for the unemployed unless old and/or invalid (Ferrera, 1996: 20). As such, the family is the protector against poverty, marginalisation and social exclusion, and it has indeed been used to explain the relatively low crime rates in face of socio-economic insecurities in those countries (Guillen, 1996).

Introducing this “familialistic” aspect in our description also provides the analytical ground for comprehending both the existence and persistence of this dualistic system of social provisions as well as the reproduction of patronage and clientelism as structural and behavioural characteristics central to the welfare states in question. More specifically, Papadopoulos and Roumpakis (2013), consider the Greek family as at once a core mechanism in the reproduction of the clientelist system and an anchor for claiming social security rights. That is because the family member under formal employment can extend their rights to other family members which might be unemployed or involved in informal labour market activities, recognised as proteges by state institutions (ibid: 208; see also Petmesidou 1991). In addition, Ferrera (1996) highlights the role of the family in navigating and manipulating the administrative and bureaucratic maze of national welfare states. This is achieved by carving and reproducing channels of information obtained informally, thus sustaining and promoting clientelism.

Clientelism is understood as a central mechanism for the production and maintenance of relationships that link partisans to welfare institutions. More specifically, the low levels of state penetration described above are accompanied by critiques to state power proper, and Ferrera describes the countries of the

European South as suffering a double deficit of “stateness”. The lack of a Weberian-type bureaucracy allows for individual and group manipulations of the welfare state apparatus, achieved both by the involvement of partisans into welfare administration for party-promoting purposes as well as the possibility of bypassing those soft and irregular administrative arrangements to ensure benefits provision on a one-to-one basis.

Moreover, and with regards to the dualistic welfare system of *iper-* and *hypo-garantismo*, powerful unions and their leaderships which, in the cases of these countries at least, are directly related to political parties, can push for the expansion of provisions and favours to particular occupational and territorial groups, ultimately reinforcing inequalities in social security. All the above carve out distinct policy paths and priorities that minimise the possibility of progressive and horizontal reform.

As we can see, those Southern particularities, both in terms of the evolution of these welfare systems and their resultant configuration chart a complicated picture that stands contrary to the other “worlds of welfare”. The persistence of corporatism is one of the main peculiarities identified here, while its interaction with the soft state seems to reinforce clientelism and patronage, disabling modernisation and progressive reform. What remains a puzzle, however, is the introduction and (partial) establishment of a National Health System onto this fragmented terrain. The European South in the mid-1980s departed from the traditional corporatist Social Health Insurance model to the universal National Health System, typically financed through tax contributions. In the ensuing discussion I will attempt to provide a developmental perspective to some of the most important characteristics of the National Health Systems of the European South. The country-based analysis shall allow us to disentangle Greece’s trajectory in establishing a healthcare system, as well as to comprehend the (incomplete) transition from one system of healthcare to the next. It will also facilitate us to tease out the problems and issues, actors and processes that contributed to this transition, alongside the explication of those dynamics vis-a-vis the developmental and institutional characteristics discussed above. As such, it will set the scene for the subsequent animation of the healthcare arena as an arena of political contestation. Last, the institutional characteristics that will be outlined here will help ground the effects of the 2010 austerity crisis onto the National Healthcare System and its contingencies.

### **4.3. Southern Healthcare**

In addition to those criticisms to the “Three Worlds of Welfare Capitalism” posed by scholars of the European South, scholars of healthcare have also raised a number of limitations. Some of the most important critiques in this direction are that Esping-Andersen’s typology is mostly applicable to cash

benefits, not services and that the universe of healthcare is complex and multilayered where all issues of funding, service provision and access need to be considered when constructing categories (Wendt et. al 2009; Bambra et al 2005). More specifically, Moran (2000) criticises welfare studies for traditionally neglecting healthcare and suggests that healthcare should, instead, be used as a prism for the comprehensive study of welfare regimes, their evolution and the pressures they come to face.

Departing from a conceptualisation of the welfare state as distinctly and originally European, Moran (2000; see also Ferrera, 1997) draws our attention to the intertwined processes of changing socio-biological trends, globalisation and Europeanisation on both economic and institutional levels, as explanations of and predictors for those challenges modern healthcare systems have come to face. In particular, Moran considers advancements in the quality of life and life expectancy of Europeans as changing the priorities of systems of social protection by taking the focus away from the labour market and concomitant issues, to groups outside of the labour market, such as children and the elderly. In addition, changes in the very composition and form of those labour markets have impacted the type of social protection needed, especially as welfare regimes come to address and cover the direct and indirect effects of deindustrialisation in Europe (see also, Pierson 1998).

The above transformations impact welfare states in general while putting additional pressures onto and heightening expectations over healthcare systems. It is important to note here some of the most important components and distinct characteristics of healthcare programmes make healthcare not only different to other welfare services and provisions but also central to them, as they neatly correspond to the developments outlined above. These are the resources consumed under this sector, the personnel employed (both in quantitative terms of numbers and in qualitative terms of expertise), the historical role and importance of healthcare programmes in the erection and development of welfare states in general, as well as the subjective attachment that European citizens exhibit towards them (Moran, 2000: 135). However, Moran warns against the conflation between and subsumption of welfare and healthcare systems, as

“[h]ealth-care institutions are influenced by, and of course influence, the wider welfare state; but they are also shaped by dynamics of their own- some of which are internal to, and some of which are external to, the health-care system” (ibid: 139).

#### 4.3.1. Types of Healthcare Systems

For the purposes of this work, I employ the most comprehensive typology of health systems put forward by the OECD in 1987, which identifies three ideal types, stemming from configurations in healthcare coverage, funding and ownership. This typology has provided a fertile ground for further elaborations and (re)configurations in the existing literature, which also consider the dimensions of production, (Moran, 1999); the tripartite relationship between the market, the state and civil society and their role in provision, financing and regulation (Wendt et al, 2009); and the privatisation of risk, doctors' compensations etc. (Wendt 2009), all of which relevant for different types of studies. However, the OECD typology shall suffice here as the aim is not an in-depth and/or comparative analysis of healthcare regimes, but a detailed account of their evolution and transformation over time so as to understand current developments and situate healthcare arenas. Very briefly, thus, the three ideal types identified by the OECD are;

- The Private Health Insurance model; where insurance and coverage are readily available by the market to consumers of healthcare services.
- The Social Health Insurance model (henceforth SHI); where compulsory insurance for healthcare provision and access is taken by citizens and is partly financed by the employee, and partly by the employer. SHI is managed by non-profit national funds which might also deal with other aspects of welfare services and provisions.
- The National Health Service<sup>5</sup> (henceforth NHS); where healthcare provision and access is universal and financed through a system of general taxation. In this model, health service delivery is dominated and dictated by public provision, and there is public ownership over the (majority) of health infrastructure.

The role of the state should not be exaggerated, however, even in the cases of the most publicly funded and owned National Health Service systems. To reiterate the point made above, the case of healthcare, even when publicly funded and managed by the state, incorporates and invites a range of actors, relations and practices that bring together both the state and the market. A good example of that is the contradictions put forward by medical technologies and their appropriation by public healthcare systems. The accelerating paces of biomedical advancements, alongside the mounting power of the biomedical and pharmaceutical industries complicate the relationship between the state and the market even in settings where healthcare is predominantly public. In addition, and as insisted upon by Schmid

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<sup>5</sup> Also found as “National Health System” or “National Healthcare System” in the relevant literature. For the Greek NHS, I use the term National Healthcare System as it translates from the original Greek.

et al. (2010), the medical profession as a group of experts with organised interests should not be undermined when considering healthcare policy. Hence, although “in NHS systems, problem pressure in mainly translated into remedies of state failure [...] [they] are not purely “command and control”, since resource allocation requires the cooperation of the medical profession” (ibid: 466). The role of information in healthcare policy will be further discussed below as it is central in understanding not only the influence of the medical profession, but other civil society actors in pushing for and/ or resisting change.

#### 4.3.2. Southern Healthcare Systems

Returning to our discussion on Southern Europe, Ferrera (1996) describes the Southern welfare model as combining two welfare cultures; that of “occupationalism” characterised by occupation-based solidarities in income maintenance coupled with an attempt to move towards national “universalism” in the case of healthcare. More specifically, he views their synchronised move from contributions-based insurance systems along highly fragmented occupational lines and concomitant inequalities in welfare provision and social protection to an NHS as guided by a sentiment of “half-hearted universalism”, only relevant for the domain of healthcare (1996: 34). The “half-heartedness” of this transition is evident in its incompleteness as contributions seem to persist even in public healthcare.

To be sure, and while all the aforementioned countries transitioned from an SHI to a NHS model, they retained elements of the previous insurance system both in terms of financing and provision (Wendt, 2009). More specifically, as public policy scholars agree, it is possible that past models, albeit radically departed from, may leave structural and cultural traces that define the implementation and success of relevant reforms. In the cases of Spain, Portugal and more so in the case of Greece, the old system of SHI was not entirely dismantled, thus creating a particular frame for the introduction of the NHS. Italy is an exception, as it single-handedly eliminated sickness funds as early as 1978 (Toth, 2010: 330). Notwithstanding these trajectories in the establishment of each national NHS, none of these countries managed to fully replace the linkage between coverage and occupation and tie healthcare entitlements to citizenship.

Toth (2010) further elaborated on Ferrera’s conceptualisation of the Southern healthcare model, to conclude that a simple list of characteristics shared among Southern European NHSs does not suffice to proclaim a separate Southern European category. For this reason, he compares and contrasts the Southern European NHSs to the rest of the European healthcare systems. The items collected at once

unite the Southern European NHSs as well as distinguish them from other NHSs. The most important characteristics identified by Toth are contextual, institutional and related to policy outcomes.

Recapitulating Ferrera's point, Toth argues that Southern European countries share a similar genesis in terms of the timing of their implementation of reform in the direction of an NHS. According to Toth, then;

“[t]he countries of the south of Europe have [...] been variously defined as national health services which are ‘in transition’, ‘semi-institutionalised’, or ‘laggard’ (Ferrera, 1996; Saltman and Figueras, 1997; Katrougalos and Lazaridis 2003), precisely to differentiate them from the former set of countries” (Toth, 2010: 327).

The issue of timing in the establishment of these National Health Services appears as key in the analysis of their development and has attracted a number of scholars. Petmesidou and Guillen (2008), for example, note the relatively swift transition of those systems to an NHS model soon after their establishment, and stress that they were latecomers compared to other EU countries (*ibid*). This bore structural implications for the establishment of those systems. The authors argue that these systems of healthcare provision were introduced upon a very mature system of social and health insurance which was hard to uproot, and is in fact responsible for the policy contradictions and system incoherences that the Southern countries exhibit.

In addition, and in line with the broader literature on Southern welfare summarised above, they make a case for the “density of historical timing” of the implementation, namely the economic difficulties and European pressures faced by these countries during the period of the NHS transition. Unlike their Northern counterparts which were able to establish their NHS during a period of prolonged and protracted economic development that expanded concessions to the welfare state, the Southern countries did so in an environment of economic crisis and austerity (in order to comply with Maastricht treaty for accession to the EMU), which was ultimately putting into question so much the sustainability of the welfare state as well as the very appropriateness of its intervention in social reproduction.

This relative delay also corresponds to a political “critical juncture” offered by these countries’ transition to democracy in the 1970s. Unlike the economic considerations put forward by Petmesidou and Guillen (2008), this juncture is widely understood as beneficial and/or responsible for the countries’ non-incremental policy shift. This point was further elaborated upon by Guillen (2011) in her study of

the policy-making process of universalisation and its outcomes in each respective country. Following the neo-institutionalist paradigm, Guillen argues that:

“It is, thus, possible to hypothesise that the concurrence of democratisation of authoritarian regimes taking place at the same time as the economic oil-shocks, the arrival of left-wing parties in office, the appearance of new political actors (including, for example, regions) and the presence of the European Community paved the way for path deviance (ibid: 52)”.

A last characteristics of the Southern model is the presence of a strong and dynamic public/private mix, as initially observed by Paci (1987) both in terms of healthcare financing and provision. The latter suggests that, unlike other NHS systems, those of the European South allow for the promotion of private providers at the expense of the public sphere (see also Ferrera, 1996). Toth also reiterates the central role and excessive intervention of the market sector into the operation of these countries' NHS. This can be captured as the interrelationship between high private expenditure (when compared to Northern NHSs), the heightened levels of private infrastructure (mainly in the case of hospital beds) and the systematic and persistent low levels of patients' satisfaction with their NHS (Toth, 2010: 338).

#### **4.4. Evolution and development of the Greek National Healthcare System**

The overthrow of the dictatorship in Greece in 1974, was followed by a fervent debate around the establishment of social policy and healthcare policy schemes, in the direction of more equity and efficiency. More specifically, increasing socio-political and financial pressures made healthcare reform a top priority in the post-dictatorship government agenda and as early as 1976 surveys and plans for reform had been submitted to the Ministry of Health outlining the main problems of and possible solutions for the healthcare system. Problem areas included regional inequalities in healthcare financing and provision, with rural areas providing limited, if any, healthcare services and the existence and persistence of direct payment methods that undermined official, institutional channels and boosted the underground economy in the healthcare sector. Among the proposals put forward, the most important ones were the merging of the various sickness funds and the introduction of family doctors to harmonise service provision in rural regions as well as facilitate referral to larger hospital units. Political and professional opposition, however, halted reform in this direction and comprehensive reform in the realm of healthcare was only to be initiated with the first socialist government.

The first Pan-Hellenic Socialist Movement (PASOK) government elected in 1981 presented a radical reform opportunity in all political, social, and economic spheres. Coming out of a conservative and repressive political period, where the dictatorship was replaced by the conservative party of New

Democracy (henceforth ND), the voters of PASOK saw in it the opportunity to modernise and refound the country on a socialist basis. Given the already existing pressures faced by the healthcare system, the increased attention it had acquired over the years of the democratic transition and the ideological underpinnings of this newly elected party, PASOK passed on what is now considered the most important legislative reform that has, thus far, been implemented for the Greek healthcare system (Economou, 2010: 21). Law 1397/1983, saw the introduction of the Greek National Healthcare System (henceforth ESY), which would operate on the basis of free, universal and equal access to high-quality health services on the part of the Greek population, as provided by the public healthcare system.

Over 30 years later, one can admit that the introduction of the ESY, albeit an important reform package, was only partially successful and particular items have provided a historical contest ground between different political parties, unions and professional (here medical) associations. Reform initiatives dating back to 1983 re-enter public policy agenda, and the healthcare reform scenery of the country seems to follow a pattern or an “epidemic” of short-lived healthcare reform proposals (Stambolovic, 2003) in line with subsequent and frequent government changes, as we will see in the following chapter.

The discussion on the Southern European welfare and healthcare system serves to introduce the more detailed discussion on the case of the Greek National Healthcare System (ESY). Before so doing, however, it is important to note how scholars have problematised the case of Greece as either an “exaggerated” case or an “ideal type” of the Southern model. This becomes particularly apparent when looking at healthcare, whereby all aspects of its financing, provision and organisation suggest that “the Greek national health service is such in name only, and in reality is a perfect hybrid between the national health service and the social health insurance models (Toth, 2010: 330)”. In what remains, I provide an developmental and institutionalist perspective onto the establishment, evolution and particular configuration of the Greek National Health Service.

#### 4.4.1. SHI/NHS mix

Although existentially contradictory to the SHI system, the NHS developed on the basis of the multiple social insurance and sickness funds that were deeply rooted in the country. Following early proposals, Law 1397/1983 intended to merge all funds under one unified fund, but partisans, alongside trade unions, powerful and generous sickness funds and their members, pushed for the protection of the sickness funds and resisted the merge proposed by the law (Davaki and Mossialos, 2006). Until very recently, Greece had approximately thirty different funds -some small, others covering whole sectors of the economy- which further exacerbated socio-economic inequities as analysed above.

In addition, the Greek peculiarity was further accentuated by the existence of what Toth (2010) calls “two parallel national health services”. That means that alongside the ESY, there existed a separate body of healthcare provision with its own personnel, hospitals and, mainly, primary health centres (Economou, 2004). This second service was under the management of the largest social insurance fund in the country, the Social Insurance Institute (IKA) which until recently covered about half of the Greek working population.

Following the familistic welfare model, and in line with the theory that sees the state and employers as hesitant to take on their share of social responsibilities, insurance was made compulsory for all workers, and their coverage could be extended to their uninsured family members. In addition, the insurance was financed partly via general taxation, in line with the NHS financing model, and in part by the employee, as direct contributions from his/ her wage.

Although the abolition of sickness funds for the creation of a tax-based system of health insurance was never explicitly in the agenda, recommendations and policy proposals related to the unification of the various funds into one periodically appears since the 1990s, as a response to both the economic pressures, related to budget deficits, they were facing, as well as a means to improve healthcare coordination in financing and spending. The system of multiple providers was seen as both ineffective, unequal, and ultimately costly, while

“[t]he common fund would play the role of a purchaser, operating as an oligopsony or monopsony, setting priorities, defining the quantity, quality and prices of services and negotiating contracts with providers” (Economou, 2010: 23).

This merging would eventually take place in 2012, after the establishment of the National Organization for Healthcare Provision (EOPPY) as a single unified and central fund in the country voted by Law 3918/11. As Polyzos et al. (2014) suggest, “[t]his step was necessitated inter alia by the pressing fiscal, financial and of course funding constraints caused by the crisis and the memorandum, and its implementation was overseen by the three lenders or else so called “Troika”” (ibid: 3).

The existential tension between SHI and NHS is illustrated empirically by the crisis and its effects in terms of coverage. The merging of the funds under the National Organisation for the Provision of Healthcare Services (EOPYY), although intending to equalise and harmonise the provisions available to the insured population as well as improve the coordination between purchasers and providers, did not have universalisation in its scope. Over the years of the crisis, EOPYY covered citizens on the basis of their insurance status and could extend coverage for up to two years of unemployment. As the crisis left some 30% of the population unemployed by 2013, a third of the country was left without health

insurance. Policy responses to this problem were limited to the distribution of “health vouchers” that lasted for four months without possibility of extension and/or renewal. As such, I argue that the crisis and its effects further problematise Greece’s position into the NHS family.

#### 4.4.2. Centralisation/ decentralisation

##### 4.4.2.1. *Administration*

Another pressing issue throughout the development and realisation of the ESY has always been regional inequalities in healthcare access, infrastructure, provision and quality of services. This has been stressed and addressed by all governments and their oppositions, but comprehensive reform has remained incomplete.

More specifically, decentralisation was a key reform proposed in the Law 1379/1983, dictating the establishment of regional health councils which would bear planning and executive responsibilities. The law stated that a Central Health Council (KESY) was to be established, in order to mediate and advise the Ministry of Health on issues of policy and medical research. The KESY would be supported by numerous regional health councils, themselves established with the intention to decentralise and ultimately facilitate planning and financing on the part of less developed regions.

This, however, was not achieved, and it was only towards the end of the decade of PASOK’s long reign that new bodies of Regional Health Authorities (PeSYs [Law 2889/2001]) would be introduced. Those were soon opened up to include other welfare services as well, and the bodies were transformed into Regional Health and Welfare Authorities (PeSYPs [Law 3106/2003]) (Kakaletsis, et al. 2013). The creation of 17 PeSYPs meant the assignment of some advisory responsibilities onto regional authorities without, however, dictating any actual devolution of healthcare competences in any of the realms of planning, financing and/or provision.

Once again, the change of government in 2004 would bring this half-hearted decentralisation effort to a halt, and recentralising measures would be taken up, dictated by reductions in public spending. The, then, Minister of Health and Social Solidarity, Dimitrios Avramopoulos, reduced the number of the PeSYPs to 7, and under this framework reorganised them as Health Region Administrations (DYPEs [Act 3527/2007]). This recentralisation effort was complemented by other policy reversals, distancing the ND path from the one drawn by PASOK over its 11-years in office. More specifically, the ND administration revised the 2001 reform that had, among other things, attempted to professionalise the selection of senior managers in the regional ESY administration and the hospital sector, for the return to the “previous pattern of political administration” (Economou, 2010: 141). On top of that, new organisational structures were established but on a vertical, centralised basis.

#### 4.4.2.2. *Provision*

The question of decentralisation was always tied up to the need for the establishment of a more holistic, responsive and inclusive primary healthcare system. Going back to Law 1397/1983, itself largely inspired by the Alma-Ata Declaration, primary care was seen as a means of bridging regional and income inequalities while improving the healthcare system's coordination and efficiency, serving as its backbone in terms of both prevention as well as referral to specialists and hospital units.

The primary healthcare sector in Greece has been highly problematic and most of its pitfalls remain unresolved. Problems pertaining to coordination inefficiencies involve two levels; the absence of a referral system provides no continuity in care and complicates the effectiveness of the system. Primary care in Greece was offered by the ESY as well as some sickness funds- most importantly IKA cited above- and private providers. Structural, organisational and technological differences between the three providers make the ESY the least appealing option for Greek citizens, as evidenced by a survey conducted by the Institute for Social and Preventive Medicine (2006).

More specifically, since the establishment of the ESY;

“The sickness funds primary care infrastructure and variable benefits remained untouched, due to opposition from physicians engaged in private practice, and social groups who received enhanced healthcare benefits. The 1983 reforms missed a unique opportunity to overhaul the fragmented system of social health insurance and to create a universal, integrated primary healthcare system (Kondilis et al. 2012: 264).”

Up until 2008 the ESY had 201 health centres in rural and semi-urban places that provided both GP and specialist diagnosis and treatment (Tountas, 2008). On top of that, there were about 1,500 primary health surgeries mostly staffed by medical graduates who are required to work in a rural surgery for at least a year before they continue with their specialisation. This relates to the particularity of the Greek geography and socio-demography, as the overwhelming majority of the population resides in the Athens greater area, but a significant portion resides in rural and sometimes entirely isolated villages, either in the mountains or in the hundreds of inhabited islands of the country.

In addition, until 2014 sickness funds provided a series of clinics and polyclinics, and each one had their own medical and nursing staff, either on a full-time basis or on the basis of private contracts. In a study conducted in 2010, Economou estimates that around 16,000 doctors operated under the two largest funds in the country. The private sector complements the picture, with private practices, laboratories and diagnostic centres that compete both in terms of efficiency and infrastructure with the public alternatives.

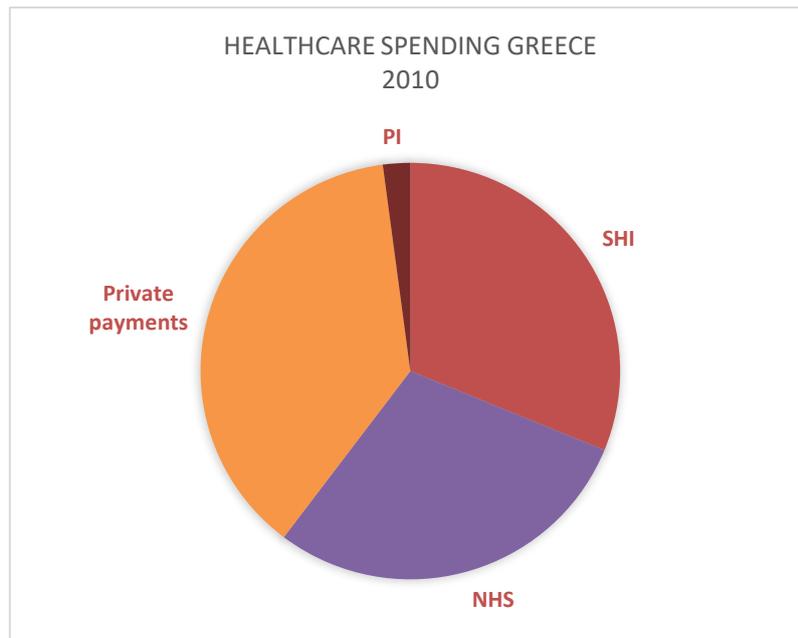
Over the course of the crisis Law 4238/14 disassociated the sickness fund clinics from the unified EOPYY and integrated them into the ESY, under Regional Health Authorities. This restructuring, however, led to the closure of a number of units, officially attributed to personnel issues related to cuts in expenditure and the placement of their professionals in probation before employing them as ESY personnel. Polyzos et al. (2014) argue that in the absence of adequate funding for these clinics problems of accessibility persisted.

Indeed, a commonly cited factor preventing primary care reform in Greece is the composition of its human resources. Greece has the highest ratio of specialists and among the lowest ratio of nurses in the European Union, while “[o]f the 50,000 doctors in 2001, less than 2 percent had qualified as general practitioners (GPs)” (Davaki & Mossialos, 2005: 155). Davaki and Mossialos (2005) explain the shortage of GPs vis-a-vis the oversupply of specialists as resulting from the relatively late introduction of general practice in national medical universities and the greater resentment of prospective professionals to choose it as a specialisation due the higher status and income enjoyed by doctors of other specialisations.

#### 4.4.3. Private/ public mix

The deep penetration of the private sector onto the ESY is one of the most important characteristics of the Greek healthcare system, one that has historically determined its evolution and setting the Greek case apart from the rest Southern European healthcare systems. As mentioned above, insufficiencies and inefficiencies of the public healthcare system have over the years invited private actors and boosted market opportunities for their expansion in the sector. The ESY currently depends on the market sphere for all aspects of financing (legal and illegal) and provision (direct and indirect).

To be precise, Greece exhibits a relatively low percentage of PI as opposed to SHI. That is because of the long history and deep-rootedness of compulsory insurance in the country. However, private spending remains very high in the public healthcare sector. According to a country-based report published by the European Observatory on Health Systems and Policies (2010) general taxation provided 29.1% of the total expenditure, health insurance provided 31.2% while private payments accounted for 37.9% of the total health expenditure in Greece “calling into question the social character of the health care system” (Economou, 2010: 47). Private spending in the ESY takes the form of legal out-of-pocket payments for services not covered by the insurance scheme of the patient (mostly pertaining to primary and dental care); for services provided by the SHI but not chosen by the patient who turns to private alternatives; and co-payments for services and pharmaceuticals. These are supplemented by the illegal payments made directly to the doctors of the ESY, the infamous “*fakelaki*” (little envelope), aiming at securing fast-tracking of waiting lists and better care from the doctor.



**Figure 3: Healthcare spending in Greece, 2010**

Source: author's elaboration.

It is obvious that this distribution of healthcare spending, structurally and institutionally hinders any attempt to universalise high-quality healthcare, as guided by the principles of the ESY.

“Moreover, it is assumed that access is free and equal, and that patients pay no official fees at the point of use, with the exception of smaller user charges for services provided by hospital outpatient departments and for the cost of medication. In reality, however, these aspects of public healthcare are significantly distorted. The high level of official and unofficial private spending on health is a factor which negates the principle of equity and the principle of zero prices at the point of use” (ibid: 148).

Inequity, then feeds back to problems of coordination and exacerbates inefficiency, as the lack of coordination between the different payers, coupled with the high levels of private spending make the imposition of ceilings difficult, resulting in excesses in the overall health budget paid retrospectively. Once again, the crisis further boosted private payments in healthcare provision (either in the form of direct out-of-pocket or co-payments), unevenly burdening those on the lower socio-economic strata (Liaropoulos et al., 2008; Kaitelidou et al., 2013). This is going to be further discussed in the ensuing chapters.

Last, but not least, over-prescription of pharmaceuticals further enhances the role of the market and the share of private spending in healthcare in the country. More specifically, pharmaceutical expenditure in Greece is among the highest in the EU. Whereas the OECD average recommends a

16.6% of pharmaceutical expenditure from the Total Healthcare Expenditure budget, in 2012 Greece spent an outstanding share of 24.8% on pharmaceuticals, an increase of 10% since 1995 (OECD Health Data, 2012).

To be sure, this excess cannot be understood outside of the competition of the pharmaceutical market and the nexus regulating its competition within the confines of the EU. More specifically, the rise in pharmaceutical prescription and concomitant consumption dates back to 1998, when Greece introduced the lowest reference pricing system in the EU, alongside a system of reimbursement for pharmaceuticals from the positive list. The reform was introduced in a spirit of controlling pharmaceutical expenditure in the EU community, while promoting the health and wellbeing of the population in the country. However, it fostered a culture of overprescription on the side of the doctors, which later backfired as the prices of pharmaceuticals rocketed during the early 2000s, influencing, among others, Greek prices and burdening the healthcare budget (Contiades et. al, 2007; Yfantopoulos, 2008). The advent of the crisis and the signing of the Memoranda of Understanding in the past years have resulted in a sharp decrease in overall and public pharmaceutical expenditure (32% and then 43.2% of the total budget) with serious implications for the access to those products on behalf of the population (Economou et al, 2015: 111).

The penetration of the market does not confine itself in the financing of the healthcare system but also influences key aspects of healthcare provision. According to Tountas et. al (2005), although the overall number of private hospitals and hospital beds assigned to the private sector had decreased at the turn of the century, the number of private doctors, diagnostic centres and laboratories had increased considerably. The reasons proposed by the authors include the low quality of and shortages in the range of services provided by the ESY coupled with the overall low levels of patient satisfaction and long waiting lists.

As such, doctors and specialists, even those university doctors under the purview of the ESY, also provide private alternatives to the ESY. This is a direct result of the organised efforts of the medical professional group that has always resisted being tied up to a public employee status, and has managed to undermine reform efforts in this direction. Although there is no way of establishing an estimation of the size of the phenomenon, patients often admit to the existence of an underground private economy operating by ESY doctors (Davaki & Mossialos, 2006).

Last but not least, during the 1990s, the overall boom in medical technologies brought about the emergence of private laboratories and diagnostic centres in the country, equipped with advanced biotechnological equipment and products. Those are, at least partly, funded by the ESY and the sickness funds via contracts for those tests that the ESY units cannot conduct due to the absence of

infrastructure. However, quality regulations fell short in restraining the expansion of the private biomedical and diagnostics' market in Greece, and even now the existing "methods of paying providers do not generate incentives to improve efficiency and equality" (Economou, 2010: 151).

#### **4.5. Conclusion**

This chapter has attempted to sketch some of the most important characteristics of the Southern European welfare systems to highlight their continuities and discontinuities with the healthcare systems in place. This was achieved with the provision of a bibliographical overview of the most defining elements of those systems of welfare provision and organisation in the European South, to include their high fragmentation, their configuration along relationships of patronage and clientelism, their relative "stateness" as well as their peculiar and swift transition from a SHI model in healthcare to that of the NHS. Explanations as to those particular characteristics are also discussed to provide a fuller and more dynamic picture of the socio-economic and political environments in which those welfare systems developed. In so doing, this chapter has aspired to at once place healthcare systems within broader welfare arrangements as well as make a case as to their distinctiveness from systems of welfare provision.

This chapter has also looked at those National Health Service systems of the European South. From that discussion, one can see the alignments of and departures from those "two cultures of welfare" underpinning institutional development in those contexts. These cover the transition from welfare occupationalism to healthcare universalism, as well as other aspects of welfare organisation that have informed the establishment of the healthcare systems in those countries- including the role of the family, the shadow economy, and the market agents that effectively distort universalism. All the above characteristics are understood as consequential for the development of welfare and healthcare policy in these countries.

Last, this chapter has provided a brief presentation of the evolution and development of the Greek healthcare system. This presentation, organised along the issues of (1) the SHI/ NHS mix, (2) the centralisation/ decentralisation of the system and its (3) private/ public mix is proceeded processually, to note important reforms and contemporary institutional arrangements and bring to light those contentious areas of healthcare policy reform.

All the above opt to provide an institutional picture in which to situate the subsequent animation of the healthcare arena as an arena of political contestation. In line with Jasper, then, this chapter opts to outline those institutional characteristics of the ESY so as to understand the fundamental stakes of the

arena, its most important actors historically and for the periods discussed in this thesis. As we will see, this presentation of the Greek NHS also grounds the effects of the austerity crisis onto the healthcare arena and concomitant collective actors and onto the ESY, its organisation, financing and constituencies.

## **5. The healthcare arena, its players and their repertoire, 1983-2010. The development of healthcare DSAs.**

### **5.1. Introduction**

In the previous chapter we saw some of the institutional characteristics of the Greek welfare state and the ESY, including its historical deficiencies and problems. In a nutshell, these pertain to three interrelated and incomplete aspects of the 1983 ESY reform that became particularly pressing over the course of the crisis; the lack of a primary level of care, the existence of multiple sickness funds and the concomitant blind-spots and inequalities in healthcare coverage. In this section I will seek to de-naturalise and de-neutralise the ESY as an institution by extending the scope to the healthcare arena in the country analysed as a field of political contestation and strategic interaction. In line with the aim of this research, the purpose of this chapter is to identify the relevant actors, their interests and tactics in shaping the healthcare arena in the country until the advent of the economic crisis and the cycle of contention. In so doing, I hope to contextualize and historicise the players that constitute the healthcare arena, in order to provide a genealogy of actors, interests and tactics that set the ground for the eventual diffusion and modularization of Direct Social Action tactics between and among emergent and existing actors over the course of the crisis' years.

The players discussed here are inferred through the review of the relevant bibliography, documents, contemporary press as well as interviews and empirical observations of current interactions and debates in the healthcare arena. In the period examined we will see that predominant actors include the medical professional group and its representative bodies, insurance funds and privileged constituencies, political parties, trade unions and the Health Ministry. According to the existing literature the incompleteness of the ESY reform is explained on the basis of the converging and orchestrated reactions in defense of the heterogeneous interests displayed by this array of actors coming together in the healthcare arena. I wish to complement this picture with the inclusion of formal and informal civil society actors that also intervened in the arena over this period. As I hope to show, these "marginal" actors inhabited the spaces carved out by these reform deficiencies, no less out of the perceived opportunities and threats offered by the shortcomings of the 1983 reform.

To be sure, public policy scholarship sees healthcare systems, in general, and the Greek ESY, in particular, as decidedly path-dependent and resistant to large-scale reform. According to this perspective, institutions produce and reproduce asymmetries of power between their composite groups and their respective access to decision making. These asymmetries are gradually engraving "paths" that can only be broken in the face of "critical conjunctures" capable of radically altering the field (Wilsford,

1994; Hall and Taylor, 1996). For the case of Greece, scholars interpret the incompleteness of the ESY reform in its early implementation stages as responsible for disabling any future reform effort. This is due to the increasing returns implied in continuing down one path once this has crystallised into a particular institutional pattern. Path-dependency in this light undermines the consideration of any previously available options, even when those could be proven to be more efficient (Mahoney, 2000: 508).

Unlike the existing literature, this chapter would like to propose a relational, dynamic and longitudinal perspective onto healthcare policy and reform in the country. Behind the path-dependency cited by numerous scholars of the Greek NHS, then, I would like to trace those emergent identities (professional and political) that intervened in the healthcare arena since the establishment of the Greek NHS, through their strategic interactions and concomitant tactics that transformed the arena, defined its stakes and allowed them to pursue and extend their interests. Seen in this light, neither the healthcare arena nor the ESY can be seen as static. According to Fligstein and McAdam (2012), “even in the most stable of fields, we can expect to see constant jockeying for advantage and efforts to marginally improve one’s position in the strategic action field” (ibid: 54). Both the establishment and incompleteness of the ESY, therefore, can only be understood as products of (political) struggles fought on the basis of the converging interests in and resultant strategies for resisting change between healthcare professionals, insurance funds and privileged groups, at least until the crisis years.

Moreover, in looking at the healthcare arena in its totality, one cannot afford to overlook third sector players. As we will see below, disparities and inequalities in coverage resulting from the incompleteness of the law were routinely addressed by international NGOs themselves competing for public funding. I hope to show that these actors were not neutral nor irrelevant in the healthcare arena. They were promoted by particular political interests and mediated the ESY’s “half-hearted” commitment to universalism (Ferrera, 1996: 34).

In addition, and by viewing formal civil society actors as relevant in the healthcare arena, we can begin to study those as consequential for healthcare policy and politics. As I hope to show in the subsequent analysis, their tactics and interventions inspired new and emergent actors that began appearing on the margins of the healthcare arena. Those actors, in turn, started sketching a “third way” for mitigating the blind spots of the ESY reform. It is in these actors that the seeds of healthcare DSAs in the country can be traced back. Through a brief historicisation and contextualisation of the healthcare arena, thus, I hope to shed light onto those emergent actors, tactics and claims that made their appearance prior to the crisis, eventually setting the ground for radical departures in collective action repertoires during the country’s contentious cycle, shifting the healthcare arena, affecting political opportunities and healthcare reform.

In so doing, I consider the arena as organic and dynamic, whereby collective actors, their tactics, strategies and configurations alter the field of collective action as much as that of public policy in a constant loop of re-configuration and re-signification to advance their position. I, therefore, aspire to complement structural accounts of stability and change with a more agentic and strategic approach that sees the crisis as a critical juncture simultaneously catalysing radical shifts in the repertoire of collective action, the configuration of collective actors as well as path departures in the pending healthcare reform.

## **5.2. Doctors, their associations and trade unions**

Medical professionals are frequently cited as decisive and central to the healthcare reform process. International comparative literature has pointed to the ways in which the internal weakening of the professional group can affect windows of opportunity for reform initiatives on the side of the government (Salter, 2002; Hassenteufel 1996; Wilsford 1995). In addition, scholars have also looked at the political and institutional environments affecting the professional autonomy of doctors, especially with regards to the collision of or distance between the healthcare and political systems, the overall architecture of the health policy field as well as the asymmetries existing between the various stakeholders *vis-à-vis* the social control mechanisms in place to moderate them (Freddi and Björkman, 1989; Tuohy, 1999).

Research on healthcare policy and reform in Greece only began in the 1990s to swiftly settle in two research agendas. One focuses on reform outputs, represented by scholars who opted to evaluate the impact of reform on funding and service provision (Venieris, 1997; Mossialos and Davaki, 2002; Oliver and Mossialos, 2005), and the other which tries to reconstruct the origins' story of the Greek NHS explained through the Southern European welfare prism (Carlos, 2001; Guillen, 2002). Both literature strands converge in highlighting the centrality of the medical profession in halting healthcare reform in the country, a *de facto* argument that is, however, often empirically unsubstantiated.

Nikolentzos (2008) and Nikolentzos and Mays (2016) were the first who attempted to cover this gap with an empirical study of the co-development of the Greek ESY and the medical professional group. In so doing, they draw from historical institutionalism and the sociology of professions to account for the processes and interactions between the state and this professional body throughout all major reform efforts since 1983. In short, the authors attempt a historical reconstruction -albeit partial and incomplete for the purposes of this thesis- of the healthcare arena as a political battlefield, through which the medical professional group constructed itself, defended and extended its collective interests.

More specifically, and in line with Mossialos and Davaki (2002) and Davaki and Mossialos (2005) the successful introduction of the ESY in 1983 by the first progressive government of PASOK can be

interpreted as resulting from the change in the size and (ideological) composition of medical graduates in the country, which ultimately pitted junior doctors against their historically conservative senior colleagues. Certified medical doctors in the country nearly doubled between 1971 and 1981, while recent graduates had become politicized and radicalized over the turbulent years leading to and/or following the end of the military junta in 1974. Those junior doctors felt that their opportunities were being repressed by the powerful strata of hospital and university doctors who held onto permanent positions and made profit from their combining public with private practice. By virtue of their participation in medical associations, therefore, junior doctors shifted the orientation of their trade unions in a socialist direction for the first time during the 1980s (Davaki and Mossialos, 2005: 158).

It was upon these emergent professional antipathies and political sympathies that PASOK managed to establish the ESY, while Minister of Health Avgerinos went on to implement the core elements of the new healthcare system. These included a comprehensive Primary Care level, the unification of the multiple existing insurance funds, doctors' commitment to full time and exclusive practice in the ESY, the restriction of university doctors' privileges, as well as the regional decentralization of the system. Problems soon arose, especially with regards to the doctors' perceived threats to their clinical autonomy and to senior doctors' self-proclaimed "right" to parallel practice both inside and outside the ESY. Characteristically, the then president of the Athens Medical Society (ISA), Dr. Halazonitis says in a contemporary interview;

"The wages proposed today may be appealing for junior doctors. [But] for those successful and professionally established [doctors] with family responsibilities they barely make up for a decent living. If one compares the proposed salaries with the progress marked by liberal professions, they are much lower and [so] the question arises; why should doctors sacrifice their own economic interests when other citizens retain them and on top of that receive free care?<sup>6</sup>"

In addition, these same doctors represented by ISA expressed concerns over the very principle of universalism implied in the reform. Dr. Halazonitis continues;

"The reformer would necessarily degrade the good quality of care received by part of the Greek population with the intention of "raising" the threshold of the rest of the population so that they become equal<sup>7</sup>."

According to Petritsi, the journalist behind this article, medical professors, medical association presidents and trade unionists raised caution against this equalization. Universalism in this light is

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<sup>6</sup> I Kathimerini Archive. (12/01/1983). Petritsi, L. *Therapy or complication*. p. 4. [in Greek; my translation]

<sup>7</sup> *ibid*

framed as harming the interests of the few without advancing those of the many, as cited budgetary restrictions outright prohibit high quality care for all.

In addition, Dr. Kaklamanis, president of the Auxiliary Teaching Staff of the Athens Medical School at the time insists that the law is more wishful than it is realistic or coherent. He condemns the proposed ban on private practice as restricting options for patients, especially for those living in remote areas where health centers are understaffed and/or not adequately equipped, for interrupting the doctor-patient relationship and for forcing his senior colleagues to exit the profession. All the above, he argues, “will result not in the advancement but in the degradation of healthcare (ibid)”.

Albeit planting the seed for the establishment of the ESY, the competition between junior and senior doctors soon ceased and the two camps came together to promote their professional interests with regards to their compensations, contracts and training, forming yet a new body of collective opposition against the successful completion of the ESY reform. More specifically, and while senior doctors were objecting the restrictions implied in the separate reform clauses, junior doctors condemned the PASOK administration for attempting to take advantage of the existing rivalry in order to undermine the bargaining position of the professional group writ large. Efforts to reform, therefore, became subject to scrutiny, critique and sabotage, as medical associations and trade unions started mobilizing against the reform, for different reasons and across generational and ideological divides. These antagonisms culminated in a mass strike in 1984, announced by the socialist Union of Hospital Doctors in Athens and Piraeus (EINAP) and backed by conservative medical associations, junior and senior doctors.

Minister Avgerinos swiftly moved to denounce the strike as illegal, and to condemn it as;

“[t]omorrow’s strike serves the delay, if not the undermining of the implementation of the ESY. [...] The government is determined to carry out the establishment of the healthcare system it promised to the people, as programmed, without delays. It is obvious that this game that is being played with tomorrow’s strike is led by the Right and it is a shame that other factions participate in making up this fictional majority in the Management Committee that decided on the strike <sup>8</sup>”.

EINAP, however, appeared as strong and decisive as ever. It immediately published a response to the Minister highlighting the historical role of the union in affecting the law and the personal sacrifices made by its members towards the establishment of the ESY. As such,

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<sup>8</sup> I Kathimerini Archive. (12/01/1984). *Hospital Doctors on Strike for 24 hours*. p. 1. [in Greek]

“it is the hospital doctors that can implement the ESY. For this reason, it is the Minister’s action that serves to undermine the ESY. With awareness of our responsibility, we call our members to militant participation in tomorrow’s strike and in the general assembly<sup>9</sup>”.

Avgerinos’ pleas for litigation alienated even those officials siding with the Minister, who soon filed his resignation and prompted the Administrative Hospital Councils to prosecute all participants, thus preparing the ground for a landslide victory on the side of the newly established medical professional corpus. The mass mobilization of doctors and resultant resignation of the Health Minister gave a new sense of confidence to the professional group, which came to openly communicate its interests as synonymous to those of its constituents. This would be further reinforced by the new Minister of Health Giorgos Gennimatas’ who, once in office, quickly moved to side himself with medical doctors.

Gennimatas eliminated the antagonism between senior and junior doctors by advancing the position of both and giving into concessions for both, namely by maintaining those privileges enjoyed by the former while also extending those of the latter. The new Minister’s favoritism for medical doctors altered the reform agenda and related priorities in implementing the ESY. Namely, “[t]he Minister declared that the funds would not be unified, and the focus of reform shifted away from primary care and universalizing the system towards hospital sector expansion” (Mossialos and Allin 2005: 424-425). More specifically, he limited his efforts in widening access to the establishment of 200 rural and semi-urban health centers and the advancement of the Agricultural Insurance Organisation (OGA) into a privileged insurance fund whose benefits’ basket would also include pharmaceuticals. His attention was, instead, focused on appeasing doctors’ trade unions and the Panhellenic Organisation of Public Hospital Employees (POEDYN). This was achieved through the development and expansion of the hospital care sector in the cities of Athens and Thessaloniki where the political influence of doctors was mostly concentrated.

The sum of the efforts of Gennimatas saw the quantitative and qualitative proliferation of medical doctors in the country, as the amount of doctors entering the newly established ESY doubled (compared to Avgerinos’ original plan), decisively solidifying that professional group into a powerful lobby that no political party could afford to overlook. In addition, he failed to exploit the divisions between conservative medical associations representing private doctors, that is the Athens Medical Association (ISA) and the Panhellenic Medical Association (PIS), and the socialist EINAP to successfully impose controls and oversight onto doctors’ activities, bolstering, instead, the alliance between them. Contrary, then, to healthcare policy literature that views the rise in the number of medical doctors as potentially affecting a decline in their collective power, Mossialos et al. (2005) argue

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<sup>9</sup> Ibid.

that Greece's fragmented healthcare system strengthened doctors' power and autonomy despite their increase in numbers as the variety of interests of the group came together in resisting the reform.

As such, the developments that led to the proliferation of the medical profession also cemented a path hostile to any reform initiatives in the original direction of Law 1397/1983 in the future, regardless of the party undertaking them. This becomes evident in the first New Democracy administration since the establishment of the ESY. Minister of Health Giorgos Sourlas announced a new reform effort that aimed to advance personal responsibility in healthcare and promote private provision and financing over the public option of the ESY. By 1992 the ban on the establishment of new private hospitals placed by the 1983 reform was lifted, and the opening up of private hospitals was legalized. In addition, Sourlas introduced flexibility in doctors' terms of employment through the creation of three different categories of contracts- that is full-time, part-time and paid-by-case and initiated a campaign to increase oversight to curb informal payments within the ESY. The complementarity of these these changes in the labour relations of medical professionals is important, as Sourlas' stated intention was to discourage individual doctors from accepting -or claiming- bribes by giving physicians the option to legally practice in the private sector if they wanted to complement their salaries.

Although largely favorable for the medical professional group, this reform was yet again opposed. As another testament to the benefits of interest fragmentation in the Greek context, medical trade unions mobilized against these proposals this time with the support of Confederation of Public Servants (ADEDY) and the public opinion. Sympathy against accusations regarding the proliferation of informal and illegal payments came from the doctors' successful manipulation of the fact that the rate of increase in the funding for the ESY had been lower than originally agreed upon. This provided them with a moral ground to continue collecting informal payments as well as rejecting the reform altogether.

As pressures from the Ministry of Health continued, however, a "compromise" on the side of the medical profession was accepted. This compromise cannot be considered as anything short of a victory for medical associations and their representatives who agreed to conduct their own research on informal payments, publicize their results to the Parliamentary Committee on Social Issues and self-regulate them within their ranks, therefore foreclosing any possibility of external supervision. The reports produced as a result were unanimously pointing to patients' responsibility in initiating informal transactions, themselves so insignificant that any further legal control would be unnecessary. The Minister accepted the report and added that indeed "there has been only one verified complaint for

corruption, [that] of a doctor that asked 10,000 drachmas”<sup>10</sup>. In this way the medical profession successfully overcame ideological divides and sealed its autonomy from any external oversight.

The next major reform initiative came from the next PASOK administration in 2000-2002 under Health Minister Alekos Papadopoulos. The main clauses of the reform aimed at completing aspects of the original Bill for the ESY. These pertained to (1) the decentralization of the ESY into 17 PeSY; (2) the coordination of the multiple insurance funds’ purchasing activities through their collective subsumption into the Organisation for the Management of Health Resources (ODIPY), a private not-for-profit fund; (3) the establishment of a primary healthcare system on the basis of contracts with General Practitioners across the country; and (4) the evaluation of hospital doctors and restriction of informal activities through the introduction of outpatient clinics within public hospitals where doctors could practice privately but under supervision. Moreover, hospitals were to be responsible for a share of their doctors’ compensation, and would respond to their regional health system (Mossialos et al., 2005).

Physicians within the ranks of the major insurance fund IKA, presented in the previous chapter, were the first to oppose the reform, with the initiation of strike action in July 2001 and the continuation of their strike activities for tenure positions throughout the year. Papadopoulos’ refusal to give in to their claims only intensified protest activity and density. Tensions culminated when university doctors joined the strike, opposing Papadopoulos’ plan to impose oversight. Interestingly, university doctors only joined the strike after their appeal regarding the violation of their human rights was rejected by the Constitutional Court (Mossialos and Allin, 2005: 435).

The following extract from the newspaper Kathimerini illustrates the way in which the reform effort united the various interests within the medical profession while dividing governmental officials to the detriment of its completion. More specifically, the article reports that;

“In the summer of 2002, a few months after taking office as health minister, Alekos Papadopoulos announced an ambitious reform plan. The Cabinet approved the plan, but soon the minister was all alone. The small and large interests that were threatened by the attempted reform got a foothold inside the government- especially the all-powerful faction of the university doctors, which spearheaded the overall campaign against the reform. At first, Papadopoulos was urged by top Socialist officials and the Prime Minister himself not to abolish the scandalous privileges of university doctors. His refusal to back down marked the beginning of the end of his career as health minister.”<sup>11</sup>

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<sup>10</sup> I Kathimerini. (20/05/1992). Patients also responsible for bribes. p. 1. [in Greek]. «Και οι ασθενείς υπέθυνοι για το φακελάκι».

<sup>11</sup> I Kathimerini Online. (12/06/2002). Health Sector Reform.

The affinities with the 1983 reform effort, thus, become apparent. Another article on the developments around the proposed healthcare reform found in Kathimerini's archives illustrates the strength of the university doctors' bargaining power;

“University doctors have proved to be extremely obstinate in their clash with the Health Ministry. They may not have hoisted red flags or taken to the streets to protest, but in essence, they make the most uncompromising unionists look like amateurs<sup>12</sup>”.

The same article provides a summary of doctors' vested interests in halting the reform;

“As is usually the case in issues like these, this is a struggle over money. There are large interests at stake. The legislation forbidding [ESY] doctors from offering their services to private clinics, on the one hand, and from running private surgeries, on the other, is depriving them of huge incomes. As is widely known, since the beginning of the new year, hospitals have hosted private surgeries that are open during the evening hours and where patients can be examined by a doctor of their choice in exchange for a considerable fee. This practice, no doubt, generates high additional revenues for doctors. University doctors [...] have reacted as they consider their immunity as an acquired right which until recently gave them the right to higher [...] and usually tax-free incomes. [Incomes] so high that even their most famous colleagues in Western countries do not earn<sup>13</sup>”.

The article concludes with a reflection upon the implications of the strike as paralyzing for both medical practice and education. We understand, therefore, the centrality of university doctors within the Greek ESY, a historically acquired centrality that reinforces the prestige of their interests and claims.

Historically socialist EINAP also singlehandedly opposed the reform. Nikolentos and Mays (2016) cite the statement issued by Tsoukalos, the association's president at the time, noting that the reform “promotes the private health sector and damages the social and public character of the system (ibid:141). According to the trade union, the unification of the funds under the private not-for-profit ODIPY and the introduction of private practices compensated by the patient within hospitals were paving the way to ESY's privatization. In addition, hospital doctors-members of EINAP mobilized opposition to the reform as they perceived it as a threat to their permanent status as civil servants through their reallocation to the regional PeSYs.

Mossialos and Allin (2005) reiterate that despite the competing interests vested in the various trade unions representing the medical profession, all representative bodies allied in countering the reform. This alliance was expanded beyond the professional group to summon the support of ADEDY and

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<sup>12</sup> I Kathimerini. (23/01/2002). University Doctors.

<sup>13</sup> Ibid.

mobilise its numerous constituents. ADEDY often intervened to protect the interests of hospital doctors as the latter often set a precedent for other employees of the public sector. In this occasion the perceived threat to the members of EINAP was framed as extendable to other areas of the public sector, capable affecting contracts for all ADEDY members and weakening the Confederation in general.

Nikolentzos and Mays (2016) successfully demonstrate not only the dominance of the medical profession in shaping the modern ESY as we know it today, they show “how medical interests were both affected by the establishment of the Greek NHS and at the same time strengthened by the new NHS (ibid: 142)”. As such, they approach ESY’s structural weaknesses and inefficiencies as products of the swift unification, solidification and hegemony exercised by this professional group onto the healthcare arena in the country.

### **5.3. “Other stakeholders”**

Notwithstanding the prominence of doctors’ interest group(s), Mossialos and Allin (2005) stress the importance of extending the scope of analysis to actors beyond the medical profession in order to explain the reform stalemate in the country.

#### **5.3.1. Fund Unification**

To that end, the authors compare the first (1983-1984) and latest (2000-2002) reform efforts to unify the historically fractured health insurance system to illustrate, compare and contrast the actors colliding with the reform and their vested interests in so doing. More specifically, Avgerinos’ attempt to unify the insurance funds in 1983 was opposed by insurance funds and university doctors on the basis of the rapid increase in public deficit during this period. Avgerinos’ replacement by Gennimatas, instead, saw the accommodation of multiple interests, including those of hospital doctors and civil servants, of privileged insurance funds that provided wide packages partly subsidized by the government, and of those members of the Agricultural Fund (OGA) whose coverage, as we saw above, extended to include pharmaceuticals.

On the other hand, the positive economic climate of the second attempt to unify the insurance funds under a single organization (ODIPY) did not allow for appeals to fiscal constraints and therefore demanded more coordinated opposition on the side of the privileged insurance funds and their constituencies. The reform formally intended to improve coordination and rationalize the purchasing system, but was interpreted as the first step towards the equalization of benefits at the expense of the more advantaged groups. These included IKA and its members who had access to their own primary

care infrastructure. As such, IKA resented the reform as it would undermine its role as a powerful player in both primary care and health insurance.

Concerns regarding the potential equalizing effect of the funds' unification were also shared by smaller insurance funds and trade unionists. Mossialos and Allin (2005) cite the parliamentary speech of the then president of the Confederation of Hospital Doctors (OENGE) communicating that the GSEE "is afraid that OGA [whose access to primary care services was limited] will be merged with IKA and ADEDY and that they may lose free choice of doctors (Hellenic Parliament 2003: 459, in *ibid*: 433)".

### 5.3.2. Decentralisation

Decentralisation was also met with unified resistance by a variety of stakeholders. Standing at the core of the 1983 Bill, decentralisation aimed at improving and harmonizing the distribution of healthcare resources, especially for rural areas that suffered from the absence of professionals or the lack of adequate infrastructure (Kyriopoulos and Tsalikis, 1993). Private doctors, insurance funds and their recipients, trade unions as well as bureaucrats who benefited from the system's centralized powers, however, saw it as posing a threat, especially with regards to the system reconfiguration the reform would imply. As a result, the various players joined forces on the basis of shared fears over the benefits reaped under the existing arrangement of the ESY, and most notably, its fragmentation. As we saw above, opposition to decentralization continued throughout the successive reform efforts, spearheaded by the medical professional group(s) and supported by their trade union allies and their members.

The "other stakeholders" identified in the literature therefore are the (privileged) insurance funds and their constituencies, trade unions and bureaucrats who benefitted from the country's fragmented system of healthcare organization and provision. This fragmentation is, then, used to explain both the reasons behind and the ways in which collective action among those diverse players took place against reform efforts pertaining to the equalization and universalization of coverage on the side of the ESY. However brief and thin this overview might be, it gives us an idea concerning the main players, their interests and strategic alliances in affecting and/or halting healthcare reform. Whether driven by concerns over fiscal constraints or loss of privileges- both in terms of power enjoyed and benefits received- these players and their strategic configurations within the healthcare arena are presented as supplementary and secondary to the medical professionals and their representative bodies.

## **5.4. The third sector**

The halting of the completion of the ESY reform, however, created inequalities of health and care. The inadequate and underdeveloped primary care level in the country, in addition to the geographic

concentration of (hospital) healthcare infrastructure and personnel in urban centers, exacerbated problems of coverage for a series of populations including the Roma, people living with disabilities or chronic conditions, as well as marginalized people and the poor. In addition to these problems, the guaranteeing of access to public healthcare *via* social contributions to the multiple insurance funds further aggravated problems in the scope of the supposedly universalistic ESY. All the above blind-spots carved the space for NGOs' interventions in disease prevention, health promotion, health monitoring and care provision.

To be more precise, the problems faced by the Romani population point to the double weakness of the social security and primary care models of the country. The Roma are largely uninsured, oftentimes with no official documents, while their nomadic lifestyle makes their monitoring and tracking by health authorities difficult. To address the needs of these communities, the state collaborates with NGOs to deliver vaccines, conduct diagnostic tests and promote health education, mostly targeting children, by means of "bringing" healthcare to these populations in their place of residence (Economou, 2010: 135-136).

These issues remained largely insignificant for the state, as these aforementioned groups were small and being catered for, albeit minimally, by the third sector. By the 1990s however, Greece saw its conversion from a migration to a destination country. Political transformations and global inequalities pushed thousands of migrants from Central and Eastern Europe, the former Soviet Union and the developing world to relocate to Greece in hope for a better future. As we have already seen, the ESY was not designed on these premises and was incapable of effectively addressing the pressures induced by these changes in the country's socio-demographic composition. It was in this context that discussions concerning migrants' access to the ESY were initiated.

The ESY responded by half-heartedly allowing access to those migrant populations on the basis of the same criteria for coverage that applied to Greek nationals, notwithstanding their particular characteristics and vulnerabilities. That meant that migrants residing legally in the country were formally given access to the ESY on the basis of their registered employment and regular status. Undocumented migrants were denied access to the ESY, apart from emergency services and treatments for critical conditions. Even then, however, patients were skeptical of addressing the ESY, as they feared that this could lead to their arrest and/or deportation. Last, asylum seekers were also restricted to emergency services until they obtained their asylum seeker status, upon which they were allowed to access the ESY similarly to documented migrants and nationals. The Ministry of Health curbed its involvement in caring for these people through its collaboration with the Centre of Disease Control and Prevention

(KEELPNO<sup>14</sup>) and NGOs, responsible for delivering medical care and psychosocial support to people in refugee reception sites (Economou, 2010: 54-55).

Changes in coverage for migrants and refugees over the course of the 1990s tied access to public healthcare and pharmaceuticals to one's residence and employment status, further solidifying the institutional logic of the ESY. In addition, in a circular issued in 2000, non-European migrants were given the same access to the ESY as Greek nationals upon proof of permanent and legal residence and work translating into social contributions in the country. Considering, however, the size of the informal economy in the country and migrants' disproportional representation therein, a large number of non-nationals fell outside the purview of the ESY. Moreover, asylum seekers and refugees who also formally enjoyed the same treatment by the public healthcare services as nationals, often encountered problems of access, especially pertaining to the long and overcomplicated bureaucratic procedures necessary to obtain asylum and relevant papers.

These groups, failed either by their restricted access to the ESY, the absence of primary care -especially in rural areas- or the mazelike quality of Greek bureaucracy, are by and large cared and catered for by voluntary organisations, NGOs and international bodies intervening directly in healthcare provision and monitoring. The official report of the WHO cites the Hellenic Society for the Protection and Rehabilitation of Disabled Persons, Médecins du Monde (henceforth MDM), Médecins Sans Frontières (henceforth MSF), Praksis, the Red Cross, The Child's Smile and the United Nations Children's Fund (UNICEF) as the most prominent and active agents in the field of primary, ambulatory and preventive healthcare provided to these populations. The aforementioned organisations are portrayed as "influential among society, political parties and the Government, managing to attract quite significant funding and donations (Economou et al, 2017: 21)".

NGOs and "organized", "formal" civil society organisations proliferated in the country over the course of the 1990s partly as a result of the unprecedented rise in migration, but also due to a shift in mainstream politics towards the promotion of civil society and volunteering (Sotiropoulos, 2013). More specifically, in his chapter on the history of the third sector in Greece, Huliaras (2015) highlights the converging strategies of both PASOK and ND in promoting and funding NGO activities and initiatives as decisive for the expansion of NGOs during that period. Of those organisations, the most prolific dealing predominantly with health issues are unquestionably the MDM and the MSF. Coincidentally, both international NGOs started their operations in Greece in 1990. Unfortunately, there is no systematic research onto the activities and impact of these organisations onto population health and/or the healthcare arena. For this reason, I attempted my own data collection, drawing from

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<sup>14</sup> Now rebranded as the National Organisation of Public Health (EODY)

the newsletters and reports the two organisations publish in their official websites, and preliminary analysis to better understand their priorities, interventions and general profile.

This investigation was proven to be difficult and partial, as both organisations report very little prior to 2008. However, the overall orientation of these two NGOs is becoming apparent. More specifically, and in line with Skleparis (2015), both organisations were focusing their emergency interventions around natural disasters, such as the disastrous earthquakes in Aigio (1995) and Athens (1999) with first aid and relief contributions. In addition, and albeit differences in their sources of funding, both organisations seem to have been providing primary and preventive care to distant and marginalised populations across the country, with health monitoring, dental services and vaccination programmes for children, the Roma population as well as people residing in desolate areas in Greece. Moreover, their regular clinics in urban centres were providing primary healthcare as well as legal and medical support to migrants, refugees and those impoverished and marginalised members of Greek society.

To be sure, the profile of NGOs in Greece seems patchy and passive all the way until the crisis. We will follow the transformations the third sector underwent during the crisis in the following chapter. For what concerns the period considered here, however, one can argue that a large segment of the work left undone by the ESY was, at least to an extent, addressed by the third sector, and that the institutional logic of the healthcare system solidified after the repeated failures to complete the 1983 reform effectively allocated these populations to humanitarian aid.

### **5.5. Emergent actors**

In proposing a more holistic, relational and dynamic perspective onto the healthcare arena in the country, we can begin to discern the emergent, at the time at least, minority players that intervened in addressing pressing issues related to healthcare in the country prior to the crisis. In what follows, I provide three instances of novel intervention into the healthcare arena traced back to the late 1990s and early 2000s. Two of these instances represent radical departures, albeit dissimilar, in primary healthcare provision in the direction of Direct Social Actions. The other refers to a radical shift in protest tactics proposed by members of the anarchist and autonomist (Marxist) movements in the country.

We can begin to understand these instances as emerging on the margins of the healthcare arena and at the interfaces between the aforementioned players and the spaces they occupy. While powerful interest groups such as doctors' professional associations and health insurance funds were trying to defend and extend their privileges against healthcare reform, while NGOs reaped public resources for intervening in the blind spots of the incomplete ESY, players who stood in opposition to both started experimenting with other forms of collective action in both contention and mediation in healthcare needs. These initiatives showcase fluctuations in the supposedly static healthcare arena; they expose the

problems arising from the policy stalemate and contribute to the development and framing of its emergent stakes that were to advance to center stage over the course of the cycle of contention.

#### 5.5.1. Volunteering doctors

The first attempt to cover for the health needs of people falling outside of the ESY by informal and grassroots civil society actors was recorded as early as the 1990s, with the initiative of a doctor Kostas Nikofoarakis in Chania in the island of Crete. Dr. Nikiforidis, was a prominent left-wing militant and among the founding members of OENGE. Upon his insisting efforts, he managed to take the soup kitchen of “Saint Nikolaos Splantzias” away from the Church and rename it “Social Intervention- Soup Kitchen Splantzias”. The initiative would soon add the provision of free medical and dental care to migrant seasonal workers, the poor and the homeless to its activities.

The clinic operated only for two years, but those medical students volunteering in it held on to the experience of direct provision of free primary care services to excluded populations from below and decided to resume their activities in 2008, this time in the neighboring town of Rethymno. According to Malamidis (2018) “[t]he clinic was granted a workspace by the municipality’s volunteer organization and opted to be absorbed into the municipality’s social structures” (ibid: 47-48). The initial approach of this clinic, however, was to change with the coming of the austerity crisis and the development of the Social Clinics-Pharmacies model that we are to follow in the next chapter.

#### 5.5.2. Anarchist and autonomous doctors

Parallel to those initiatives, the autonomist, anarchist and anti-authoritarian movements in the country were attempting to organise and mobilise their constituencies in healthcare sectoral mobilisations over the same period, to a large extent in competition with the hegemonic syndicalist and/or left-wing platforms and traditions. As Hobo, a General Practitioner and member of the *autonomia* recounts in an interview, the state of those movements was poor at the time and in dire need of organisation and redefinition, while public healthcare provided the ground to attempt both. He said;

“I came to Athens shortly before December [2008] to work in a Health Center [...] Here [the autonomist movement] is very weak, you know, there’s not much organisation, never was. [...] Unlike Thessaloniki for example. [...] In Athens you had the EAAK<sup>15</sup>. Or the humanitarian organisations such as the MSF or the Mdm etc. [When in university] you were either in the one or the other. [Since] the anarchists and anti-authoritarians didn’t want to go to the EAAK, they were instead going to the others. So when I first came

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<sup>15</sup> United Independent Left Move (EAAK): Coalition of radical left-wing university student and syndicalist groups involved in tertiary education politics.

[to Athens] I tried to find people, my specialty was such that I had to move around [...] it was difficult to establish connections.”

Despite these difficulties, Hobo managed to create a small coordinating group within the health centre where he worked, and later came in touch with other doctors of similar political backgrounds to plan a strike against negotiations initiated between healthcare trade unionists and the Ministry of Health concerning the extension of the overtime from 40 to 48 hours. Hobo continued;

“[...] Then just before December [2008], we had made a group and decided to participate in the strike; it was a good strike, even though we had our differences. [...] I have made my criticisms to our position since. [...] I don't *dig* the overtime; I think it destroys your life. That's one [thing]. The other thing is that it divides the health workers among workers and 'lay' staff. Doctors want to work overtime to complement their wages, other members of staff cannot do so. So [unlike the rest of the participants in the strike] we wanted more homogenous contracts and working conditions, and for the whole of the health personnel to unite and fight for more decent wages and common goals, you know.”

The takeaway from this mobilisation demarcated the anarchist and autonomous section of the striking medical professionals from the rest and set the ground for their regrouping in December 2008. This demarcation was achieved through both the announcement of separate and distinct demands on the part of the collective Hobo refers to, and their choice of tactics. More specifically,

“Then the question of the *way* we fight became pivotal. What the Left used to do historically -both the doctors and leftist groups in general- [was] that they would close down the overtime during the strike. They would basically go in front of the hospital gates and tell patients [that] they cannot come in. I mean, the patient would come and the doctors would confront them [saying], 'you're not an emergency, go home'. And then they would cross swords with the patients. [...] Then the media would report on the events, show pictures, the fights with the patients. The whole thing would turn against us. [...] In 1995 in France, there were massive strikes against flexible contracts [in hospitals]. How did they go about it? They went to the hospitals and closed down the cash registers. So, people can come through, but the state bears the price. Motherf\*\*\*\*s, you'll be losing money for every day we are on strike! This is one [thing]. The other is winning over the people. Earning their solidarity. And this is what *we* wanted to do [in this strike]. Show a paradigm of struggle. And indeed we went to two on-call hospitals, [we] had fights etc. with the personnel, we [received] threats from the hospital management... But we knew some people in those hospitals, which is key to making this work -it demands a great deal of organisation, it's very risky. The cops couldn't come in easily, but it was an emergency hospital so you understand, people coming in were in a critical condition, you cannot afford delays. So these were our experiences prior to December. And these practices of padlocking the registers etc., let me tell you, it started from us. We brought it here [to Greece] which is something I'm proud of, one of the very few things I'm proud of. Since then no one obstructs the overtime. They either do nothing or they close the cash registers.”

The picture of the blockaded overtime that turns into a battlefield between doctors and patients, and attracts the media at the expense of the striking personnel's reputation was disputed by many of my medical professional interlocutors, but it does point to the difficulties, restrictions and contradictions inherent in the successful organisation of a hospital strike. Albeit not a hospital doctor, Hobo and his collective were aware of these complications and attempted to think outside the (tool)box of the traditional repertoire, in planning an innovative and effective striking tactic that would target the state while servicing the patients. This commitment echoes the collective's medical humanitarian ethic, its anti-statist ideology and its strategic goal to foster solidarities and create alliances with both patients and healthcare staff across the board.

In addition to the strategic benefits of this innovative tactic, Hobo and his collective also had to consider the potential pitfalls involved, especially with regards to the bureaucratic complications padlocking might imply for the successful admission of patients into care. The remedy to that, as Hobo suggests, is the existence of allies within the striking hospital, people who will guarantee the admission of patients and mitigate the risks of intervening in an emergency hospital.

As such, alliances and solidarities beyond the strict confines of the medical professional group are not only a strategic goal, but a prerequisite for successful mobilisation. This can be achieved by highlighting their shared structural positions, common aspirations and grievances. As stated by the collective;

“It is wrong not to understand that we need the alliance with the patients to achieve our goals. Instead of obstructing the overtime when we strike, why not obstruct the hospital registers and hold the knife at the neck of the state and the local health representative? Why not cause the state to lose money, have the patients on our side and stand by the side of those colleagues who want to participate but happen to be working overtime during the strike? Why not organise claims-making -in practice not just words- around the issue of primary care, the issue of the ‘tired doctors’ [that can be] dangerous to their patients, the issue of health as a social, non-marketable good that concerns health workers as much as patients who need to take [health] into their own hands and not leave it to the hands of the state and capital? [...] Colleagues, what we were taught in [medical] school concerning ‘the scientific expertise that makes the doctor the principle [agent] in managing patients’ is a monstrous lie. Whoever does not want to understand that the care of the patient is not only a matter of the doctors, but of a whole group of people who moves and works in and around the hospital, should consider what would happen in the event of a general strike of nurses or stretcher-bearers. Only then would we realise how important the role of every single health worker really is<sup>16</sup>”.

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<sup>16</sup> Health Workers' Collective “Saleu Bellum”. We're on war, it's no joke, baby. [in Greek] «Έχουμε πόλεμο, μην το γελάς μωρό μου».

What we see, therefore, is that even in this period of relative path-dependency, if not acquiescence around the preservation of certain privileges and benefits, there are actors that view health and care as a fertile ground for contention and mobilisation around “marginal” stakes. These actors mobilise outside of the traditional protest repertoire and in the direction of innovative tactics, that are, however, ideologically aligned with broader strategies. Moreover, and in deliberating over, choosing and enacting those tactics, they opt for more inclusive alliances with patients and healthcare personnel, they formulate grievances around primary care and healthcare more broadly, and project visions of a more participatory, self-organised model of health and care.

#### 5.5.2.1. *The Health Assembly of December*

Hobo’s timeline of events center around the December 2008 riots in the aftermath of the assassination of 15-year-old Alexandros Grigoropoulos by policeman Epaminondas Korkoneas (for more see Johnson and Seferiades, 2012). December 2008 is a reference point for the anarchist and anti-authoritarian movements in the country that have historically been overshadowed by the strong communist traditions that date back to the Second World War and socialist traditions that solidified after the overthrow of the military junta in 1974. In addition to the momentous demonstrations and riots that shook numerous cities across Greece for weeks, by effectively linking the mobilisation of young students with the labour and trade union movements, members of the local anarchist and anti-authoritarian movements also led the occupation of some central universities and the organisation of the assemblies held therein. It was through these processes that the anarchist and anti-authoritarian movements rejuvenated in the country.

The issue of health and healthcare (re)surfaced over the course of these assemblies, to eventually crystallize in the separate Assembly for Health. The Assembly for Health was organised by the “Collective of workers in health Saleu Bellum” referenced above, but extended beyond it, with the participation of members of the autonomist and anarchist movements as well as the involvement of new people mobilised by the December events.

The Assembly for Health moved from the occupied Athens University of Economics and Business (ASOEE) to the historical occupation of Villa Amalia over the months of February and March when it was dissolved. According to participants.

“The December riots freed the territory of the city, [they] freed spaces in which we, people who were trying to approach the issue of health individually and spasmodically, managed to meet and talk outside and away from the institutional framework that, until then, was offered to us as the only option”<sup>17</sup>.

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<sup>17</sup> Health Assembly. (01/04/2010). *Salute-PIKPA*. [in Greek] «Την υγεία μας να ‘χουμε- ΠΙΚΠΑ».

This newly introduced heterogeneity of the Assembly and the momentum gained by the movements, however, soon exposed unresolved and pressing issues concerning the Assembly's identity and, relatedly, diagnostic and mobilisation frames, that ultimately caused it to split over questions of tactics, strategy and goals.

More specifically, in another document produced by participants reflecting on these experiences, we find that beyond the "practical" issues of organising interventions and strikes in healthcare, the Assembly had yet to decide on its collective identity. "Who *is* the Assembly", the document asks; "is it healthcare workers or recipients, anarchists or autonomists?". This question of identity is intimately linked to the strategic orientation regarding the Assembly's goals. The document ponders over the framing of the Assembly's initiatives;

"Is it an *intervention* that wants to bring back the spirit of December in the work space? Is it a form of *solidarity* with the struggle of healthcare workers? Is it a *protest* of patients against the hegemony of the doctor and the commercialisation of healthcare?"<sup>18</sup>.

These questions derive from the involvement of new actors in the healthcare arena, which introduce new stakes and grievances, namely away from benefits and compensations and towards the multitude of opportunities in mobilizing and envisioning alternatives to health, care and wellbeing that had, until then, remained unexplored. We understand, thus, that December 2008 stirred the healthcare arena, creating a wave the ripples of which would become apparent over the course of the crisis.

At the time, however, it was upon these questions and tensions that the Assembly for Health dissolved only a few months after December. Upon that dissolution, participants split into two tendencies; one in which reinforced existing contentious efforts in the healthcare arena and one that birthed yet a new tendency of healthcare activism.

#### 5.5.2.1.1. Innovative tactics to foster class alliances

The first, represented by activists such as Hobo and his collective, remained faithful to their position concerning the importance of taking struggles over health and healthcare into hospitals and health centers, with the intention of extending alliances and solidarities beyond the insulated circles of medical doctors. More specifically, Hobo reiterates:

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<sup>18</sup> Health Assembly. (2020). *The experience of the Health Assembly*. In CareNotes Collective, For Health Autonomy: Horizons of Care Beyond Austerity, Reflections from Greece. Brooklyn, NY: Common Notions. (emphasis in the original).

“We believed that we should go into hospitals and intervene mostly around problems concerning our labour relations, the hospital, patients’ health etc. and [starting] from that, we could start investigating other issues concerning health. Search for other dimensions. Problematised medicine, sure. But we ought to start from there [the hospitals]. What could we do alone? We have to find allies. Class allies.”

And so they did. Following the dissolution of the Assembly, individual activists focused on establishing networks within their hospitals and/or clinics with a heightened emphasis on innovative tactics opting to involve all healthcare workers as well as local constituencies. We understand, therefore, that the Assembly for Health facilitated the spread of Saleu Bellum’s goals and tactics to those (new) constituencies which mobilized in December and participated in the Assembly later that year.

The Assembly also verified their perception of the healthcare arena as a fertile ground for political action and intervention. In this period, activists adhering to this tendency became involved in deliberations over tactics and begun to reflect on their configuration within larger sets of strategies. The tactics developed over this period ought to capture and communicate their ideological and strategic orientation towards the framing of health and healthcare as a class issue. This was seen as imperative in advancing the position of healthcare personnel and recipients alike, whilst establishing those links and developing those resources necessary to start challenging medicine and its conduct in “the hands of the state and capital” as well as creating the conditions for people to take health into their own hands. In addition, these tactics needed to represent a radical departure from the traditional repertoire of contention in healthcare to sufficiently demarcate the political spaces competing for influence, starting from the healthcare arena and spreading to other realms of politics.

#### 5.5.2.1.2. Innovative tactics for self-organisation

Activists adhering to the other tendency in the Assembly for Health drew their own conclusions from their participation in it. Activists who set up the Social Space for Health in Ano Petralona, narrate their experience;

“People from the Assembly for Health (a collective of health practitioners and others formed in December 2008) also participated in local neighbourhood assemblies. Thus a parallel processing of issues such as health-as-a-right, free access to medical services, and working conditions in the medical field was initiated. Aside from intervening in medical issues and creating an accessible health space for everyone (which would not only service the poor), the main aim of the Assembly for Health was to develop a theory and practice for another kind of healthcare- one that deviates away from commercialisation, oppressive, unbalanced power relations, and medicalisation- and moves towards our aim to diffuse knowledge and maximise the ability of individuals to participate in decisions for their own health.”

These activists were largely medical professionals who have had experience with the aforementioned NGOs, and thus with direct healthcare provision, and whose political socialisation in medical school involved the Foucauldian critique to medical power and control.

This tendency soon mobilised in and gathered support from the Neighborhood Assembly of Petralona, Koukaki and Thissio in Athens, ultimately paving the way for their occupation of the former PIKPA<sup>19</sup> in Petralona and its utilisation as a Social Space for Health (henceforth SSH) as early as April 2009. Unfortunately, I did not manage to obtain an interview with activists from the SSH, as they are against representing the space individually. However, a series of documents produced by them have been compiled through extensive internet searches and printed material collected over time. In a document produced for the collective volume *“For Health Autonomy”*, members of the SSH outline their initiative as follows;

“After a series of theoretical studies and practical interventions in hospitals, the next step for [the] SSH was to squat the stone house in Ano Petralona. Housing this project in a squat was intentional. We defend this choice and juxtapose it to the authorities’ abandonment of PIKPA as a primary healthcare point. Housing our project in PIKPA had a double meaning from the beginning: [it was] both practical and symbolic. The former [is] because the equipment that was abandoned is now being put to use; and the latter [is] because the local community has effectively self-organised an alternative healthcare structure to compensate for the state’s closure of a primary healthcare center. Our existence and the consistency of our activity throughout these years is [the] living proof that such a choice is possible. Naturally, we also defend this choice as a tool in our struggle with which we need to respond to social needs. In this context, the prospect of getting licensed by the state sounds to us rather like an oxymoron and a joke. The only licensing that self-organised projects require is the sense of responsibility [shared among] people who build them and grant them their social legitimacy. The SSH is housed in a squatted building and as such has always been extra-legal –not with regards to established medical criteria, but rather in relation to the statist criteria set by its language of power, which wants everything to be controlled and mediated by it. We believe it is time for us to reclaim our confidence in interpersonal dependency and move away from the concept of service as a product or commodity<sup>20</sup>”.

In another document, the SSH adds yet another, more encompassing goal for the self-organised movement. They say that;

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<sup>19</sup> ΠΙΚΠΑ: (Patriotic Foundation of Social Welfare and Culture). [in Greek] Πατριωτικό Ίδρυμα Πρόνοιας και Αντιλήψεως. PIKPA was a philanthropic organisation in protection of children founded by Queen Sophia in the aftermath of the Balkan Wars, which gradually became absorbed by the state and was responsible for delivering some primary care services in certain areas.

<sup>20</sup> Health Assembly. (2020). *The experience of the Health Assembly*. In CareNotes Collective, *For Health Autonomy: Horizons of Care Beyond Austerity, Reflections from Greece*. Brooklyn, NY: Common Notions. pp. 94-95.

“What we are interested in is “palpating” the possibility of the creation of a structure that breaks from existing models of health management and sees itself as part of a broader, more holistic social proposal for the self-organisation of people<sup>21</sup>.”

The above summarise the tactical and strategic opportunities as well as limitations encountered by the SSH. First, the practical and symbolic aspects of housing the SSH in an occupation not only takes advantage of the unutilised abandoned equipment in the space of the old PIKPA- the space is also used to highlight the state’s negligence of primary care in the area. The SSH stands against the mediation of the state while, and unlike the state, it caters for social needs wherever those appear. This sets an example for the superiority of self-organisation and direct service provision on the community level. The SSH rests on two pillars of “extra-legality” which it does not care to address. This is due to the very status of PIKPA as an illegal occupation, as well as its function as a medical center, subject to contestations concerning the “statist criteria” it does not meet. The SSH rejects both issues as products of the oppressive, hegemonic and paternalistic role of the state, on both levels of social organisation and healthcare provision. Yet again, the SSH serves as an example of the redundancy of the state and the reality of possibilities offered by self-organisation starting from the provision of health and care, to extent to all realms of social life.

In other documents authored by the group, the SSH exerts serious criticisms to an array of issues pertaining to health, medicine and healthcare in contemporary Greek society. These are as general and global as the depoliticisation and medicalisation of health and wellbeing as promoted by the medical system, the deepening of social control as secured by the medical establishment as well as issues specific to the contemporary Greek reality. This line of critique is fashioned against the historical and structural weaknesses of the ESY, which they see as

“a healthcare system which, since its establishment, lacked a point of departure (health education, prevention, primary care) and an intention (the capability of addressing complex medical problems shared among a great segment of the population)<sup>22</sup>”.

Among the structural problems of the ESY, they highlight the grave problems of bureaucracy and clientelism encountered among medical professionals and sustained by political and economic interests. In addition, they stress the insidious undermining of public healthcare by politicians, administrative staff, and doctors alike, which paves the way for its effective privatization. In addition, this undermining helps brew xenophobia, as incapacities of the ESY are “blamed” on migrants overcrowding it. They condemn the ESY as an inherently corrupt system of healthcare delivery,

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<sup>21</sup> Health Assembly. (01/04/2010). *Salute-PIKPA*. [in Greek] «Την υγεία μας να ‘χουμε- ΠΙΚΠΑ».

<sup>22</sup> Health Assembly. (10/12/2010). *Through the looking glass: health, exclusion and the state of exception in times of crisis*. [in Greek]. «Κοιτάζοντας την γυάλινη σφαίρα: υγεία, αποκλεισμός και κατάσταση εξαιρεσης στους καιρούς της κρίσης».

suffering from criminal shortages in basic equipment and staff which, by nature of its affiliation to and dependence on the state, is complicit in committing “state murders” of negligence. Last, they predict that the 2008 financial crisis will be used as an opportunity for the state to extend its biopolitical management over those “surplus” populations of the poor, the unemployed and the migrants and normalise exclusion writ large.

The group wishes to address these issues through the direct provision of healthcare and consultation services as well as through neighborhood discussions on health and politics. The group announced the various specialties offered by SSH, since the early days of its operations, to include orthopedic and socio-psychological care –as they were understood to be most pressing in the neighborhood- as well as a general internist, an otolaryngologist, a pulmonologist, a dentist and a dental technician. These were complimented by the activities organised by the group and publicized as follows;

- Discussions around particular illnesses (as defined by western medicine),
- Discussions on the impact of environmental degradation on health,
- Discussions on the impact of work on health (stress, occupational diseases),
- Lessons in first aid,
- Mental health self-help groups,
- The investigation of needs by socially marginalised groups such as the uninsured, the unemployed and the migrants, and solidarity support through collective processes,
- The study of the therapeutic capacity of plants (herbs) and their cultivation as alternatives to pharmaceuticals,
- The creation of a medical library where people can access information about health,
- And the allocation of times for interaction and counselling on health issues.

The group also reports on its impact in the local community, something which unfortunately cannot be verified due to the lack of empirical data. From their documents, however, one derives that the SSH attracts more young people than old, due to the relative “inaccessibility” of a squatted space by members of the older generation. They also claim to have been successful in involving local patients to their assembly and their decision-making processes. On an organisational note, the SSH runs on the basis of the assembly held once a week, and refuses any collaboration with parties and NGOs, while the money needed for the space’s operation is collected through private donations inserted anonymously in the donation box found in its space, as well as through solidarity efforts organised by sympathetic groups.

## 5.6. Conclusion

This chapter opted to animate the Greek healthcare arena by identifying its main actors and their vested interests, their interactions and configurations, as well as the various tactics they employ in order to intervene and advance their positions within it. In so doing, I have attempted to approach the healthcare arena as an arena of political contestation to then study it over the years of the creation and development of the National Healthcare System. This chapter should complement the discussion on the institutional characteristics of the Greek healthcare system presented in the previous chapter, as well as introduce a more dynamic, relational and longitudinal perspective to our understanding of the development of the ESY, its acquired characteristics and, most importantly, weaknesses.

As scholars of healthcare policy agree, the medical professional group and its numerous representative bodies are perhaps the most important players in the Greek healthcare arena. To be sure, and as I hope to have illustrated here, the founding of the Greek NHS was decisive in advancing this professional group as a significant actor, both quantitatively and qualitatively, that in turn determined the development of the National Healthcare System. As we saw, Greek doctors managed to form a powerful professional alliance by swiftly overcoming ideological and/or generational divides and strategically moving to advance their collective position and unite in the protection of their interests, oftentimes against reform efforts to improve and expand public healthcare. Indicatively, organized medical professionals have been responsible for the resignation of the two Health Ministers that showed the greatest determination to reform the ESY.

The previous chapter outlined four main historical weaknesses of the Greek NHS. Those are the half-hearted turn to healthcare universalism that did not break the ties between coverage and contributions, the retainment of the fragmented system of social contributions, the high amount of private payments made to the sector, as well as the absence of a comprehensive system of Primary Care. This chapter has explained these weaknesses as products, at least partial, of collective reactions to reform in any of these directions.

More specifically, since the announcement of the founding reform for the ESY, medical professionals have been critical of the principle of universality and equality propagated and envisioned by the ESY. Senior doctors and their conservative representative bodies contested the curbing of private provision of healthcare in the country as negatively affecting their income as well as limiting the options available to patients. Indeed, over various reform efforts doctors have participated in militant strikes to counter limitations and/or oversight to their private practice and/or compensations.

The unification of insurance funds was also resisted by medical doctors across the board. As I argued in this chapter, the second attempt to merge insurance funds made by Papadopoulos during the favorable

economic period of 2000-2002 was met with strong collective reactions. Those were spearheaded by those doctors working under the insurance fund of IKA who translated the merge as a threat to their positions and initiated strikes for tenure. Medical trade unions also joined the struggle of the striking IKA personnel, albeit not out of solidarity, but out of suspicion that the unification would be the first step towards the privatization of insurance in the country. This is yet another example of how the fragmented healthcare system in the country led to the convergence of different interests, thus uniting a number of collective actors against reform.

The medical professional group has also stood against the decentralization of the healthcare system, both in terms of provision and administration. Gennimatas' term, still in the early days of the ESY, was decisive in this. More specifically, and in siding with doctors, Gennimatas enhanced the centralization of provision through the expansion of the hospital sector, especially in the country's two largest cities where medical associations were strongest. This focus on hospital care and medical specialization undermined Primary Care and general practice in national university curricula as well as in medical students' career choices. All the above resulted in the marked imbalance of specialists vis-à-vis GPs in the country, as we saw in the previous chapter. ESY doctors also resisted the administrative decentralization of the healthcare system, as they feared it might threaten their civil servant status.

The group, however, did not stand alone in defending its interests. The corporatist culture that molded the fragmented healthcare system in the country provided opportunities for alliances hostile to reform. These alliances, as I have tried to summarise here, included larger segments of the Greek trade union movement - as doctors were understood to be a barometer of labour relations in general- large and privileged sickness funds, their personnel and constituencies, as well as bureaucrats. All the above saw their interests converge in resisting and halting reform in the original direction of the ESY.

The successful strategic alliance between those different players, however, also created and reproduced problems within the national healthcare arena. The incompleteness of the ESY reform, created problems for both the quality and the equity of the healthcare system, as well as coordination deficiencies in all aspects of financing, provision, and organisation. For the period studied here, the sum of these problems left segments of the population residing in the country uncared for by the Greek NHS. As such, marginalized, excluded and poor people in need of healthcare would be allocated to humanitarian aid and would be covered by international NGOs operating in the country. I argue that the establishment and growth of the third sector in the 1990s is intimately linked to the inability to reform the ESY in a more equitable and comprehensive direction.

Viewed in this light, the blindspots of the ESY carved the space for NGO intervention in the national healthcare arena, and advanced the third sector as an important player within it, in terms of both

provision as well as competition for resources. The “silent” complementarity and complicity of all these actors, thus, contributed to the policy stalemate in the country and to the relevant acquiescence of the issue of universal and Primary Care up until 2010.

Notwithstanding these observations and while the healthcare arena was congested by established actors and their converging interests in defending their benefits, compensations and privileges there was still room for the reappropriation and resignification of healthcare by new collective actors that entered the arena over this period. As all the above actors were busy establishing and holding on to their hegemony in the arena, new actors began to explore and politically exploit the “definitional vacuum” (Halfmann, 2011: 23) of what constitutes health, care and wellbeing, attaching new meanings and roles to both universalism and Primary Care. These actors and their impact on the arena over this period would had gone unnoticed had not been for the approach adopted in this study.

These actors deriving from the (extra-institutional) Left, the autonomia and the anarchist milieus in the country, also began to intervene in the healthcare arena over this period, to mediate healthcare needs on the ground and/or criticize ESY’s deficiencies and deformities. Not surprisingly then, these actors developed alternative tactical tools to the typical healthcare repertoire in the country. These tactics are the products of the ideological distancing of those actors from the hegemonic actors in the arena and reflect different stakes. They can be resonant with the groups’ broader ideologies, in line with their overarching strategies and consequential for the composition of the arena. In this chapter we saw two new tactics of collective (contentious) action pertaining to healthcare that advanced over this period.

The first is the tactic of padlocking, introduced by the autonomist movement in the country with the intention of proposing another way of struggle (to the one historically devised by the Left) as well as overcoming the difficulties of organizing a strike in an emergency hospital, and helping advance solidarities among healthcare personnel and affected patients. The collective actors behind the importation of padlocking in the Greek healthcare repertoire understood their organization within their profession and the extension of alliances with both “lay” staff and patients as pivotal for any collective contestation of the ESY and the medical model more broadly. As such, the workplace would become the center of interventions for the summoning of “class” allies to reconfigure (Greek) healthcare.

The second tactic that emerged in this period was that of the provision of healthcare services from below, or healthcare DSAs in this thesis. This tactic comes from two different traditions and opts for different mobilization outcomes. The clinic attached to the “Social Intervention- Soup Kitchen Splantzias” in Chania, comes from the Left tradition and is inspired by a secular and medical humanitarian ethos to help those in need, regardless of class, origin or circumstances, away from NGOs. It is for this reason that the main transversal made by Dr. Nikiforidis and his group of

volunteer medical students was the reappropriation of the soup kitchen from the Church and its extension into a medical center.

On the other hand, the Social Space for Health was created by members of the anarchist and autonomist movements in the country after their experiences with the Health Assembly of December 2008. It was housed in the occupied building of the abandoned PIKPA, a previously Primary Care delivery point in the neighborhood of Ano Petralona, Athens. The members of the group were socialized in the Foucauldian critique to modern medicine and the role of the state in healthcare provision and as such they decided to establish their own Primary Care center with a two-fold goal. On the one hand, they wanted to mitigate healthcare needs that emerged in the neighbourhood. On the other, they wanted to educate people on an alternative model of healthcare delivery and together explore the possibilities offered by this new approach. This model would prefigure a healthcare system that is social and truly public, not formally public and dependent on the state. More broadly, this intervention in the healthcare needs of the neighborhood would serve as a bright example of the possibilities of self-organisation of people and, as such, would radicalize locals and recipients against the state and its healthcare system.

The sum of the interactions between those actors and their tactics set the ground for both the health crisis that broke out in the following period as well as for the radical transformation the healthcare arena underwent. More specifically, in what follows, we will see how the institutional characteristics and historical weaknesses of the ESY led to its (near) collapse during the financial crisis in the country, how blind spots in coverage and provision triggered a health crisis and how the tactics developed in the period discussed in this chapter were appropriated by players which entered the arena and stirred it in the direction of new stakes.

## **6. The healthcare arena, its players and their repertoire, 2010-2015. The diffusion and modularization of healthcare DSAs.**

### **6.1. Introduction**

In the previous chapter we saw the main actors, their vested interests and chosen repertoire in affecting stability and/or change in the healthcare arena and policy. This should provide a holistic overview of the arena as it developed since the establishment of the Greek ESY to the years of the crisis. In sketching the arena, I also shed light to the structural deficiencies of the ESY, especially those pertaining to its organization, financing and coverage. More specifically, the ESY never managed to achieve universalism in coverage as entitlement was bound to social insurance, itself fragmented among a range of health insurance funds further complicating ESY's operations, coordination and planning. In addition, the ESY lacked a solid and comprehensive Primary Care, it was overly centralised in and around urban centers and hospitals and was too reliant on specialised care, debilitating prevention and population health, complicating and overpricing the provision of services, and contributing to both the expansion of public expenses for care as well as of out-of-pocket payments- both formal and informal.

Relevant bibliography sees the ESY prior to the crisis as being immersed in a policy stalemate. As I hope to have shown in the previous chapter, this is understood to be the very product of the fragmentation of the healthcare system, resulting in the convergence of various and different organized interests in defending and reinforcing fragmentation whilst preventing reform in any comprehensive direction. In line with the Greek healthcare policy literature then, I have showed that those interests are represented and actively pursued by the medical professional group, its associations and trade unions, broader segments of the labour movement as well as bureaucrats benefitting from the centralization of the healthcare system. Resistance to reform is also passively sustained by those international NGOs intervening in those blind spots of healthcare coverage.

I argue that the healthcare arena was not animated by those actors alone. In the previous chapter I have attempted to trace the origins of some marginal actors that appeared in response to those same deficiencies, in light of the policy stalemate and despite the saturation of the arena by those organized players. Albeit coming from different political traditions, already before the years of the crisis we see the emergence of actors which either challenged the existing contentious repertoire, contributing to its innovation, or intervened in the blind spots of the ESY through Direct Social Actions in healthcare. The tactics devised and employed by these players on the margins of the arena attest to their distancing from traditional grievances and their fashioning of new stakes in healthcare.

This chapter will follow the diffusion of DSA tactics among a range of actors over the course of the country's most recent contentious cycle. These actors are understood as new players that entered and stirred the healthcare arena over the crisis' years. As I hope to show, the combination of the structural problems of the ESY with the harsh austerity policies imposed on public healthcare as part of the Memoranda of Understanding –sometimes overzealously implemented by Health Ministers in the country- brought the ESY to its knees. It was in this context and amidst the country's often cited cycle of anti-austerity contention that healthcare DSAs became modular among collective actors with the strategic intention of mitigating the impact of the healthcare crisis, contesting austerity as well as prefiguring a holistic concept of health and a more comprehensive model of healthcare provision.

As we shall see, the diffusion and modularisation of DSAs in the country cannot be understood in isolation. Any analysis of healthcare DSAs during this period should follow a longitudinal, dynamic and relational approach that considers the structural and historical problems of the ESY in triggering a health crisis, the dynamics of the contentious cycle in the country as well as the competition between political actors in the fluid and fluctuating political scenery induced by the crisis. In addition, the proposed approach should be attentive and sensitive to the different ideological, practical and pragmatic trajectories to healthcare DSAs, as those are carved by the various collective actors that appropriated and utilized them in this period.

In line with the theoretical intention of this thesis, thus, this chapter proceeds with a contextualized approach to transformations in patterns and tactics of (contentious) collective action, and infuses those with the players' strategic capacities as witnessed in their tactical choices and interactions. For this reason, the chapter is divided into two levels of analysis. In the beginning, I provide a picture of the macro-level, that is the socio-economic shifts the country underwent over the years discussed here, to then move onto outlining some of the effects of the crisis onto the realm of healthcare as well as peoples' health. I consider health in its comprehensive state, and as such my approach goes beyond the weakening of the system of the provision of services in the name of public health, to also capture the degradation of population health more generally, through the deterioration of living standards and the corrosion of the social contract. I argue that linking and tracing these changes is crucial to our understanding of the heightened interest, relevance and prominence of health frames and healthcare claims as central mobilizing narratives during the country's cycle of anti-austerity contention.

In line with the recent bibliography, I argue that those macro-level changes triggered a prolonged cycle of contention in the country. The cycle is presented here through its successive and consequential waves, distinguished by their particular dynamics, the collective actors mobilised, their tactics and claims. This chapter follows these trends in the healthcare arena and zooms into the diffusion of DSA tactics therein, as representative , if not paradigmatic, of broader collective action dynamics. As we will

see, the cycle of contention sees the gradual transition from indirect, protest tactics countering austerity, to direct tactics of healthcare and welfare provision from below. Linked to this is the processual diffusion of DSAs from formal civil society to informal and contentious civil society actors.

This relational and dynamic approach allows us to understand this shift in the repertoire as a strategic choice that is consequential for the arena, its players and their tactics. As I hope to show, the diffusion of healthcare DSA tactics among different actors attests to their perceived success as well as to their different appropriations and strategic utilizations. In addition, I argue that the proliferation and eventual modularization of healthcare DSAs not only compelled other actors to adopt them, they also stirred and changed the very foundational stakes of the arena.

To better capture these transformations, I organize the discussion around five “ideal-typical” cases of Social Clinics-Pharmacies intervening in the healthcare arena with DSAs. These represent five trajectories that converge in the utilization of healthcare DSAs. I present those trajectories as emergent and informed by the relations and dynamics of the arena over this period, to be consolidated after the closure of the cycle of contention and the institutionalisation of the Social Clinics-Pharmacies’ movement. As we will see, each trajectory in its early stages is configured around five broad axes. These are (1) the milieu appropriating DSAs, (2) their diagnostic frames over the crisis and its effects on health, (3) the sum of their tactics, (4) their prognostic frames and (5) their relationship to the state.

Last, this presentation opts to explain how these collective actors affected opportunities for themselves, decided to cooperate with each other and/or other social movement milieus and parties, as well as compete with each other over the strategic utilization of healthcare DSAs. As such, I approach fluctuations and transformations in the healthcare arena during those years as resulting from shifts and interactions on the macro- and meso- levels. Those transformations are what allowed emergent actors, their tactics and claims to bolster, ultimately contributing to the expansion of the arena and the politicization of both health and healthcare, either in the direction of the invigoration of healthcare reform, or in the development of visions of alternative medical paradigms. This chapter, therefore, roots tactics of collective action firmly within the anti-austerity contentious cycle, whilst highlighting their transformational dimensions for the arena, its actors and its stakes.

## **6.2. MACRO LEVEL**

### **6.2.1. Austerity crisis**

Greece was among the countries hit the hardest by the economic crisis of 2007. To avoid default, the government of PASOK inaugurated what was going to be a series of bailout packages, in the form of

Memoranda of Understanding issued by the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) (the so-called Troika), effectively pushing the country into a vicious cycle of internal devaluation and debt-deflation depression (Armingeon and Baccaro, 2012; Frangakis, 2015). For the purposes of this thesis I approach the crisis through the effects of the austerity policies introduced in its response in 2010.

The MoUs prescribed the combination of fiscal consolidation measures, labour market reforms and structural changes. Fiscal consolidation was to be achieved through reductions in government spending and an increase in tax revenue. This implied the downsizing of the public sector by 23% as well as the cutbacks in wages for its remaining employees. Further measures in this direction affected the education sector (through the closure and merging of schools), the health sector (through the closure of hospitals, units, and rural centers) and reductions in pensions and cash benefits (ibid). At the same time property and VAT taxes increased (Mavridis, 2018). This trend soon spilt over to the private sector, which saw a drastic deregulation of labour relations through the reduction of the minimum wage and the effective abolition of collective bargaining (Achtsioglou, 2013). In addition, layoffs were made easier and social contributions shrunk.

The negative effects of the crisis have also been noted on the societal level, observed through the deterioration of all socio-economic indicators. Matsaganis and Leventi (2013) report a 9.1% decrease in average wages and a rise of unemployment from 9.5 to 12.5 already by 2010 (ibid: 85). Official unemployment rocketed from 8.4% in 2008 to 26% of the population in 2013, 63% of which was made up of the long-term unemployed. The youth was disproportionately affected by the rising unemployment rates, as from 36.6% in 2009, it went up to 65% in 2013 for women and from 12.1% in 2009 to 52% in 2013 for men under 25 years of age (EL.STAT., 2009; 2014). In addition to these pressures, poverty was further exacerbated by cuts in benefits, both in size and scope (Vaiou and Kalandides, 2016). Meanwhile, flexible employment soared; INE-GSEE's report (2013) shows that between 2009 and 2013 new fixed-term contracts declined by 50 per cent, while part-time and temporary contrasts increased by more than 50 per cent. A report issued by the Hellenic Statistical Authority (EL.STAT.) shows that by 2010 the number of impoverished people in the country reached 30% of the population (in Ifanti et al. 2013: 9). These measures were accompanied by structural changes, mostly pertaining to the deregulation of professions and the privatisation of public assets, including transportation, energy, water, and large public infrastructure such as airports and ports (Frangkakis, 2015).

### 6.2.2. Health crisis

The effect of economic crises onto population health have been the subject of vigorous, yet divergent, research. Prior to the recent global financial crisis, scholars of public health and health policy have

studied the relationship between the two historically and comparatively across crises and settings. Two approaches can be deciphered from the existing historiographical literature.

The first views economic crises as *procyclical* with regards to population health. This is explained on the basis of evidence suggesting a positive correlation between falling incomes and rising unemployment and the adoption of healthier lifestyles. These scarcity-fashioned lifestyles are characterized by reduced consumption of alcohol and tobacco products, the replacement of driving with walking and, relatedly, the benefits reaped from physical activity and the avoidance of fatal accidents. In addition, the free time deriving from under- or unemployment is also viewed in a positive light, due to the possibilities of self-actualization it provides (Breman and Shelton, 2001; Walker, 2010).

The other approach is less optimistic about the effects of crises onto peoples' health, and is critical of the reading of the aforementioned findings. More specifically, scholars adopting this approach criticize the procyclicality arguments as particularistic and narrow, and for neglecting indicators that disfavor the thesis, such as the rise of suicide or homicide rates historically linked to recessions which most often than not balance-out the "health benefits" outlined by the scholars of the procyclical approach. What is more, researchers adhering to this agenda also criticize procyclicality arguments as simplifying of the various ways in which the economy interacts with physical and mental health. Notwithstanding the validity of the evidence examined by the former, therefore, scholars that view the relationship between crises and health as *countercyclical*, consider health as a holistic state. As such, they highlight the strains placed on healthcare systems as crises deepen and warn against the adverse effects of cost-containment logics onto the quality and scope of healthcare (see Yang, Prescott and Bae, 2001; Simms and Rowson, 2003; Cavagnero and Bilger, 2010).

Puzzled over the disparity between those two camps, Stuckler and Basu (2013) were prompt to respond to the challenges posed by the most recent global financial crisis. In their book "Body Economic", they compare and contrast health policy in eight different crisis settings across time and space, to evaluate the impact of economic recession onto population health. Drawing from both literatures, and combining both perspectives and lines of evidence, they masterfully portray that what does have an effect onto population health is not the recession per se, but the policy prescriptions followed in each context. Viewed in this light, the authors argue that whereas health can indeed improve in settings where the crisis is addressed with stimulus policies -such as the case of the New Deal in the US-, crises can also be proven detrimental and countercyclical when met and addressed with austerity measures.

For the purposes of this thesis I approach the impact of the crisis onto public health through the combination of the various ways in which austerity, healthcare policy and population health interacted. As such, Greece provides an excellent ground on which to expose the direct and immediate impact of

austerity onto public health and healthcare. The policy prescriptions laid out by the troika and agreed upon by the government of PASOK in 2010 and the technocratic government of Lucas Papademos in 2012, involved the restructuring of the public healthcare system and the reorganization of the funding for healthcare through the merging of the existing fragmented health insurance system into a single organisation EOPYY in 2011. Some scholars viewed the onset of the crisis and the involvement of the troika onto the Greek ESY's financing as a chance to break from path dependence and move towards progressive and rationalistic reform. Very quickly, however, it would become apparent that austerity policies focused almost entirely on the depletion of the ESY, through cuts in personnel, compensations and benefits, through reductions in the benefits' basket of recipients and the closure, merger and privatization of hospitals, clinics, units and beds in the name of cost-containment.

One such example is that, and “[d]espite health being deemed a matter of internal governance, the troika [...] demanded that public spending on health should not exceed 6% of GDP, setting a precedent for the European Union on acquisition of control over national health systems in individual countries (Karanikolos et al 2013: 1324)”. Numerous researchers raised their suspicion towards the MoU's cap on healthcare expenditure, deeming it arbitrary and extremely low (Stuckler and Basu, 2013; Karanikolos et al. 2013; Kondilis et al. 2012; Kentikelenis et al. 2014). However, Health Ministers at the time went beyond their commitments to the troika, effectively reducing public health expenditure to 5.7% in 2012 and to 4.6% in 2014.

These changes happened against the backdrop of the, already discussed, dramatic impoverishment of the population. In that atmosphere, the utilization of ESY services over private options grew. Indicatively, and as “hospital budgets were reduced by 40%, the admissions and utilization of public health services were increased by 30% [between 2011 and 2013] highlighting the shift from the private health sector to the public one (Ifanti et al. 2013: 10)”. That brought great strain to the public health system, exacerbating long waiting lists and negatively affecting the quality of care delivered. Self-reported unmet medical needs for the lowest population quantile increased significantly (while at the same time reaching historically low levels for the richest population group) and so did the self-reporting of bad and very bad health. Those indicators, typically used to ascertain a society's health and inequality levels, have been attributed to patients' inability to afford care, long waiting lists and distance to care (Kentikelenis, et al 2011; Stuckler and Basu, 2013; Karanikolos and Kentikelenis, 2016).

The case of crisis-stricken Greece confirms the countercyclicality thesis also with regards to other bold indicators. The combination of the recession and the slashing of mental health budgets by 45% after the First MoU contributed to the rocketing of mental health problems, with a marked increase in one-month prevalence of major depression from 3.3% in 2008 to 8.2% in 2011 (Kenikelenis et al., 2011; Economou et al, 2012). In addition, suicidal ideation and reported suicide attempts increased

substantially between 2009 and 2011 (Economou et al, 2013), while EL.STAT reports that the number of deaths attributed to suicide went up by 33% between 2009 and 2014 (in Vaiou and Kalandides, 2016).

Infectious diseases also made their (re)appearance since the advent of the crisis. To quote Stuckler and Basu (2013);

“The Hellenic Centre for Disease Control and Prevention detected a series of outbreaks immediately after large cuts had been made to infectious disease prevention programs. For forty years, insecticide spraying programs had effectively prevented mosquito-borne diseases from spreading in Greece. After funding had been cut for the southern part of the country, an outbreak of West Nile Virus occurred in August 2010, killing sixty-two people in southern Greece and central Macedonia. Then, for the first time since 1970, there was a malaria outbreak in the southern Greek regions of Lakonia and East Attica. The European Centre of Disease Prevention and Control recommended that travelers to southern Greece stock on anti-malarials and take other precautions like mosquito spray and nets. It was a special warning that had previously been reserved for travelers to sub-Saharan Africa and tropical parts of Asia (ibid: 86)’

Moreover, HIV infections skyrocketed between 2011 and 2012, to levels never before witnessed in the country. The Hellenic Center for Disease Control and Prevention in 2012 reported the increase of HIV infections among injecting drug users from 15 cases in 2010 to 522 cases in 2012<sup>23</sup>. Relevant research concludes that the rise in infections can be attributed to the cuts to preventive care as well as rehabilitation, needle exchange and street intervention programs (Karanikolos et al., 2013: 1327; Kentikelenis et al, 2011; Stuckler and Basu, 2013). The news about the spread of HIV/AIDS in the country made it to international media, drawing the attention of researchers and policy-makers alike who appealed to Greek officials and European patrons against the spread of the epidemic so much in Greece as much as to the rest of Europe. Amidst these news, and in anticipation of the May 2012 national elections, Minister of Health Andreas Loverdos joined forces with Minister of Citizen Protection Michalis Chrysochoidis and responded with “police sweep” operations, including that of the arrest of sex workers as “health time-bombs” and their public naming and shaming as, and in the words of Health Minister Loverdos, AIDS is “transmitted from the illegal female migrant to the Greek customer, to the Greek family<sup>24 25</sup>”.

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<sup>23</sup> ECDC. (2012). Technical Report on Risk assessment on HIV in Greece.

<sup>24</sup> News247 Online. 16/12/2011. *Loverdos: Deportation to the alien virus carriers* [in Greek] « Λοβέρδος: Να απελαθούν οι αλλοδαπές, φορείς του AIDS».

<sup>25</sup> Minister of Health Andreas Loverdos in association with the Minister of Citizen Protection Michalis Chrysochoidis, passed a decree allowing the police to detain anyone for the conduct of compulsory tests for infectious diseases in the name

While the successive governments tried to cover up the first symptoms of the health crisis through the use of xenophobic and sexist discourses and practices, the aggregate effects of the recession on both levels of individual and population health were feeding to the growth of health and care inequalities. More specifically, the austerity packages implied policies that transferred healthcare costs to patients, including the increase in user fees for outpatient visits from € 3 to € 5 in 2011, the removal of a number of services and pharmaceuticals from the benefits' basket and the introduction of co-payments for a series of medicines and clinical tests.

Albeit difficult to estimate the overall increase in private payments for public healthcare services due to the historically high level of informal payments made to the sector, Kondilis et al (2013) attest that “[i]n 2011 Greek patients spent more than € 25.7 million on out-of-pocket payments for outpatient services delivered during daytime hours in public hospitals, services that were free at the point of use before the crisis (€3)”. So as patients were turning to the internally undermined ESY to avoid the costs of private care, the private costs for public healthcare were multiplying. In addition, the merging of the largest insurance funds in the country under EOPYY, a reform pending since the establishment of the ESY and in line with troika's recommendations opting to advance the bargaining power of the unified fund vis-à-vis its suppliers, brought diverse groups of beneficiaries together and, confirming the fears of the constituencies already in previous reform efforts as seen in the previous chapter, effectively reduced the benefits' package for all (Economou et al, 2016: 106).

This vicious cycle of internal devaluation and debt-deflation depression described above for the country's economy was, therefore, also reflected in the healthcare arena. Soon, the combination of these measures would deplete the hospital sector, the backbone of the country's healthcare system in the absence of a comprehensive Primary Care level, which suffered grave shortages in basic pharmaceuticals and equipment. International media report on these shortages as extending to

“everything, from sheets, gauzes and syringes, to doctors and nurses. By 2011, supplies were critically low, says Athena, a former nurse in a hematology unit. ‘We did not even have the most basic of materials [such as] surgical spirit’<sup>26</sup>.

Another article in the New York Times, exposes how hospitals were urging patients to bring their own syringes and stents for treatments while demanding cash payments for drugs. Some of the therapies,

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of public health. On these grounds, and before the decree becomes overturned in 2015, thousands of migrants, homeless people, sex workers and drug users were arrested, prosecuted and publicly humiliated (Burgi, 2018: 25; see also Mavroudi, Z. (2013). Ruins- Chronicle of an HIV witch-hunt. Ερείπια- Ορθοπετικές γυναίκες. Το χρονικό μιας διαπόμπευσης. [in Greek with English subtitles]).

<sup>26</sup> BBC News. (06/09/15). Christides, G. *Greece crisis: cancer patients suffer as health system fails*. Available

such as cancer, the article adds, would require the payment for pharmaceuticals amounting to tens of thousands of dollars, money that an increasing segment of the population could no longer afford <sup>27</sup>.

My interlocutor Hobo through his experiential account of working in the regional health Centre near Attica as a GP painted a similar picture. When talking about the reasons behind the mobilisations himself and his colleagues organised around the clinic, he spoke of the potentially criminal shortages in staff and his continued efforts to install a second medical practitioner during the overtime shifts, as “[o]ne doctor can attend to one person [...] What if we need to take the patient to Athens? Who’s going to be left behind in case of another emergency?”

The picture of the understaffed night shifts was complimented with that of shortages in basic supplies. He continues;

“It was all these things, all of them [acted as] motives [for mobilization]. It was a general climate that made us think, things are getting rough and we’re going to get in trouble. And then some guy came to the center, his kid was out on the street, he rushed to get it and run through a shop window. A piece of glass cut his throat. He came in, [the health center] didn’t have any gauze. And we start wrapping him up in sheets... We call the ambulance. His pressure had dropped so much [from the blood loss], we barely made it to Athens [...]”

Meanwhile, the number of the newly unemployed in the country was growing, and those already unemployed were pushed into long-term unemployment. These people, alongside the increasing number of migrants coming into the country, were falling out of the purview of the ESY- due to existing gaps in social protection as well as newly installed restrictions. To be sure, “[a]fter July 2011 [...] new regulations stemming from the MoUs required that Greeks pay all costs out of pocket once their benefits had expired [...] Moreover, in March 2012, the amounts and duration of unemployment benefits were drastically reduced (Burgi, 2018: 20)”.

In addition, existing deficiencies in the planning and provision of healthcare to migrants only deepened with the crisis. The first MoU eliminated a third of the country’s healthcare services dedicated to them, while further cuts implied in the second MoU exhausted them (Stuckler and Basu, 2013: 89). A study concerning migrants’ health insurance conducted in 2012 showed that of the documented migrants participating in the study, only 56.5% had health insurance, while 62.3% reported unmet medical needs (Galanis et al., 2013). Again, respondents explained their dissatisfaction on the grounds of long waiting lists and high related costs. A follow-up study shows that by 2014 the number of the uninsured had climbed to 67.4% of the participants (Economou et al, 2016).

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<sup>27</sup>New York Times Online. Alderman, L. 24/10/12. *Amid cutbacks Greek doctors manage the poor: you are not alone.*

Undocumented migrants face even greater difficulties, as the system is not open to them unless in cases of emergency. Although nothing has formally changed pertaining to this configuration during the course of the crisis, exclusion did become stricter as “providers do not any more turn a blind eye, as they used to do often in the past, since they are obliged to strictly follow the rules for uninsured people, who are only eligible for treatment in cases of emergency” (ibid: 109). In addition, the number of migrants and asylum seekers significantly increased over these years, due to war and poverty in Middle Eastern and African countries. Those people are currently being faced with the already incomprehensible and by now congested asylum system in the country, which has become even more dysfunctional due to the combined pressures of austerity and rising migration.

To address these problems, national branches of international NGOs took on ever greater responsibilities in caring for these populations. My research over the activities of the MdM and MSF, cited in the previous chapter, indicated not only the intensification of NGOs interference in the provision of medical and preventive care for migrants and refugees but also the extension of their interventions to camp and detention centers’ sanitization programs and the distribution of basic hygiene and sustenance products. In addition, both organisations started catering for the needs of uninsured Greek natives as a result of the crisis. Indicatively, MdM released a report highlighting the increase of Greek incomers to their street clinics from 3% before the crisis to 30% in their polyclinic in Athens and to 95% in their polyclinic in the port city of Perama by 2012 (MdM, 2012: 14). It is important to note here that the expansion of those NGOs’ activities happened despite their restricted funding, as the state interrupted NGO funding in August 2012<sup>2829</sup>.

### **6.3. MESO LEVEL**

#### **6.3.1. Anti-austerity contention**

The global financial crisis of 2008 was met with the advent of anti-austerity contention worldwide, by now linked to the mass mobilisation of citizens against neoliberalism; demanding the rejuvenation of

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<sup>28</sup> To Vima. 22/08/2021. After NGOs, they are cutting funds to Public Organisations. [in Greek] «Μετά τις ΜΚΟ κόβουν λεφτά και σε Οργανισμούς του Δημοσίου».

<sup>29</sup> From my research onto the reported activities for each organisation it becomes apparent that the intensification of the work on the part of both NGOs reinforced their complementarity. More specifically, MSF dealt almost exclusively with migrants and refugees and, as such, its operations accelerated over and following the “hot summer of migration” in 2015. MdM, on the other hand, intensified its vaccination and dental care programs for marginalized children and/or children residing in remote parts of the county as well as uninsured nationals in urban centers. It is for this reason that their interventions increased over the austerity crisis, supported, in the absence of public funding, but large foundations and firms.

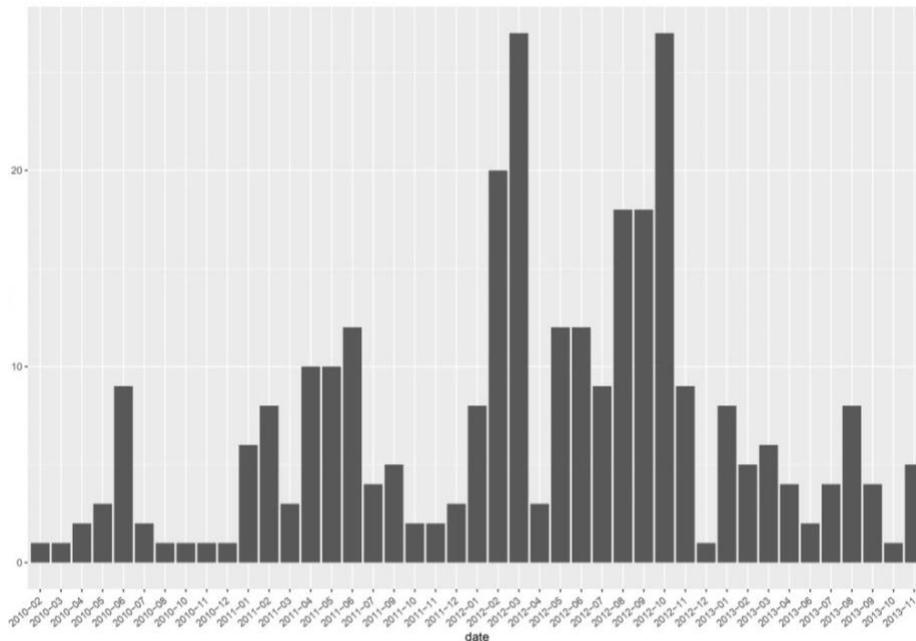
their economies, the fostering of their welfare states and the enhancement of democratic accountability on the side of institutions.

Scholars working on the political effects of the economic crisis in Greece have adopted a cyclical approach to the analysis of contentious and collective action in relation to the crisis. Sergi and Vogiatzoglou (2013), Karyotis and Rudig (2017), Serdedakis and Tobazos (2018), Kotronaki (2018) and Kotronaki and Christou (2019) have all tried to order the (co)dense(d) time of anti-austerity protest and/ or contention, albeit adopting a different temporal scope and research focus. For the purposes of this thesis, I consider the contentious cycle to extend over the period between 2010 and 2015, beginning with the introduction of austerity programs that fed into anti-austerity mobilization and closing with the election of SYRIZA into office. In what follows, I will try to shed light onto the healthcare arena over this period, to follow the innovation of the repertoire. As I hope to show, healthcare DSAs diffused and modularised in the arena through the entrance of new and emergent actors therein. The broader dynamics of contention, here explicated in the form of waves of contention, reinforced the overcoming of indirect tactical forms by DSAs as well as their spread and appropriation from formal to informal and contentious collective actors. I present these meso-level transformations through the relational and dynamic presentation of the five ideal-typical clinics-pharmacies discussed in this thesis.

#### **6.4. First Wave**

Research on contentious collective action during the crisis in the country suggests that the beginning of the cycle saw the proliferation of mass mobilisations against austerity, mostly by traditional political actors such as parties and syndicates. The first wave was initiated with the signing of the first MoU in 2010 to peak during the mobilisations of the Aganaktismeni (Greek Indignados movement) and subside after their dissolution. This wave saw the development of anti-memorandum and anti-austerity frames and claims, that would solidify over the course of the following waves (Kotronaki and Christou, 2019; Kousis and Kanellopoulos 2014; Serdedakis and Koufidi 2018).

The dynamics and patterns identified for the first wave of contention are also present in the healthcare arena. More specifically, the results of those data I extracted for healthcare from the Protest Event Analysis database of the University of Crete are in line with the protest cycles' broader trends identified by Serdedakis and colleagues (for more see Serdedakis and Tombazos, 2018). More specifically, we see a rise and peak of protest events with regards to health in the period between 2011 and 2012, before they subside the following year.



**Figure 4: Frequency of protest events related to health, 2010-2013**

Moving onto the qualitative analysis of this data, news articles collected for the purposes of the dataset point to the types of collective action and related claims around health and healthcare. The events are distinguished by their sectoral profile. They include strikes and stoppage action of ESY doctors, health personnel and pharmacists throughout the country as well as occupations in hospitals, Primary Care centers (including IKA centers) and the Ministry of Health. As such, the first wave is animated by the main players in the healthcare arena which utilize the traditional contentious repertoire presented in the previous chapter and mobilise in defense of the historically foundational stakes of the arena. More specifically, mobilisations pertain to the mass firing of personnel, the change in the contracts for the public sector, the capping in the hiring of new staff and reductions in wages and benefits. What is distinguishable from previous periods of contention, however, is the anti-austerity and anti-memorandum framing of those grievances, which ultimately set those instances of contentious collective action within the broader anti-austerity cycle of contention.

The events are frequent and appear to be culminating in periods where relevant bills and reforms are being voted in parliament. In what follows, I provide some reports on indicative instances of sectoral action over the period.

“Public hospitals will be operating with security personnel starting today and in anticipation of the five-day strike of hospital doctors who reject the ‘privatisation attempts of hospital care through the reform put forward by the Minister of Health’ [they] urge him to take it back and [to] cover the running expenses

of hospitals and Health Centers in the country by the public budget' [...] Finally, OENGE and Unions of ESY doctors will continue with the coordination and militant engagement with the rest of the Federations and Syndicates of the public and private sectors, in the attempt to overturn the government's measures, the rejection of the Stability and Growth Pact and the disengagement of the country from the IMF<sup>30</sup>”.



Picture 1: Doctors at Attikon Hospital on five day strike (19/07/2010)

“Hospitals in Athens and Piraeus will be operating with security personnel today, as the Union of Hospital Doctors of Athens-Piraeus participates in the 24hour warning pan-medical strike announced today by the Panhellenic Medical Association and the Medical Association of Athens. [Their] joint demand [is] the withdrawal of the austerity package submitted yesterday in the Parliament by Min. of Health A. Loverdos. According to EINAP's president, Stathis Tsoukalos, the package condenses the public health sector and expands the private [one] reinforcing big healthcare monopolies, [it] excludes people from care and forces thousands of doctors into unemployment. As noted, among others, by the Board of EINAP, the austerity package was drawn hastily and clumsily, with the collaboration of extra-institutional ‘buddy-consultants’ and in the occasion that it passes, ‘the consequences will be catastrophic and possibly non-reversible<sup>31</sup>”.

So far, it becomes apparent that the first wave of anti-austerity contention exhibits continuities with the previous period, as analysed in the previous chapter. More specifically, we see the overrepresentation of medical professionals, and more so, doctors, in defense of the public healthcare system following sectoral interests. These are complemented by grievances and claims pertaining to austerity and the

<sup>30</sup>Eleftherotypia. 19/07/2010. Hospital Doctors on Five-day strike. [in Greek] «Πενθήμερη απεργία νοσοκομειακών»

<sup>31</sup> Eleftherotypia. 20/01/2011. 24hour strike of doctors in Athens and Piraeus. [in Greek] «24ωρη απεργία γιατρών Αθήνας- Πειραιά».

MoUs, something which is further highlighted by the concentration of such instances around periods of healthcare related reforms and clauses.

The database presented above is an excellent archive of Protest Event Analysis and a key tool for anyone who wishes to look into the protest cycle in the country. However, its focus on protest misses out on those Direct Social Action tactics that were employed already in parallel to sectoral mobilisations, to progressively replace them.

One example of those transformative contentious dynamics in the period is showcased by the Social Clinics-Pharmacies. As we will see below, this period saw the mushrooming of clinics-pharmacies across the country, covering the immediate needs of the excluded and marginalized people while also advocating and mobilizing for the universalization of ESY coverage, the preservation of its public character, progressive reform in Primary Care and/or changes in the predominant healthcare and medical paradigms. These clinics-pharmacies contributed to the modularization of healthcare and solidarity frames, the diffusion of DSAs in health as well as to the creation of visions concerning better medical practices – either inside or outside the ESY.

#### 6.4.1. KIA: Solidarity with Migrants

In 2011, and during the country's first wave of contention, a large group of migrant workers living in the island of Crete traveled to the mainland to occupy public buildings and announce the commencing of a hunger strike until they received recognition of their human and legal rights. This hunger strike was the most numerous the country had ever witnessed, summoning mass support and solidarity that led to the formation of the “Solidarity with the 300 hunger strikers” campaign. Of those 300 hunger strikers, 250 settled in the Athens Law School- a school with heavy anti-dictatorial historical connotations- with the help and support of local social and student movement milieus. Fifty strikers continued to Thessaloniki, the country's second largest city.

In Thessaloniki, members of the campaign composed a medical team to stand on the side of the hunger strikers, committing to their health monitoring and support. This team was made up of various specialties and attended to the medical needs of the strikers that camped on the top floor of the Trade Unions' Centre, to secure the safest possible conduct of the strike. The team would also bear witness to the struggle, publicly report on its advent and openly condemn the government for its disregard of human life and dignity. Their critique would incorporate appeals to the centrality of the socioeconomic determinants of health, both physical and mental, especially with regards to insecurity and precarity. In addition, they would hold press conferences where they would exert political pressure onto the government and expose Minister of Internal Affairs Yiannis Ragousis and Minister of Health Andreas

Loverdos' stance towards the strike and their migrants' rights agenda, with a special emphasis on healthcare rights.



Picture 2: Snapshots of documentary *Solitaire ou Solidaire* (2016)

The strike came to an end on the 44<sup>th</sup> day, after a meeting between representatives of the strikers, members of the solidarity campaign and members of parliament. The meeting reached some concessions for the strikers themselves and some for migrants in general, albeit short-lived and incomplete. At the time, however, those concessions stirred intense debate between right- and far-right MPs, who criticised Loverdos for giving in to migrants' demands. This polarization, alongside with the successful avoidance of the health risks implied in any hunger strike, gave the impression of an overall victorious struggle and elevated the spirits of the migrants, the members of the solidarity campaign, and especially, the medical professionals involved.

Amidst the euphoria of this victory and deep into the country's austerity crisis, the activists that facilitated the strike decided to continue and routinize their medical interventions. As GP Thodoris Zdoukos comments in the documentary *Solitaire ou Solidaire*;

“We were delighted to be the positive outcome of so much hardship and fierce ideological and political war waged against us by the state and conservative groups during the strike. [...] And we all had in mind those with no social security whose number was ever increasing, so while we were talking about it over a glass of distilled spirit [*raki*] that Irene had brought back from Crete, we said let's do something about those with no social security. That's how we embarked on this idea, on the spot [*orthio*], on the 7<sup>th</sup> floor of the Trades' Union Centre, we came to the decision that something ought to be done.”

The idea pertained to the creation of the Social Clinic of Solidarity (henceforth KIA) that would provide free primary healthcare services and pharmaceuticals to all without health insurance. Christina Kydona, an intensivist who participated in the solidarity campaign adds that their newly established relationship with the Trades' Union Centre provided them with a working space in a government-owned building on Aesopou Street, at the center of the city. This space was transformed into a healthcare unit which included a Primary Care clinic, a dental clinic, a reception area and a pharmacy,

hosting a series of specialities. In the months that followed, KIA started to attract more activist-volunteers as well as patients, while the activists therein were becoming increasingly aware of the impact of the crisis onto health and care, so much for migrants as well as locals.

KIA began its operations on the basis of direct democracy applied and exercised in its regular assemblies open to all. Through deliberations, discussions and debates therein, its members started compiling a holistic picture of the size and severity of the health crisis. Activists in KIA saw the crisis as intrinsic to capitalism, and austerity as one political strategy used by capital to pass its own contradictions and dead-ends onto the people of labor, resulting in mass unemployment, poverty and marginalization. In the context of this “trickle-up” response to the crisis, representatives of capital were understood as imposing restrictive fiscal policies which, among other things, acted as catalysts for the privatization of healthcare. At the same time and as government expenditure towards welfare and healthcare was shrinking, the state was seen as abandoning its responsibilities to cover even for the most basic health needs for the ever-growing segment of the population left impoverished by the crisis. All of these factors led to the exclusion of people in need, the deterioration of their health, the growth of their misery and, their premature death.

The sum of these observations motivated activists at KIA into two interrelated and complementary tactical directions. On the one hand, they would provide free healthcare services and pharmaceuticals to those in need, through healthcare DSAs, while pressing for immediate reform in the system of coverage and for the expansion of public spending for the ESY, through contentious action. The combination of DSAs with contentious tactics was explained on the basis of their admission that they have “no intention, nor any illusion” to substitute for the state and their awareness of the tangible limitations of any grassroots solidarity effort in covering for peoples’ healthcare needs. Solidarity, however, as they set out to practice it, was direly needed so much for supporting people who fall through the cracks produced by the political management of the crisis, as well as for preserving the social fabric, recuperating the social body and reinstating relationships and behaviors that center on the collective. The mobilizing frame of solidarity, thus, saw healthcare DSAs as a prerequisite for the possibility of fighting against individualism and exploitation. To this end, members of KIA had extended their invitation to participate in solidarity healthcare to broader segments of healthcare professionals. More precisely, they were asking doctors to join them in “disobedience” within their places of work, and against the dictates of the Ministry of Health and those hospital managements who stand in the way of their medical practice. In appealing to doctors’ medical humanitarian ethos, members of KIA insisted that they should comply to the Medical Code of Conduct that binds health

workers against “discriminatory treatment deriving from educational, legal, economic, social, geographic and other differences”<sup>32</sup>.

In addition to healthcare professionals, KIA would also work towards the formation and/or strengthening of alliances and networks of cooperation with a range of social movement milieus in the city. These boosted their indirect and contentious interventions which included demonstrations and pickets outside of local hospitals, the interjection of hospital management meetings as well as marches co-organised with local antifascist and antiracist groups.

KIA activists oftentimes portrayed their clinic as a direct inspiration from the first “social clinic”, that is the “Social Intervention- Soup Kitchen Splantzias” in Crete presented in the previous chapter. Unlike the clinic in Chania, however, KIA would become a hub of solidarity and resistance at the heart of Thessaloniki, covering for the needs of thousands of people while becoming a symbol of active struggle and resistance in the city.



Picture 3: Snapshot from documentary *Solitaire ou Solidaire* (2016)

## 6.5. Second Wave

Later that year, in May 2011, the heterogeneous movement of the Aganaktismeni square occupations marked another transformation into the country’s contentious cycle that fed into the second wave of contention that would bolster the diffusion of DSA tactics among and across actors. More specifically, the Aganaktismeni, itself an innovative movement with regards to its composition, tactics and claims,

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<sup>32</sup> Social Clinic of Thessaloniki. 23/09/2013. Press Release: For all the workers at the hospitals and health centers. [in Greek]. «Για όλους τους εργαζόμενους στα νοσοκομεία και κέντρα υγείας».

gathered people in thousands in Syntagma square, the central square of Athens as well as central squares of other urban centers, to camp, protest and deliberate over the country's future.

In tracing the origins of the *Aganaktismeni*, Roos and Oikonomakis (2014) point to its “multiple sources of inspiration”. More specifically, the authors argue that, to view the mobilisations as a direct adoption and national appropriation of the Spanish *Indignados* and/or a direct response to the signing of the first MoU would be an oversimplification that would overlook at the dynamics that had been brewing under the surface over the years leading to the crisis. They therefore conclude that the *Aganaktismeni*, apart from those new constituencies they mobilized, also relied on those tactics and networks of the anarchist and anti-authoritarian milieus dating back to December 2008, as well as the networks established by the “I won't pay” disobedience movement against tolls and public transportation fees.

This is an important point for our discussion here, as the affinity and proximity between the 2008 mobilisations and the *Aganaktismeni* could account for the subsequent spread and diffusion of DSA tactics from anarchist/ anti-authoritarian groups prior to the crisis, to wider, and arguably less radical, social movement milieus during the cycle of contention. That is because the square occupations and their assemblies provided the setting in which mobilized constituencies –old and new- came into discussion and deliberation with each other, sharing grievances, frames, claims as well as prescriptions of what is to be done. To quote Theodossopoulos (2013) “their campsite was a starting point of dynamic protest but also worked as a communication station, a forum of debate, and a space of socialization more generally” (ibid: 200).

Briefly, the *Aganaktismeni* shared many attributes with the square movements we saw around the globe following the financial crisis, demanding “Direct Democracy Now! Equality- Justice- Dignity”. Overviews of the existing literature around the Greek square movement, Marilena Simiti (2014) notes the creation of working groups and assemblies concerning specific issues and themes, not dissimilar to those following December 2008 that we saw in the previous chapter. Although the *Aganaktismeni* set themselves against political representation, two marginal left-wing parties, SYRIZA and ANTARSYA, participated in the squares, whereas the stronger Greek Communist Party (KKE) was not only distancing itself from them but condemned them as apolitical. In line with Roos and Oikonomakis (2014), Simiti affirms that other political groups, including extra-parliamentary, anti-authoritarian and anarchist groups also engaged in the “lower square”<sup>33</sup>. The encampments however did not last long, and police evacuated the squares a few months later.

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<sup>33</sup> The square in Syntagma was divided between its nationalist upper and left-wing lower parts.

According to the relevant literature, the Aganaktismeni marked the end of the first wave and planted the seeds for the second wave of contention in the country, adding new elements to the repertoire of action -as traditional protest was supplemented with square occupation tactics- and affecting the mobilized constituencies- as anti-austerity protest moved away from syndicalist and sectoral mobilisations and into a leaderless mass of contesters of austerity. In addition, the Aganaktismeni fed into the expansion and reappropriation of public spaces as spaces of democratic deliberation in a period marked by a more general expansion of building occupations (Dalakoglou 2012; Leontidou 2012; Kavoulakos 2013). These dynamics led to the growth and multiplication of local and regional networks addressing pressing issues and needs in the aftermath of the square occupations (Ishkanian, Glasius and Ali, 2018: 10; Malamidis, 2019: 41; Arampatzi, 2017).

I argue that this “decentralization” of contention from central squares to neighbourhoods (Malamidis, 2019) coincides with a shift in tactics of collective action and its “specialization” into particular domains and/or sectors identified in the square assemblies<sup>34</sup>. Anti-austerity specialization following the Aganaktismeni, therefore, favored grassroots solidarity initiatives of direct (social) action over contentious protest, effectively shifting the paradigm of contentious collective action from indirect to direct tactics. I would thus argue that although the Aganaktismeni marked the end of the *protest* cycle in the country, they also provided the ground for the extension of the cycle of *contention* through direct action and Direct Social Action tactics.

As other scholars have already noted, by virtue of these transformations and as a response to the pressing material needs put forward by the crisis, this wave saw the proliferation of alternative social spaces often hosting alternative economic practices (Kavoulakos and Gritzas 2015). These would include the numerous grassroots solidarity initiatives, such as collective kitchens, cooperatives, time banks, solidarity stores and schools as well as the Social Clinics-Pharmacies investigated in this thesis (Kousis and Paschou 2017). In addition, Loukakis (2018) points out the convergence between a range of actors, including informal networks, citizens’ groups, NGOs, Church organisations, businesses and local authorities, in providing support to “individuals facing hard economic times in order to improve their means of subsistence and healthcare” (Garefi and Kalemaki 2013; Sotiropoulos and Bourikos 2014; Vathakou 2015).

Other researchers complement this picture through the enhanced role and interventions of NGOs substituting for the gradually collapsing welfare state, albeit with fewer resources (Simiti 2014; Clarke, Huliaras and Sotiropoulos 2015; Skleparis, 2015; Afouxenidis 2015), while Rozakou (2016) brings our

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<sup>34</sup> The mechanism of movement specialization has also been identified in the Spanish protest cycle and has been used to explain the extension of the country’s cycle after the Spanish Indignados (Portos, 2017).

attention to the spillover of volunteering from formal to informal civil society through the flourishing of “[s]ettings of open and fluid public sociality” that brought “to the fore the key political significance of the social in crisis-ridden Greece”.

Last but not least, this wave saw the effective destabilization of the political system, through the collapse of the two-party system set in place after the fall of the military junta and the phenomenal growth of SYRIZA. SYRIZA was a small party of the Left with close ties to social movements that in 2012 rose as a main challenger to New Democracy (Seferiades 2018). We follow these transformations through the lens of the Social Clinics-Pharmacies below.

#### 6.5.1. MKIE: Solidarity as best practice

Following the summer of Indignation and in line with the “decentralization” trend observed above, the “Assembly for the struggle for the Elliniko Park” regrouped with the aim of organising a festival. The Assembly, formed earlier that year, had already been successful in mobilising thousands of people in demonstrations, talks and festivals against the privatisation and development plans for the utilisation of the space that hosted the Athens airport for over sixty and the American Airforce base for over fifty years. Locals and activists that contested these plans for years, had instead been proposing for its maintenance and preservation as a public space through the creation of a public park.

The festival organised by the Assembly that September was a big success. Activists, public figures, musicians and thousands of people from all over Athens joined in the talks, workshops, concerts and athletic activities. Undoubtedly, however, the festival’s main attraction was the concert by Mikis Theodorakis, one of the country’s most important composers and prominent dissident against the military junta whose music has become symbolic with anti-fascism and democracy. The Assembly decided to invite Theodorakis due to the public support he had announced for the Aganaktismeni with an open letter urging Greek citizens into struggle and their European neighbours to solidarity.

The festival was to be decisive for the Assembly’s trajectory and Theodorakis held a central symbolic place in the emergence of Elliniko as one of the hubs of anti-austerity and anti-privatisation activity for the years to come. Dr. Vichas, member of the Assembly recalls in a recent interview;

“In 2011 a small team of six people was formed in Syntagma and through the processes that unfolded during that summer, the idea of active resistance was brought up. The words of Mikis Theodorakis were the trigger for this effort. In a small group of friends, just before the beginning of his concert at the old airport of Elliniko, he told us “no Greek should starve, no Greek should be left without a doctor”. Together with the initially small team of volunteers, we approached the Municipality of Elliniko-Argyroupoli which was very willing to assist in the realisation of this idea. And this small team became

bigger. The space of Elliniko was chosen because of the infrastructure it provided- the old American base could host the clinic. Our purpose was, and continues to be, to provide free primary healthcare and pharmaceuticals to all those uninsured, impoverished and unemployed patients without any discrimination<sup>35</sup>.

The story has been recounted numerous times starting with Vichas, the “founder” of the clinic and the doctor that Theodorakis was addressing, as well as by others who only joined the clinic later. Vichas and his team established the Metropolitan Social Clinic of Elliniko (henceforth MKIE) inside the abandoned airport-park, seizing the opportunity to combine their struggles for the park with those for healthcare. As volunteers explained in our discussions, the utilization of the existing infrastructure was a practical but also an explicitly political choice, that intended to showcase the potential of public spaces if utilized by the community for the community. MKIE would very soon change its native orientation to include migrants and refugees and become the biggest, most professional, most frequented and internationally known Social Clinic-Pharmacy in the country.



**Picture 4: Entrance of MKIE**

From my collection of internal monthly reports I have estimated that over the period of 2012-2015, MKIE was visited by an average of 1,300 patients per month and involved 280 volunteers –usually not identifying as activists- in activities within its space. Those included a wide range of services, such as Primary Care, check-ups and meetings with specialists, dentists, mental health practitioners, and social workers as well as the provision of pharmaceuticals, paramedical equipment and nutritional supplements free of charge. In addition, the clinic would use its connections and networks to secure free access to secondary and even tertiary care to people who had been excluded from the ESY. MKIE

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<sup>35</sup> Vichas Giorgos, in interview. Neos Kosmos. 02/01/2019. Zarakovitou, A. “We have to find our lives back. Now that we have nothing” as Seferis says.

also publicly announced its active support to pharmacies and hospitals with pharmaceuticals collected by its volunteers and/ or donated to its pharmacy.



**Picture 5: Pharmacy of MKIE**

MKIE exhibited a more pronounced medical humanitarian ethos than KIA, as its founding principle resided in doing service to people, while KIA combined humanitarianism with migrant struggles and social rights. MKIE's stated goal was to protect the vulnerable from the inhumane policies imposed by the troika and implemented by the governments managing the crisis. The clinic's reading of the crisis reflected this approach, as its framing was limited to tragic stories and dramatic figures of its impact on healthcare. Volunteers often referred to the crisis and its effects on pauperisation, unemployment and health as a tragic bleak which does, however, offer an opportunity for cultural change. Solidarity, therefore, was the silver bullet out of the misery induced by the crisis, but also out of practices and social arrangements that –at least in part- contributed to it. Greed, individualism and even corruption, which participants often cited as prevalent in the ESY and in Greek society more broadly, could and should be addressed through the paradigm of solidarity, which they believed to be spearheading.

MKIE was keeping and was publicly releasing reports on the number of people visiting, the number of pharmaceuticals received and delivered, and the number of hospitals, health centers and pharmacies it supported with its services. The success of their interventions was measured in terms of (clinical) outputs. Relatedly, MKIE also exhibited a great emphasis on bureaucratic procedures. One example of this is its “Observatory of Health Issues” established in 2013 where volunteers recorded and regularly reported on news and developments concerning health and care. The stated aim of the observatory was to be “user-friendly” for anyone seeking information on public healthcare and updates on the changing healthcare-related policies.

Already since its first steps, MKIE had installed a system of attentive profiling of its incomers against the changing laws regarding coverage and contributions. Complementing this, was MKIE's commitment to professionalism, showcased, among other things, in their careful selection and training of volunteers. The sum of these efforts made up a clinic that was claiming legitimacy in the eyes of the state, proving the viability of an efficient and cost-effective Primary Care, and setting an example of "best practices" for its state counterparts to follow.

Unlike KIA, MKIE was a grassroots initiative that was relatively isolated from broader social movement milieus, with the exception of the Assembly for the Elliniko Park. This was made clear in their insular perspective on healthcare DSAs, exemplified in their persistence to present themselves as the first to adopt these tactics, as well as their relatively apolitical orientation, witnessed in their insistence to define their interventions *vis-à-vis* charity. To be sure, MKIE did not have and neither did it develop a coherent and explicitly political framing of the crisis, which was approached strictly through its inhumane outcomes. Last, MKIE refrained from engaging in contentious activities. The few instances in which it did were in mass mobilisations where a number of other social clinics would participate.

#### 6.5.2. KIFA: Solidarity or Barbarism

A few months after the opening of MKIE, another Social Clinic-Pharmacy was established, this time in the center of Athens. The Social Clinic-Pharmacy of Solidarity (KIFA) was an initiative put forward by Professor of Architecture Eleni Portaliou, at the time leader of the municipal party of SYRIZA "Open City" (Anihti Poli) in the municipality of Athens. According to my interlocutors, Portaliou was anticipating the detrimental effects of the crisis onto healthcare coverage and prompted her local branch to take action and set up a free clinic to address the needs of those hundreds of thousands uninsured people living in the urban center. After her call in 2012 a small team mobilised and started preparing the clinic and Portaliou decided to not become involved. Open City initially offered a space for the clinic, but shortly after its establishment the space would be deemed too small. Members of Open City would then appeal for international support, motivating a group of French sympathisers to form a campaign titled "Support for the Social Clinic of Athens". The campaign started collecting money towards the rent of a larger space for KIFA.

Soon thereafter the clinic grew, occupying more and more spaces within a building in the center of the capital and still relying on the financial aid of the French group and other international sympathisers. By virtue of being in the center, it attracted a number of patients with severe health problems that were also facing extreme social exclusion. Over time, the team of doctors and activists spilt beyond members of SYRIZA, to include members of KKE -which in line with their hostility towards the Aganaktismeni

stood in open opposition to the social clinics- as well as conservative people with humanitarian “reflexes”, according to my interlocutors.

According to my medical professional interlocutors, their involvement in KIFA was a direct response to the lived experiences of working in the ESY over the recent years. More specifically, they told me that their motivations stemmed from their everyday witnessing of the effects of the crisis onto people’s health and care, as well as their inability to bypass admission criteria as they did before the crisis. According to Dr. Vaso Vasiliou

“I could feel that people were not coming [to the hospital]... Why? They were uninsured, back then you still needed the € 5 [for admission], which really impacted their sense of exclusion. What had happened is that they knew that once they came in, whatever they utilised they would be charged for, they would have to buy it. Diagnostic tests, drugs, they knew they were not covered. Maybe the € 5 was also the problem [for some], but they knew they were in a dead-end. If they came in for an emergency and had to be admitted to care, the tax authorities would charge them. [...] So what we could not do in the hospital, we had to do here.”

KIFA was therefore created on the premise of mediating the health needs resulting from the imposition of exclusive policies onto coverage. For its activists, the real crisis was the lived impact of austerity onto people’s lives. Activists at KIFA saw a direct link between the chronic and intentional devaluation of the ESY and its rapid collapse during the crisis’ years. More specifically, they acknowledged that the public healthcare system was operating on the verge since its establishment. As such, the ESY was sustaining a process of internal devaluation that did service to private interests but was not detrimental until the crisis as a large share of the population could afford private alternatives. In addition, and as accused by Health Ministers and European patrons alike, they agreed that the ESY was overspending, but not in its attempt to cover for peoples’ needs in scope and quality. Instead, public money was used to cover for the soaring costs of private care and infrastructure that had intruded into the ESY, following a logic of a free market that was, however, funded by peoples’ taxes.

KIFA, therefore, framed the problems of inequality in or inaccessibility to health and pharmaceutical care, in explicitly political terms. The diagnostic frame concerning the collapse of the ESY went beyond its structural problems as, according to activists, healthcare was not a political priority of the respective governments over the course of the crisis. This framing of the crisis and its effects on health and care allowed them to go beyond the inhumane and unjust aspects of austerity and see opportunities for intervention to affect change. To be sure, my interlocutors argued that inattention to health and care was in fact unstrategic on the side of the government; it amplified a humanitarian crisis that could be used to advance and promote anti-austerity contention. This reading of the crisis, as we will see below, was dialogically linked to its party-ally SYRIZA. As such, KIFA combined healthcare DSA tactics with contentious tactics to affect political change, at least in the realm of political representation and ESY

reform. The combination of the two opted to build and sustain the momentum necessary for the collective backlash to the government's indifference.

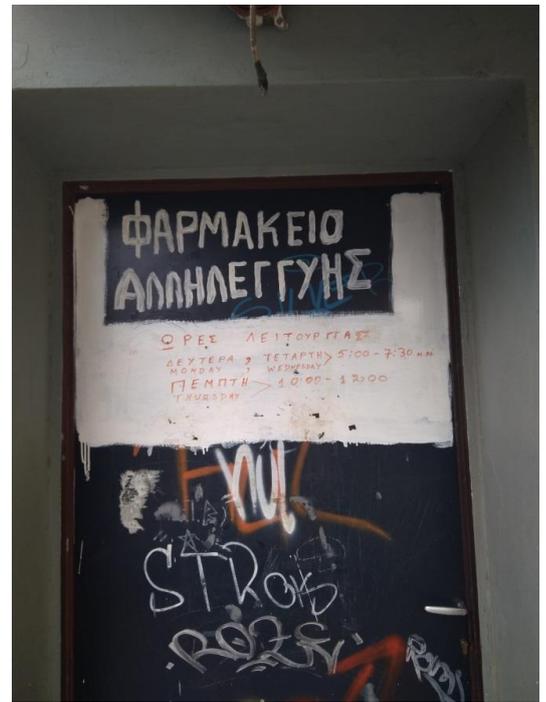
Activists in KIFA retrospectively described their interventions as providing a critical “pillow” for the ESY whilst weaving a “net of social protection” against the detrimental socioeconomic effects of the crisis and the barbarism these could bring forward if not addressed. Barbarism for KIFA, as for many of the clinics(-pharmacies) I investigated for this thesis, was the felt threat posed by the growth of fascist and neo-Nazi groups over this period, and especially the Golden Dawn which was voted third in the Greek parliament in 2012. As such, healthcare DSAs, in this strategic alignment, were to provide the basis (in terms of the satisfaction of needs) for politicization and empowerment to be possible. As social worker and activist Eleni Sotiropoulou told us;

“We believe that the person should be standing on their feet, hold their head high, look up, not down. [...] When someone is impoverished and miserable they give up, they collapse. What can you do with them [once they are] down?”

In line with the aforementioned characteristics of the clinic, including its activists' devotion to public healthcare, KIFA's ultimate goal was for the state to take on its responsibilities and for themselves to be deemed “unnecessary”. They recognised the limitations of their intervention in Primary Care which could not match that of an organised national system as they lacked infrastructure and could not guarantee continuity of care. In addition, they cared little about experimentation with alternative forms of organisation and/or healthcare delivery. Their demands, which to a large extent shaped SYRIZA's agenda on healthcare, focused around the end of austerity in healthcare, universal coverage and the (re)structuring of Primary Care. To fully understand this point, one should consider the strategy and dynamic growth of the party of SYRIZA during this same period and the relationship it established with the Social Clinics-Pharmacies through the creation of its own SMO, Solidarity4All.



Picture 6: Health is a RIGHT for everyone! Social Clinic-Pharmacy of Solidarity Athens



Picture 7: Entrance of Solidarity Pharmacy in Patissia

### 6.5.3. Cooperation in the healthcare arena: Solidarity4All

During the summer months of 2012, SYRIZA marked an incredible growth and secured its position in the opposition, at the detriment of PASOK. The marginal left-wing party that never before exceeded the 5 per cent of the vote climbed to 16.8 per cent in the national elections of May 2012 which failed to form a government, and 26.9 per cent in the follow-up elections of June, thus rewarding SYRIZA’s intervention in the Aganaktismeni and subsequent movements, and instituting it as the main political victor of anti-austerity contention.

Already by August 2012, SYRIZA’s leader Alexis Tsipras made an appeal to his party urging for the strengthening of bonds between party members and local branches with grassroots activists and initiatives. In response to this appeal, a “Working team for the strengthening and organisation of social solidarity structures” produced a strategic document outlining the reasons for and ways in which SYRIZA should intervene in the expansion of social solidarity. The following extracts of this document capture the interrelationship between the dynamics of anti-austerity contention, the growth of a marginal political actor into a leading party and the significance of healthcare claims and tactics therein;

“Greece is a country [immersed] in a deep humanitarian crisis. The memorandum policies and the increasingly harsh measures are sinking large segments of the population into pauperization and misery. [...] The welfare state is collapsing, health, education and insurance are crumbling, the municipalities are

going bankrupt. [...] This is another form of violence, harsh, inhumane, and out-of-control, a violence that neoliberalism wages against the people of labour. We will not remain with folded arms [apathetic]. In this war that we are facing- because it is a war- we respond with the greatest [form of] resistance, the resistance of solidarity. Popular resistance, self-organisation and solidarity are not just a choice of the Left, they are the only way to not surrender our society to disintegration. [...] The slogan ‘noone alone in the crisis’ distills the logic of our intervention”.

The same document goes on to say how solidarity-as-resistance has had a long history in the country as a means, albeit minimum, for the people to rise up and counter-attack. Solidarity DSAs in this light find themselves in direct affinity to the National Liberation Front (EAM), the main actor in the Greek Resistance during the Axis occupation. EAM, a social movement made up predominantly by members of the KKE would work on the side of its guerrilla counterpart, the Greek People’s Liberation Army (ELAS) to cater for the basic needs of the starving Greek population.

In addition to this historical cleavage, the document also pointed to the spread of the paradigm of solidarity over the years of the crisis. The working team insisted that SYRIZA is

“not proposing something new- in Greece there is a constant flourishing of solidarity initiatives. Citizens, including members of SYRIZA, are taking up initiatives and come up with collective ways of dealing with the crisis”.

The document reiterated that the purpose of solidarity in this context is not to substitute for

“the crumbling welfare state, but to operate as a catalyst to the activation and self-motivation, the claiming of social provisions for all, either with the creation of independent structures of social solidarity [...] or with the extension of social solidarity within public services”.

The document also outlined the immediate steps that SYRIZA and its members needed to take in that critical, at least for the party, period. More specifically, all members of SYRIZA were urged to participate in solidarity structures and initiatives and were instructed that the identification and mitigation of immediate and everyday needs constituted core elements in the party’s strategy in that conjuncture. Moreover, the party committed to record and map all solidarity initiatives across the country, to publicize those in a user-friendly platform online and to facilitate channels of communication with people in need. The document concluded that SYRIZA supported, participated and created solidarity initiatives that ought to remain open, invite and involve people from a range of social and political milieus without coopting them with their party label. Finally, the thematic areas of engagement were prioritized as follows: “(a) health, (b) food, (c) education, (d) culture, (e) solidarity economy and (f) legal support.”

In realizing the strategic goals outlined by SYRIZA in this document, the party swiftly moved to the creation of Solidarity4All, an “initiative that aims at facilitating, re-enforcing, spreading and promoting grassroots solidarity”, funded by the wages of SYRIZA MPs as well as peoples’ donations. Solidarity4All was made up of paid members of the party and was responsible for implementing the solidarity strategy of the party. As such, Solidarity4All took the lead in mapping the relevant initiatives, in facilitating their networking and in fostering their collaboration as well as in assisting them to carry out their interventions, often through the provision of necessary resources.

Christos Giovanopoulos, one of first recruits and “architects” of Solidarity4All gave me the context in which the SMO was created, and explained the logic of their intervention.

“I was there since the start [...] in August 2012. [...] Two things fed into it; one was the growing speed with which solidarity initiatives were being created throughout Greece. [The other] was the growth of SYRIZA after the elections in May and June 2012.[...] People across the solidarity movement had the impression that we would overthrow the government of Samaras [New Democracy] in six months [...] [It was] a creative and optimistic period. The idea was for Solidarity4All to be a facilitator... to facilitate information exchange... on how to build such initiatives. [Solidarity4All] was not to build them, but to operate as a networking node for these initiatives... a useful tool. SYRIZA’s reasons for establishing it are irrelevant [as they are] many, it was not just to be used [for its purposes]. But the idea that we had in mind was very difficult to convey [and] many people in the party could not understand it. It was unprecedented, it was hard, both for those members of SYRIZA that wanted to showcase the party’s intervention, [say] that those initiatives were indeed ours, and for those in the solidarity movement that saw us as reps from ‘corporate’” .

Solidarity4All, therefore, captured all the contradictions, tensions and asymmetries as well as those continuities and discontinuities between the movement and the party, that will only later become apparent. To be sure, the SMO was created by the party with no clear or coherent intention as to its ultimate goal and loyalties, mediating and being torn between the party and the movement.

According to Christos, the clinics-pharmacies had obtained a central role within the movement, Solidarity4All and SYRIZA. In his words;

“For us, health and the clinics were among the top lines [of work] [...] But the clinics proliferated because they were the most tangible example of [the impact of] austerity. That 35% of uninsured and excluded was an issue that could be used [politically] for both its quantitative and qualitative implications. [In addition] the clinics were better organized and structured, both in their rhetoric and interventions, because of the social and cultural capital they deploy. They cannot be compared, say, to the food networks [developed in the same period]. Seeing a debate in a clinic’s assembly was a different experience to [that of] a food assembly, different levels, different worlds [...] They were also more understood by people and networks abroad. In Europe, when you say “welfare state” you mean healthcare. It’s easy. They can see the

possibilities for transformation within it. [...] When you say food, well... you invoke the picture of a developing country, [and it is] harder to summon support for ... what seems to be humanitarian aid for a developed country. [...] They had a different relationship to... they would give medicines. They wouldn't give food, even though it was more needed.”

The acquired centrality of the clinics-pharmacies is therefore attributed to their inherent organizational capacities as well as the opportunities they could affect for SYRIZA. Much like KIFA's activists, Solidarity4All perceived the injustice frame of the 35 per cent uninsured as something that could be shared between the anti-austerity movement and an anti-austerity party competing for power and to the benefit of both. That stems from the SMO's understanding of the alignment between the goals of the movement with those of SYRIZA. The clinics were, thus, seen as capable of devising issues of healthcare and welfare that proved to be particularly potent in addressing and fostering networks of cooperation and support abroad, networks that appear as important for Solidarity4All and so also for SYRIZA. Last, the social and cultural capital set in motion in and around the clinics gave way to proposals and visions for health and care in a way that was appealing for the SMO which saw itself as a “social change” laboratory.

This idea of Solidarity4All as a laboratory of social struggles was rooted in the double affiliation implied in SMO's *raison d'être* and created tensions, dilemmas and paradoxes for SYRIZA, for those initiatives under its umbrella as well as its very employees. Christos continues;

“The people involved in Solidarity4All in the beginning, they had to be very patient [...] and flexible, especially with the clinics. Because there were differences. Political differences, even within SYRIZA, we had the different tendencies, right? In the first period. Then, there were differences between the individual clinics [...] and how to connect them all? At the time the prevailing logic [on the side of the clinics-pharmacies] was that we are here... so that we don't have to be here anymore. They developed this strategy in demanding and showing the possibilities of public healthcare by acting, making claims through their paradigm of action. But the claims were finishing there. In the reorganization, the reopening of the public healthcare system, things like that. But Solidarity4All did not share this, it was opting for something more transformative. I remember I kept saying back then that, on the one hand we are trying to help people stand up on their feet so as to be able to resist. On the other, and while doing that, we give life to new types of social relations, new types of relations to politics too. Our framework was broader. Whoever restricted themselves to the first had a narrow understanding, within the confines of the crisis. We did not only see the crisis in it. We saw it as the way to exercise another paradigm of social change. And this was a big thing, especially for us that left [Solidarity4All] in 2015”.

The tension deriving from the different strategic goals of those actors within and around the clinics-pharmacies -that is the strategic prioritisation of either parliamentary change and reform channeled by SYRIZA, or social change- was felt by Solidarity4All which tried to reconcile and instrumentalise it. In

addition, this tension triggered the shift in the dynamics of collective action that affected the transition from the second to the third wave of contention in this period. The SMO's ambiguous affiliations and ambitions become even more pronounced in Christos' explication of the strategic dilemmas posed by healthcare DSA tactics. Albeit not exhaustive, the list of dilemmas as put forward by Christos serves to show some of those layers of possibilities offered and limitations posed in the provision of healthcare from below, as well as the tensions that those create for different sets of collective actors- here represented by the clinics, by Solidarity4All and SYRIZA.

“At the same time, I do believe that this [tactic] of saying we exist so that we can close is interesting... it was effective and it was smart, a way of highlighting the issue of public healthcare. [...] [But] what does it mean for conditions to deem you unnecessary? Which conditions would those be? Would it be after the uninsured regained access to the ESY? When the migrants were granted access? When you transform the ESY? Or the practices therein? That sets the horizon into the distant future. [...] It's not about reopening [the ESY]. But [about] transforming it into something else than what it is today. When you'll make it public again, but really public, public as in [managed by] society not state”.

We understand, therefore, that as healthcare DSAs spread and diffused among a range of actors, they acquired different characteristics, obtained different meanings and became attached to different strategies and concomitant goals. Solidarity4All in this light captures all the unresolved contradictions stemming from the attempted alignment of social movement tactics and goals with those of an ascending political party. Despite these inherent tensions, however, Solidarity4All advanced SYRIZA into a main actor in the Solidarity Movement, one that the various clinics-pharmacies could not overlook but were invited to either collaborate with or oppose. The various profiles advanced by different clinics against this rapidly changing political landscape will become more apparent in the following, and final, wave of contention.

#### 6.5.4. Cooperation in the healthcare arena: The Panhellenic Network of Social Clinics-Pharmacies

The establishment of Solidarity4All coincided with the peak in the diffusion of the Social Clinics-Pharmacies paradigm and the modularization of DSA tactics writ large, and the SMO swiftly intensified its cooperation with and networking of those initiatives. The second wave of contention saw three major events that effectively solidified and delineated the interventions of the clinics-pharmacies, laying the seeds for an emergent anti-austerity Health Social Movement and stirring, yet again, the healthcare arena and its players.

The first event was the informal meeting of the various Social Clinics-Pharmacies in Thessaloniki, following an open invitation by KIA. Clinics alongside anti-racist and anti-fascist collectives from all around Greece attended the gathering, including the skeptical SSH discussed in the previous chapter.

The meeting reached the decision to organize monthly contentious actions in the cities of the respective groups attending, to bring attention to the crumbling of the ESY and the exclusion of people from healthcare. In addition, they agreed to build networks of cooperation to facilitate both their contentious activities as well as their provision of healthcare services and pharmaceuticals. The first step in this direction was the organisation of a formal “Panhellenic Meeting of the Social Clinics-Pharmacies” later that year in Athens<sup>36</sup>.

The organization of the meeting dictated the creation of a coordination committee for the region of Attica. This committee was made up of twelve clinics-pharmacies, including MKIE and KIFA. The number of clinics that attended the meeting is difficult to estimate as some of those were still in formation and participated with the intention of learning more about the clinics-pharmacies paradigm. After discussions and deliberations, the meeting concluded with a common “Map of the Social Clinics-Pharmacies” outlining the main characteristics and code of conduct that any initiative that wanted to participate in the Network of the Social Clinics-Pharmacies had to share and comply with.



Picture 8: Map of Social Clinics-Pharmacies in Attica

More specifically the code of conduct defined the clinics’ “autonomous, independent, self-organised and self-managed” *modus operandi* seeing to the “provision of services of primary healthcare to all uninsured people, the unemployed and the poor, on a completely volunteer basis”. The Map was fashioned vis-à-vis existing municipal initiatives, NGOs and the Church, and highlighted the clinics’ grassroots and contentious profile and orientation. The Network called Social Clinics-Pharmacies to the

<sup>36</sup>Forum Prevezas in the milieus of the left of the movements and ecology. 14/05/2013. Panhellenic meeting of social clinics in Thessaloniki. [in Greek] «Πανελλαδική Συνάντηση των Κοινωνικών Ιατρείων στη Θεσσαλονίκη».

“collective struggle for our right to public healthcare” and for “free access of medical and pharmaceutical care for all”.

The Map also prescribed the tactical combination of healthcare DSAs with indirect forms of action in healthcare and broader anti-austerity and anti-fascist contention. Additional tactics included the organization of educational and informational events pertaining to health as well as the clinics-pharmacies’ connection to local anti-racist and anti-fascist struggles. These collaborations were meant to feed into the formation of a “permanent, quotidian, democratic, social and political struggle” in the name of human rights and public healthcare. In this strategic alignment the Social Clinics-Pharmacies were to maintain the social fabric and serve as the basis for the development and channeling of collective action oriented towards “equality and equity”<sup>37</sup> (see also Kotronaki and Christou, 2019: 335).

## 6.6. Third Wave

The spilling of the second wave of contention (2011-2014) into the third (2014-2015) is more debated than the previous two examined above. However, for the purposes of this thesis, I consider the third wave as distinguishable on the grounds of (1) the plateauing of new initiatives focusing on DSAs and (2) the overall domestication of protest forms. In addition, and as protest was “partially displaced from the streets to the electoral arena, with SYRIZA emerging as the main political opponent to austerity through conventional channels” (Karyotis and Rudig, 2017: 5), we also observe (3) the channeling of contention from movements to parliament, and consequently (4) the shift in collective visions for social change to visions of change in representative politics (see also, Kotronaki and Christou, 2019; Aslanidis and Marantzidis, 2016; Karyotis and Rudig, 2017).

### 6.6.1. Competition in the healthcare arena: Health Autonomy Network

The dynamics of the second wave also saw the diffusion of healthcare DSAs among those anarchist and autonomist milieus and clinics subscribing to self-organisation and fashioned after the SSH also started to appear. By 2014 these clinics had established their own networks of collaboration, albeit less formal than the Panhellenic Network presented above, and in direct competition of it. In a document produced for the book “For health autonomy”, the healthcare collective OKTANA in Heraklion, Crete, outlined the members of this network to include the SSH in Petralona, the Social Clinic-Pharmacy in Heraklion, the Self-Organised Health Structure (ADYE) at the emblematic squat of VOX

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<sup>37</sup> Network of Social Solidarity. 15/11/2013. Map of Solidarity Social Clinics- Pharmacies. [in Greek] «Χάρτα Κοινωνικών Ιατρείων- Φαρμακείων» Pharmacies.

in Exarchia, the “Action Group against Police Violence/ Arbitrariness and Fascism in the Everyday” of the occupied theatre Embros, and the Hellenic Hearing Voices Network <sup>38</sup>.

What we observe in this period is that the flourishing of healthcare DSAs among grassroots collective actors, attracted formal political actors to the healthcare arena in an attempt to foster cooperation and capitalize on the former’s claims, frames and tactics. In addition, it also promoted the collaboration of the various initiatives in defense of public healthcare, best exemplified by the Panhellenic Network. These dynamics of tactical diffusion and strategic convergence in the arena, however, also intensified competition between some milieus employing them, thus pushing for ever greater boundary definition and for renewed understandings of DSA’s tactical and strategic uses.

#### 6.6.2. SSH: Health prefigures Autonomy

Perhaps the greatest example of competition in the arena during the final wave of contention was represented by the aforementioned anarchist and autonomist initiatives. In the document introduced above, the clinics subscribing to self-organisation distinguished themselves from those of the Panhellenic Network in at least in three ways.

First, members of the Health Autonomy Network insisted on their awareness of the dialectic connecting their organization and the services they provided and their goal to affect change through its reversibility points. More specifically, they saw the general assembly as their prime tool in overturning the hierarchies implied in medical practice and their alternative, more participatory model of (health)care delivery as foundational to their health autonomy paradigm. Their services of primary, preventive and psychosocial care were complemented by direct action tactics, intending to expose exclusionary practices and foster solidarities with affected populations on the neighborhood level. These public acts of contention were neither sectoral nor mediated by third parties. Last, and unlike the Panhellenic Network, the strategy of these clinics opted for the de-hospitalisation and de-institutionalisation of care. In their document they clarify that “this is not to be confused with the neoliberal strategies of de-hospitalisation via closures, privatization, and criminalization, but rather the societal re-appropriation and control of state hospitals and research/ manufacture centers” (2020: 106).

Another defining characteristic of those initiatives was that they saw their establishment and operations as irrespective of the crisis- or at least not as direct products of it. While acknowledging that the crisis and its effects on both population health and the healthcare system has indeed increased demand for their intervention, their overall objectives go beyond its scope to include the reconfiguration of health and care on an anti-hierarchical, self-organised and autonomous basis. In accordance with the relational

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<sup>38</sup> Descendent of the anti-psychiatry movement in Greece.

approach proposed here, then, we observe that the creation of the Panhellenic Network of Social Clinics-Pharmacies prompted the self-organised clinics to more articulate critiques and reflections on healthcare DSAs.

The most representative such distancing and critique can be found in the leadoff of an event organised by the SSH in the summer of 2014, indicatively entitled “From the (first) social clinic, the Social Space for Health, to today’s galaxy of social clinics: an investigation into the dynamics of undoing existing institutions [antithesmis<sup>39</sup>] through the current experience in the healthcare arena”. The leadoff summarizes the development of the clinics-pharmacies paradigm, the central role of the self-organised movement therein and explains their choice to continue operating independently from the Network.

First and upon reflections of its interactions with other social clinics belonging to the Panhellenic Network, the SSH warns against attempts to control and coopt the paradigm of self-organisation from above. More specifically the SSH raises caution against those organized actors and interests which pursue cooperation with the clinics in an attempt to reconcile and align “horizontal struggles” with left-wing governmentality. This tendency observed by the SSH can indeed be extended to the broader dynamics of the final wave of contention described above, especially to the observed domestication of protest forms though SYRIZA’s appropriation of anti-austerity and solidarity claims and tactics to attract support and develop its agenda in preparation of elections. They continue with exposing the contradictions and paradoxes pertaining to this process;

“The first event for Health and Self-Organisation happened in the summer of 2012 [held] by the SSH [and] targeted the self-organised movement. It was the first attempt to reach out to movement milieus.

In spring 2013, at a time of the diffusion of the paradigm [of the social clinics], the meeting of the social clinics in Thessaloniki [organized by] KIA revealed a range of contradictions.

In the autumn of 2013 a new Panhellenic meeting in Athens illuminated and crystallised the intentions to control and coopt the social clinics movement. The infiltration of the world of health self-organisation by parties and, more generally, institutions is deepening the antagonistic directions within this field of struggle.

[...] Most of the social clinics were created in the period of the so-called economic crisis, with reference to the adverse social conditions of the time. The two proposals of the common “Map” find their enemy in the “austerity policies”. Those social clinics that perceive themselves as an answer to the crisis-induced

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<sup>39</sup> Antithesmis: A term used strictly by the anarchist/ autonomist milieus in the country. Building on Castoriadis’ concept of “autothesmisi”, the self-constitution of an autonomous society “that not only knows explicitly that it has created its own laws but has instituted itself so as to free its radical imaginary and enable itself to alter its institutions through collective, self-reflective, and deliberative activity” (Castoriadis, 1975: 132), “antithesmis” points to the parallel and necessary process of unmaking those laws and institutions a society has set to replace.

policies set their redundancy as their goal, and announce that they will thereafter dissolve. In this way, they indirectly recognize the instrumentalisation of self-organisation within the established status quo.

The othering from the destruction of public healthcare leads to a contradiction: [on the one hand the clinics] struggle for the defense of the public character of health. But the assertive struggle cannot immediately affect new conditions for the healthcare sector. On the other hand, [the clinics] insist on service delivery. But the movement structures cannot cover for the increasing [health] needs, as they still do not possess the necessary resources. The same social clinics that claim that “the struggle for public and free care by the state is the point that unites us” later recognize that they operate as “crutches” of the existing underutilized state structures.

This vicious cycle loses sight of the reflection and the capacity to affect health institutions. The following extract [by the social clinics] eloquently expresses this situation: “it is not an attempt to substitute the real need for FREE PUBLIC HEALTH for the people, neither is it an attempt to create parallel structures within the bankrupt system. It is a struggle of survival against the system...”

The sweeping reestablishment of state institutions that service capital’s profiteering, not only misses out on the question of “what kind of health do we want?” but advances the question of whether health can truly be public unless self-organised into a fundamental issue<sup>40</sup>.

These self-organised clinics see themselves as products of the Assembly for Health in December 2008. The document, alongside many others, states that clinics should not see themselves as responsible for covering the gaps left by the state. Instead, they should fight against the state and its institutions as those exist today, while prefiguring alternative social relations from below. In this way they do not limit their efforts to the reopening and reworking of the ESY, as it is riddled with weaknesses and problems, stemming from its very role in the state mechanism. They therefore see themselves as the living cells of resistance, as active destructors of existing orders that, alongside other grassroots initiatives, prefigure autonomy.

Moreover, these clinics stand against any sense of legitimacy and professionalism. Unlike the clinics belonging to the Network then, they ask no proof of status and/or identification in caring for people and accuse the existing clinics’ as copying the state. This is best captured by the existence of a reception that “profiles” and files patients in an attempt to mimic hospital bureaucracy that plays out as a caricature at best. Instead, clinics subscribing to health autonomy prompt people to take matters of their health and wellbeing into their own hands, through active participation in the clinics and in society writ large, countering alienation and isolation. People should actively participate in the many debates

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<sup>40</sup> Social Space for Health. 06/10/2014. Leadoff for the event on Health and Selforganisation that happened in the summer [organised] by the SSH. [in Greek] «Η εισήγηση της εκδήλωσης για την Υγεία και την Αυτοοργάνωση που έγινε το καλοκαίρι από τον ΚΧΥ».

brought forward by the experience of self-organisation as well as diffuse those ideas widely. Moreover, these practices and ideas should be combined with other tactics of resistance and institutional unmaking, including the closure of cashiers that discussed in the previous chapter. The sum of these tactics is meant to spread the “spirit of December” and contribute to “movement continuity” within the autonomous/ anarchist milieus and across time and space.



“On the occasion of the 5 years since the occupation of the old ΠΙΚΠΑ, the Social Space for Health organizes [the event]:

Health and Self-Organization- Reloaded

Saturday 19th July:

Event-Discussion, Polytechnic 17:30

The **social projects** in the health arena, their role and characteristics.

The state of **public health** and coverage and perspectives of resistance and struggle.

**Antithesmis**, their limits and contradictions today, questions about the future.

DISCUSSING about the PRESENT, we BUILD a FUTURE and a DIFFERENT HEALTH”

Picture 9: SSH poster

By outlining the paradoxes of the interventions and goals of the Network, then, the self-organised clinics rediscovered themselves not only as the original but also as the only consistent practitioners of DSAs in the healthcare arena. The project that these clinics put forth is that of the experimentation with self-organisation in care, the constant reflection upon their experiences, the creation of knowledge inside and through the community level and the confidence of spreading those practices from below. The transformative project starts from health to also prefigure social relations on larger and wider scales. In this way the ESY is irrelevant, while the crisis is a mere opportunity to spread these practices and ideas, as more people are turning to them and potentially become involved in self-organising (their) alternative healthcare structures.

It is interesting to note here that some of the criticisms to the Network made by these milieus echo the aforementioned reservations on the side of Solidarity4All, especially with regards to the scope of change envisioned by the clinics and the temporal horizon of their interventions. Both the actors mobilizing for health autonomy and SYRIZA's "solidarity bureaucrats", then, see the reconfiguration of healthcare as an ongoing struggle that escapes the confines of the crisis, and aims at its transformation into a truly public and social good. In so doing, both actors see the prefiguration of different social relations on the ground as both a necessity and a product of the struggle for public healthcare. This strategic convergence is paradoxical, but it can be explained on the basis of the different structural position of each actor into the healthcare arena and the relationships they have developed and fostered in this period.

All the above are lie with the ideology and strategy of those anarchist-autonomist actors and their traditions indeed before the crisis. For Solidarity4All, however, those ideas flow from SYRIZA's underdeveloped strategy of the functional separation between the party and the movement, and its unresolved theorization over the relationship between the two. For members of Solidarity4All, as well as cadres of SYRIZA, the movement was supposed to push the party forward, as parties are inherently rigid organisations. At the same time parties, unlike movements, are at greater structural position to grant movements' minimal goals. It is upon these dynamics and asymmetries that the Social Clinics-Pharmacies would institutionalise, as we will observe in the following chapter.

For what regards our discussion here, I would argue that the convergence between those radically different and antagonistic actors demonstrates the possibilities brought forward by the employment of healthcare DSAs by contentious actors. What is more, it shows that the introduction of new actors in the healthcare arena by virtue of their shared preference over DSA

tactics during the cycle of contention, fundamentally altered the stakes and imaginaries concerning health and care in the country. In addition, the assembling of actors around healthcare DSAs expanded and diversified their various strategic uses and their places within broader contentious strategies.

### 6.6.3. Nea Smirni: Class Solidarity

Despite the curtailment in the creation of new Social Clinics-Pharmacies during the third wave, new initiatives continued to emerge over this period. One such example was the Clinic-Pharmacy of Class Solidarity in Nea Smirni, Athens. The clinic-pharmacy was the product of deliberations in the regular Assembly of the Workers' Club of Nea Smirni. The Workers' Club was founded in 2011 on the premise of “introducing all workers to trade-unionism”, “developing a feel for changes in local society” and “promoting all forms of working-class emancipation and independence from the state and parties”. The Workers' Club was since very active in the municipality of Nea Smirni, providing a space for discussion and socialization, organizing cultural events and educational classes as well as collecting, organizing and acting upon grievances of local workers- natives and migrants, employed and unemployed.

The Workers' Club was heavily influenced by the Marxist-Leninist(-Trotskyist) tradition and many of its main participants were members of the extra-parliamentary left (ANTARSYA<sup>41</sup>, EEK<sup>42</sup>, M-L KKE<sup>43</sup>). These parties are often forming electoral coalitions and, in the most recent contentious cycle, worked together to form Workers' Clubs around the country. Nea Smirni was among the municipalities where this tactic proved most effective, eventually leading to the creation of a new municipal party “City Upside-Down” (Poli Anapoda) in 2019, represented by activists at the Workers' Club and advertised as an extension of the Club and the clinics' interventions in the local political scene.

The Class Clinic-Pharmacy was a relative latecomer to the Social Clinics-Pharmacies universe. It was created in 2014 and is since hosted in one of the spaces of the building rented by the Workers' Club. It is important to note here that Nea Smirni already had two healthcare solidarity structures in 2014. Like many municipalities by then, Nea Smirni had a municipal Solidarity Pharmacy, established by the local authorities that was largely underfunctioning. In addition, and

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<sup>41</sup> Anti-capitalist Left Cooperation for the Overthrow

<sup>42</sup> Worker's Revolutionary Party.

<sup>43</sup> Marxist-Leninist Communist Party of Greece.

similarly to KIFA, the municipal party of SYRIZA “Nea Smirni’s Turn” (Strofi Neas Smirnis) had also established its own Social Clinic-Pharmacy which participated in the Panhellenic Network. In the announcement for the establishment of the Clinic-Pharmacy of Class Solidarity, therefore, one can see its constitution *vis-à-vis* what is already on offer in the area. The main marker of that difference was its class orientation. For the Workers’ Club, and by extension, the Clinic-Pharmacy, solidarity could only be exercised between and among members of the working class and could only be mobilized to organize and defend their collective rights and interests.

The Clinic-Pharmacy, therefore, complemented the activities of the Workers’ Club in (1) assembling local workers, (2) mediating their most pressing needs while (3) politicizing their grievances and claims. The crisis, and its effects on health, were read as products of an ever-deepening capitalist crisis that has waged war on the people of labor, leading to the deterioration of their living standards, the erosion of their rights and the disruption of their health and wellbeing. At the same time, the crisis was seen as offering the opportunity for the deregulation and eventual annihilation of public healthcare, as dictated by the combined policies of “capital, the government and the troika”, who push public money to their allies. The 3.5 million uninsured, the closure of hospital units, the firing of personnel, the dismantlement and privatization of the feeble Primary Care and the transference of costs to the patient were all understood as results of those political decisions.

To these serial but interconnected attacks, the clinic responded with solidarity. In its founding document, the clinic refused to, figuratively, “give away painkillers”. Its goal was to “persuade about the cause of the disease and fight for its annihilation”. The disease here is capitalism, understood as a model of economic organization that oppresses, represses and fundamentally exploits working people. Solidarity in this context offered the possibility of aggregating and mobilising working people in exposing and reversing inequality and injustice, stemming from the capitalist mode of production and accumulation.

The Clinic-Pharmacy of Class Solidarity in Nea Smirni set the precedent for the development of similar clinics-pharmacies across the country, usually affiliated to Workers’ Clubs, the EEK and/or other extra-parliamentary parties and their constituencies. These clinics participated in the Panhellenic Network and subscribed to the main principles outlined in the Map above. At the same time, however, they shared a number of particular characteristics that set them apart from the clinics discussed above.

KIA, MKIE and KIFA discussed above all address people from their respective cities, if not the entire country, who come and seek their services and help. The Class Clinics-Pharmacies, on the

other hand, exhibited a heightened emphasis on the neighborhood level. By virtue of their affiliation to Workers' Clubs, the clinics extended the activities and constituencies of already existing local grassroots collectives. This becomes apparent in their choice of tactics which included alliance-building with local movement milieus, exposing and addressing neighborhood-based health needs, organizing educational events on preventive healthcare, and intervening directly to promote environmental health in the neighborhood. All the above resonate with those prefigurative tactics of the SSH and the anarchist- autonomist clinics.

In addition, the class clinics were stating their commitment and promptness to support and stand in solidarity with victims of (political) repression. The class element of their DSAs was further highlighted by their insistence to cover for the needs of members of the working class. In making sure that the class element is preserved, they requested proof of working-class status from the patients coming in, something that stirred the already long and complicated debate concerning the criteria for those constituents covered by healthcare DSAs.

As the class clinics were latecomers in the expansion of the clinics-pharmacies paradigm, they benefitted from the combined experiences of the self-organised clinics and those belonging to the Panhellenic Network and configured their own strategy from a bricolage of practices. They therefore saw a "third way" in appropriating and utilising healthcare DSAs, neither restricting their vision to healthcare reform nor propagating self-organisation through the paradigm of healthcare from below.

This is reflected in their hybrid strategic elements which stem from both directions. More specifically, their strategy was configured in the necessary intersections between the mitigation of immediate health needs, the politicization of these needs for the purposes of strengthening the trades' union and labor movements as well as the alternative practice of medicine as enabled by the space of the clinic. Psychiatrist Katerina Matsa, one of the most prominent figures in both the anti-psychiatry and the extra-parliamentary left movements made a case for the defense of healthcare DSAs from the "substitution" criticisms they receive from left-wing milieus. She told me that criticisms derived from

"The perception of many people on the Left that "it's the responsibility of the state to provide public and free healthcare". I know, I agree. I have been fighting for this all my life. However, the objective situation is like it is and you ought to face it, not just in the best way you can, meaning to provide healthcare to those people who do not have [access to] it, but to provide it in such a way that it helps [people] develop their consciousness over their situation. To change themselves and their way of life. To break free from individualism, to work in the context of solidarity, to [become]

mobilized. To give, not only take things that they need, but to also offer themselves. This is not something that can be done in the context of classic syndicalism. [...]"

It is worth mentioning here that none of the clinics-pharmacies presented above make any explicit effort to connect their struggles to the trades' union movement in the country. The only such relationship can be found in the case of KIA whose space initially belonged to the socialist Trade's Union Centre that hosted the hunger strike. This is, on the one hand, due to the weakening and historical undermining of the labour movement, and on the other, and especially for those clinics' that found themselves close to SYRIZA, due to the party's inability to effectively infiltrate trade unions still dominated either by PASOK or the New Democracy. Linking the solidarity movement to the trades' union movement, however, was at the center of the strategic orientation of the class clinics. Katerina Matsa continued;

"No the clinics are not antithetical to syndicalism. Because the social clinics are forms of self-organisation of the people. On the contrary, these structures must join forces with the trades' union movement sharing the same goals. The goal is the same. And they [the clinics] attract some people that the trades' union movement cannot mobilise, especially in this period that it [the union movement] is in such a decline. [...] And you make claims to the state, you don't stop making claims. But the needs are objectively there, and in addition individualism is rising. These forms of self-organisation are fighting it [individualism], meaning that they give people the possibility to clear up some things, to take a stance, to change and contribute to what is really important."

Psychiatrist Thodoros Megaloikonomou is a colleague, friend and comrade of Katerina for decades. The two of them were volunteer-activists in the class clinic of Nea Smirni and among those that first started the class clinic in Ilion. Thodoros explained the logic of their interventions;

"Look, [our work in] the clinic [in Ilion] we see as part of a broader political work which is not strictly political, but it responds to the problems of the neighborhood and the people therein more generally. So the issue of class solidarity for the clinic was one of the first issues. [...] Because there is a more general issue, beyond the fact that one does not have their medication, [one does] not have a doctor, there is the issue of what type of medicine we are talking about. Ok let alone what kind of psychiatry we're talking about, this is yet another discussion. [laughs] What kind of medicine are you practicing, what kind of relationship do you establish with the other person, how you see them- at least for the part of psychiatry it is obvious. How to communicate with that person, how to understand them, what kind of dialogue do you engage in, outside of any coercion, of any imposition. There is this part. Against the one-way street of pharmaceuticalisation. Because you see people coming in [asking] "Give me my medicine, I need it to sleep." And I say "no, you won't take it, we'll sit here and discuss, why are you not sleeping, what are you thinking about

when going to bed, what's going on in your life lately". And they reply "leave me alone, just give me my meds, you don't understand, I want to sleep, I don't want to think!" [laughs]. And a whole discussion starts on this basis."

This brings us to the final characteristic that is particular to the class clinics, that is their early orientation towards mental health. This strategic decision derives from a number of considerations, that include the timing of their creation, their human resources, as well as broader ideological foundations. First, those clinics-pharmacies developed towards the end of the cycle of contention, at a time when the cumulative effects of austerity on mental health had become apparent for large segments of the population. In addition, both Matsa and Megaloikonomou were respected figures in the psychiatric community, they were known for their activism in both the anti-psychiatry and the labor movements and were prominent members of one of the parties that set up the Worker's Clubs. As such, one can argue that the class clinics focused their interventions to mental health, the one aspect of the healthcare arena where they had competitive advantage.

Having said that, this decision is not necessarily based on a calculation of benefits. The long participation of these figures in extra-parliamentary left-wing milieus over the years, had integrated critiques to predominant models of health and psychiatric care to broader visions of socio-economic change and had informed broader strategies pertaining to class emancipation. This becomes apparent in their use of healthcare DSAs as tactics that, on the one hand mitigate and tackle alienation and depression, seen as obstacles to collective action and mobilization, while offering opportunities to continue the efforts of advancing an alternative psychiatric model beyond existing institutions. Katerina Matsa continues explaining the benefits reaped from the continuity between the anti-psychiatry movement and the clinics-pharmacies. She says;

"Yes, yes this [tradition of anti-psychiatry] can be exercised in the social clinics. And it helps a lot too. All these traditions, all these lessons... This social approach to health [represented] by an absolute minority in the country is something that really advances the work of the social clinics. I mean it is something you can add to your therapeutic toolbox."

Thodoros Megalooikonomou continues;

"The reception team will get to know you, they will start chatting with you, see what you do, where you are. Slowly, without [subjecting you to] an interrogation, this can be done in the first, second meeting, getting to know who you are, that is. For example you might be facing eviction, you might be worried that they'll be taking your house and might be ashamed to say it, the way that social shame operates and all this... which means that [we] need, to understand the complexity of your

needs, [in order] to see what we can do, beyond the narrow medical approach of taking your pill etc. I mean some people have problems with the social services, with their pensions, with, with... a thousand things. So this [the reception] is where a discussion is initiated and the effort –although not always possible- of responding holistically begins. And if it is possible, the other person [will] become conscious of the social root of their problems and involved in the movement [laughs]. OK, without it being a prerequisite of course [...].”

The Clinic-Pharmacy of Class Solidarity in Nea Smirni, therefore, learnt from the joint experiences of social clinics prior to its establishment, and appropriated healthcare DSAs to fit into its strategy. This tactical choice, however, can only be understood as a product of the dynamics of the healthcare arena over the course of the cycle of contention. By then, healthcare frames and concomitant DSAs were proven successful for any constituency employing them, and as a result, had become modular, leaving little tactical choice to other actors “jockeying for advantage” in either the healthcare arena, or in the arena of contentious politics, more broadly. This is the case for the Worker’s Club in Nea Smirni whose participants decided to intervene in the provision of healthcare services and pharmaceuticals to local workers, at the end of the cycle of contention. In so doing, they oriented themselves towards mental health, no less due to the specialists and activists at their disposal and their wide influence and popularity, so much in the Workers’ Club but also more broadly. The Workers’ Club, therefore, which had no prior involvement in healthcare issues and/or DSAs, at least directly, found itself employing DSAs in the direction of its own established agenda for class emancipation from below.

**Table 1: Trajectories to Healthcare DSAs 2010-2015**

	Original Milieu	Diagnostic Frames: Crisis and Health	Tactics	Prognostic Frames	Interaction with State	Strategic Use of DSAs
SSH (before cycle)	Anarchist- Autonomist milieus - 2008	Crisis relevant only as opportunity for mobilisation ESY as inherently deformed and corrupt	Healthcare DSAs Environmental health Health education Direct action	Self-organisation through paradigm of health People take health into their own hands	Hostile Extra- Legal	Prefiguration of self-organisation through the “undoing” of the model of healthcare provision
KIA (first wave)	“Solidarity with 300 migrants” campaign	Capitalist crisis Privatisation of health Exclusionary politics	Healthcare DSAs Protest for healthcare reform Protest with anti-racist and anti-fascist groups	Universalist healthcare reform End of austerity State to resume responsibility in healthcare provision	Appealing to it through disobedience and contention to affect reform	Mediate, highlight and politicise needs Promote and uphold social and human rights
MKIE (second wave)	“Assembly for the struggle for the Elliniko Park”	Not coherent Weak connections between MoUs, austerity and health crisis	Healthcare DSAs Cultural activities Solidarity economy Protest in defence of public healthcare (rare)	Changing attitudes in ESY through paradigm of solidarity	Seeking legitimation and recognition	Humanitarian ethos Serving people Promoting culture of solidarity Developing “best practices” for ESY
KIFA (second wave)	SYRIZA’s municipal party “Open City”	Crisis induced by austerity policies attached to the MoUs ESY in crisis due to historical internal undermining	Healthcare DSAs Protest with anti-austerity, anti-racist and anti-fascist movements Pickets outside of closing ESY structures	End of austerity (in healthcare) Healthcare reform in direction of universality Development of Primary Care	Exposing effects of austerity onto health and care Press for reform	Mediate humanitarian crisis Recuperate social body (Expand SYRIZA’s constituencies) (Inform SYRIZA’s healthcare agenda)
Class Clinic of N.S. (third wave)	“Worker’s Club” Extra-parliamentary left	Capital wages war on working class Alienation and mental health Social determinants of health	Healthcare DSAs Protest with Workers’ Club Direct actions in neighbourhood	Working class emancipation	Critical Marxist-Leninist approach to the state In defence of ESY	Working class solidarity Against alienation Strengthening trades union movement

## 6.7. Conclusion

In this chapter I have tried to compile a dynamic and relational account of the healthcare arena, its actors and their tactics over the course of the crisis and the cycle of contention. In so doing, I have attempted to bring to light those strategic decisions that led to the renovation of the healthcare repertoire in the country in the direction of DSAs, without losing sight of the political, economic and social context of the period. In this way, I hope to have captured the dynamics and mechanisms that prompted the diffusion of healthcare DSAs across a range of contentious actors and culminated in their modularisation in the anti-austerity repertoire. In addition, I have set to trace the effects of their employment on those actors, their interactions and the healthcare arena, more broadly.

More specifically, this chapter had three interrelated goals. First, it set the scene of the austerity-induced crisis and its effects on health. For the purposes of this thesis, I approach health holistically, which is why I focus on the interactions between austerity, the socio-economic determinants of health, the healthcare system, public health and population health over the period studied here. In adopting this perspective, I have concluded that the austerity-induced crisis had countercyclical and, in fact, detrimental consequences onto health and healthcare, at least in the short-term. Moreover, the impact of austerity onto health and care largely fed into and exacerbated those historical weaknesses of the healthcare system in the country. To be sure, the persistence of the attachment of coverage on contributions, the feebleness of the Primary Care level and the high costs related with public care, depleted the ESY over the course of the crisis and hampered patients' accessibility to care.

The second objective of this chapter was to show how healthcare claims and frames proliferated in the anti-austerity cycle of contention, thus stirring, and transforming the healthcare arena towards the diffusion of DSAs. Building on the previous chapter, I have traced how claims, stakes and tactics previously on the margins of the arena gained center stage over the period discussed here. In line with my proposed approach, I have attempted to showcase these changes through the close inspection of the cycle of contention, and the analysis of the dynamics, collective actors and tactics of each of its waves. In presenting those waves of contention, I hope to have unearthed those mechanisms that lead to the innovation of the healthcare repertoire, to include DSAs.

Briefly, I have argued that the first wave constituted mostly of mass sectoral protests, mobilized by trade unions that articulated the first anti-austerity and anti-memorandum grievances. This

changed only towards the end of this wave and with the advent of the *Aganaktismeni*. The *Aganaktismeni* themselves innovated collective action both in terms of tactics, by innovating square encampments and public deliberations in the repertoire, as well as composition, by affecting the transition from sectoral protests to a leaderless mass of protesters. All these developments were critical in solidifying the anti-austerity and anti-memorandum frames that would define the cycle.

Following the *Aganaktismeni*, and during the second wave of contention we have observed a double movement away from sectoral mobilization and protest tactics, and towards direct tactics of collective action, including DSAs. The aggregation of contention around DSAs can be explained on the basis of the decentralization of contention from squares to neighbourhoods and its “specialization” into particular domains and/or sectors identified in the square assemblies. I have argued that the second wave saw the end of the protest cycle but also the expansion of the cycle of anti-austerity contention, facilitated by the diffusion and the modularization of Direct Social Action tactics.

Finally, the third wave of contention saw the overall domestication of contentious politics from the streets to parliament, through the gradual assimilation of anti-austerity and solidarity frames and claims by the party of SYRIZA. This is dialectically linked to the relative deceleration of new DSA initiatives, as visions of social change attached to those turned into collective aspirations for change in government, culminating in the election of SYRIZA into power and the closure of the cycle of contention.

As such, this chapter wished to contextualise contention and account for its dynamics over time as well as for their transformative effects on both contentious collective action and formal politics. What is more, these fluctuations in collective action are also used to explain the radical diffusion of the Social Clinics-Pharmacies paradigm over this period. More specifically, this chapter has attempted to “weave” the five ideal-typical clinics-pharmacies chosen for this thesis, into the dynamics of contention. The presentation of each clinic-pharmacy within the dynamics of the period that birthed it serves to highlight the contingency of these trajectories as well as their consequential effect onto other clinics and the arena more broadly.

First, and through the example of KIA, we see that the first employment of healthcare DSAs during the cycle was the result of the successful intervention in a migrant hunger strike and in anticipation of the effects of the crisis onto health and care. MKIE, at the beginning of the second wave of contention, confirms the connection between the *Aganaktismeni* and the diffusion of DSAs as well as the causal mechanisms of movement decentralization and

specialization, identified above. In addition, KIFA created during the same period as MKIE exemplifies the diffusion of the Social Clinics-Pharmacies' paradigm and its swift adoption by the party of SYRIZA. The proliferation of healthcare DSAs brought to the fore those opportunities for cooperation between the different collective actors employing them, culminating in the Panhellenic Network of the Social Clinics-Pharmacies in 2013. As DSAs became modular, however, we also observe the brewing of competition on the side of certain collective actors. This is particularly evident in the case of the SSH, which involved itself in another network and (re)defined its tactics as the "original" DSAs which are only coherent when employed in strategies for self-organisation from below. Last, and into the third wave, we observe the slowing down of the paradigm, which does not, however, imply its halting. As such, the Class Clinic-Pharmacy of Nea Smirni, a relative latecomer to the Social Clinics-Pharmacies' universe, adopted healthcare DSAs due to their widespread popularity and strategically positioned itself towards class emancipation, with a particular and specialized focus onto mental health. These decisions were meant to give competitive advantage to the Class Clinic-Pharmacy and allow it to distinguish itself from the already existing options in the vicinity.

The dynamics of contention tell part of the story, however. Each of the ideal typical clinics-pharmacies discussed in this chapter have carved their own trajectory to healthcare DSAs. These trajectories were still emergent in the context of the cycle of contention, but they were consequential for the eventual institutionalisation of the Social Clinics-Pharmacies' movement as well as for the paths of each clinic-pharmacy following movement dissolution, as we will see in the following chapter. In tracing these trajectories, I have identified five characteristics that shape each clinic-pharmacies' strategic utilization of healthcare DSAs in this period. These are (1) the milieu behind each ideal type, (2) their diagnostic framing of the crisis and its impact on health, (3) their tactics, (4) their prognostic frames and (5) their relationship to the state, and by extension, the ESY.

In the following chapter, we will see how each of these trajectories is affected by the closure of the cycle of contention, the advent of healthcare reform and movement institutionalization. As we will see, both institutionalization and the dissolution of the Panhellenic Network can be explained on the basis of those different trajectories to and fro DSAs, thus contributing to more refined, relational, dynamic and longitudinal accounts of Direct Social Actions.

## **7. The healthcare arena, its players and their repertoire, 2015-2020. The institutionalisation of healthcare DSAs.**

### **7.1. Introduction**

In the previous chapter, we looked at the ways in which austerity affected health and healthcare in Greece over the course of the crisis years, deepening inequalities in the scope and quality of coverage for an ever-increasing segment of the population. Briefly, we saw how the economic recession and adjacent austerity programs implemented to address it, led to the corrosion of the social fabric and the marked increase in poverty, marginalization and morbidity already with the signing of the first MoU. In addition, we saw that the rise in the demand for public healthcare services –due to both health and financial pressures- soon exhausted the already limited capacities of the ESY, as cuts to healthcare budgets exerted further pressures upon the existing infrastructural problems of the system. As such, I have argued that the country is an example of the countercyclicity thesis concerning the impact of economic crises and austerity onto health.

The case of Greece has also become the focus for contentious politics' scholars and scholars of social movements, if not political projects more generally over the past decade. That is because in the wake of the crisis, and amidst anti-austerity mobilisations across the globe, Greece entered an intense and prolonged contentious cycle that destabilised and, effectively, dissolved the bipartisan system in place in the country for over four decades. The dynamics of the cycle of contention affected the realm of collective action writ large. More specifically anti-austerity contention mobilised new constituencies and modularised DSA tactics for an array of actors. As we saw in the previous chapter the protest cycle faded against the broader and longer cycle of contention which was characterized by the gradual replacement of sectoral mobilizations and concomitant protest tactics by solidarity DSAs set in motion by grassroots collective actors in all domains of subsistence, welfare and healthcare. My literature review and empirical research both point to the interrelated mechanisms of decentralization and specialization in affecting a qualitative transformation of anti-austerity collective action during the cycle's years from protest forms to (contentious) DSAs addressing pressing needs.

All of these changes affected the healthcare arena in its totality and advanced it into a main arena of and for contention. More specifically, the crisis stirred the arena, it shifted its players and their configuration within it, in turn affecting change with regards to its predominant repertoire and concomitant strategies and redefining the very stakes of the arena. The modularisation of DSAs in the healthcare arena enabled and reinforced the introduction of new constituencies therein

and reshuffled the arena's hegemonic interests and chronic characteristics. As opposed to claiming and defending sectoral interests, our emergent actors became socialized and politicized around healthcare DSAs, proliferated in the healthcare arena and pushed for new demands. Those included the recognition of health and healthcare as a right for all, the reform of the ESY in a more equitable and comprehensive direction and/or critical visions concerning the very principles guiding medical practice. The sum of these efforts can be captured in the emergent Health Social Movement, spearheaded by the numerous Social Clinics-Pharmacies that mushroomed across the country over the same period.

Players partaking in contentious DSAs however, were not as homogenous and unified as the literature of the period suggests. It is for this reason that I consider the sketching of the healthcare arena in the years prior and during the crisis as pivotal for our relational and dynamic understanding of the evolution of (1) the players, (2) their tactics, (3) their strategies and their impact onto (4) the healthcare arena before, during and after the closure of the contentious cycle and through the prism of movement institutionalization.

In this chapter, I wish to continue with the longitudinal exploration of the healthcare arena after the closure of the cycle of contention. Departing from the “strategic paradox” on the part of the clinics-pharmacies to remain in operation despite -or exactly due to- the reform initiatives put forward by the new coalition led by SYRIZA, I wish to address the various tactical dilemmas our clinics-pharmacies went through in the period following the change in government and the curtailment of contention. In so doing, I will be attempting a bridge between the literatures on latency and institutionalization and try to disentangle their combined impact on DSA tactics, the actors choosing to continue employing them as well as the healthcare arena more broadly.

## **7.2. “Hope is coming”: From visions of social to visions of parliamentary change**

Scholars of contemporary Greek politics recognize the role of the crisis, austerity policies and the collective reaction to them in disrupting and dissolving the established New Democracy-PASOK bipartisanship (Tsakatika and Eleftheriou, 2013; Stavrakakis and Katsambekis, 2014; Aslanidis and Marantzidis, 2016). Moving away from the analysis of contentious collective action and into that of formal and institutional politics, we can safely argue that the main victor of this period was the party of SYRIZA which grew from 4.6% of the vote in 2009 to 26.9% in the elections of 2012 to eventually climb to 36.3% of the national vote in the January 2015 elections. This electoral boom was achieved at the large detriment of PASOK, whose radical decline

mirrors the growth of SYRIZA falling from 43.9% of the vote in 2009 to its historically low 4.7% only six turbulent years later.

Kotronaki, among others, has studied the historical development and recent growth of SYRIZA through the examination of the dynamics of contention *vis-à-vis* concomitant changes in the configuration of the party's organizational structures. She argues that SYRIZA's strategy closely echoes the shifts in the cycle of contention, as the party moves to embrace and promote street protest tactics to later appropriate those to its benefit (see also Tsakatika and Eleftheriou, 2013). To be sure, SYRIZA's overarching strategy throughout the cycle of contention can be captured through the prism of the attempted "parliamentarisation" of protest, *pace* Tilly (1997). As such;

"[In] defining [...] "parliamentarisation" as a process of transference of contentious energies and demands that emerged in the context of protest events into fields and contents of party competition through the practices, rules and hermeneutic routines dictated by the existing parliamentary institutions, it is possible to argue that the "certification" of SYRIZA in the first phase of the anti-memorandum protest (2010-2011) largely contributed to the diffusion of the questioning of governmental policy to inactive social audiences and the parliamentary solidification of the emergent "street" memorandum/ anti-memorandum cleavage (Kotronaki, 2018: 141, *my translation*).

If SYRIZA provided the first wave of protest with certification, the second wave of Direct and Direct Social collective action saw SYRIZA's close assistance- if not guidance- best captured in the example of the expanding Solidarity movement. As we saw in the previous chapter, SYRIZA was quick to establish its own umbrella SMO, Solidarity4All, to facilitate the coordination between and materially support the various grassroots solidarity initiatives. Prior to the first national elections that SYRIZA would win in 2015, the party was heavily relying onto Solidarity4All so much for extending its constituencies and building (alternative) hubs of support across the country, as well as for the purposes of designing the party's social policy agenda. This was, to a large extent, due to the party's inability to penetrate trade unions that were historically captured by either PASOK or KKE and, as such, create a base within that movement (Karyotis and Rüdiger, 2017).

Once elected in government in 2015, therefore, a lot of the contentious energy and visions for change attached to the Solidarity movement were captured by this newly hegemonic formal political actor. This is best understood through the closer inspection onto the dynamics of the third wave of contention that saw;

“the “domestication” of claims-making passions and the denaturation of movement expectations into parliamentary [ones], based on elections aiming at the coming into power of an anti-memorandum government under SYRIZA (Kotronaki, 2018: 144 *my translation*),”

Meanwhile, the party was rearranging its organizational structures and shifting its horizontal relationships to movements to vertical patterns of mutual dependencies. More specifically, and according to Kotronaki (2018), Kioupkioklis and Katsambekis (2018) and Karaliotas (2019), during its accelerated preparations to take power, SYRIZA swiftly institutionalized democratic practices within the party to affect greater centralization and the solidarity movement to secure its instrumentalisation. Or, according to Karaliotas (2019);

“The horizon of SYRIZA’s political strategy became confined within the realms of institutional politics both in terms of its negotiating strategy around the memorandum and more importantly with regards to its relationship with movements, and alternatives to the crisis. SYRIZA’s government was re-oriented towards an exclusively institutional politics coupled with the statist institutionalization of solidarity to ameliorate the consequences of austerity (Karaliotas, 2019: 15)”.

In what follows, we will trace how the parliamentarisation of anti-austerity and anti-memorandum contention fed into the institutionalization of the Social Clinics-Pharmacies’ movement.

### **7.3. Hope interrupted: Memorandum with a social face**

Despite SYRIZA’s phenomenal growth, the party fell short of acquiring the parliamentary majority, and thus formed a coalition government with the marginal nationalist right-wing party ANEL. The coalition of SYRIZA-ANEL was justified on the basis of the two parties’ convergence in their anti-austerity and anti-memorandum programs. In January 2015, SYRIZA-ANEL committed to halting the MoUs and reversing the austerity policies attached to them while bringing the country out of the crisis. This hope, however, did not last long, as the coalition was faced with yet another MoU in July 2015. Due to its pre-election commitments, the government shifted this dilemma to the people and announced a referendum where citizens were invited to vote for or against the clauses of the MoU put forward by the Troika.

The results of the referendum on July 5<sup>th</sup> were largely against the signing of the third MoU. Prime Minister Alexis Tsipras, however, signed the adjustment program only a week later, due to financial and political pressures put forward by European patrons and the troika alike. What happened over the course and in the aftermath of this week is beyond the scope of this analysis-

what is important, however, is SYRIZA's decision to call for another election in September in an attempt to re-legitimise its government. SYRIZA-ANEL were yet again voted into government, albeit both suffering some marginal losses.

## 7.4. Social Clinics-Pharmacies

### 7.4.1. Movement institutionalization as a process

Upon signing the third MoU and upon losing its anti-memorandum profile, SYRIZA was prompt to shift its agenda to the promotion of some social policies that escaped the strict purview of the troika. In so doing, the party could not lose sight of its solidarity movement constituencies and promises to elevate poverty, exclusion and marginalization for those suffering the most from the austerity regime (Mavrozacharakis et al, 2017:41). SYRIZA, therefore, transformed from an anti-austerity party to a party that was more willing, if not capable, of making concessions to the most vulnerable members of the population- with the help and mediation of the solidarity movement where this was appropriate. One such example was the institutionalization of the social solidarity card issued by the rebranded Ministry of Labour, Social Insurance and Social Solidarity <sup>44</sup>. In the words of Theano Fotiou, Alternate Minister of Social Solidarity in both successive coalitions;

“This is how in 2015, within a month [after the elections] we voted for the law to counter the humanitarian crisis, [a law] inspired by the unprecedented solidarity movement (the social clinics-pharmacies, markets without middlemen) that developed in our country. A great innovation [in this direction] was the Solidarity Card (a prepaid bank card) which gave citizens dignity and boosted local markets. We saw to the free distribution of 300KW of electricity per month per household and to the free reconnection of electric supply as well to rent subsidies that were directly credited to the owner's account. The Solidarity Card is now being adopted by the European Union to replace food provision services to deprived persons in all European states for the new period [of] 2021-2027<sup>45</sup>”.

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<sup>44</sup> Ministry of Labour, Social Security and Welfare under the previous New Democracy administration (2012-2015).

<sup>45</sup> I Avgi. 28/07/2019. Fotiou, T. *An emblematic accomplishment of the SYRIZA government/ With the Social Income of Solidarity we tackled the humanitarian crisis.* [in Greek]. Ένα εμβληματικό έργο της κυβέρνησης ΣΥΡΙΖΑ / Με το Κοινωνικό Εισόδημα Αλληλεγγύης καταπολεμήσαμε την ανθρωπιστική κρίση.

This shows the orientation of SYRIZA-ANEL during the period as well as the direct links made between the Solidarity movement and the government's social policy agenda. SYRIZA not only claimed inspiration by the solidarity movement in formalizing and institutionalizing its social policy agenda whilst in office; building on the words of Fotiou quoted above, we see that those "best practices" of the movement were also celebrated as inspiring international efforts and as already exported on the supranational level. This strategy brought about blended outcomes for the movements of the period, or in the words of Karaliotas (2019);

"While partially vindicating movements' demands, what these policies also achieved was to confine radical democratic initiatives and movements into a statist perspective. The perceptible and permitted solidarity was now the one that the state was articulating. In this sense, SYRIZA's policies were depriving democracy and democratic politics by reducing them to institutional politics and established actors (ibid: 15)".

The simultaneous processes of party centralization, movement instrumentalisation, and SYRIZA's transmutation into party of the memorandum block presented a new range of challenges so much for the party as well as the Solidarity movement. On the one hand, SYRIZA lost a number of its activists, cadres and constituencies, some of which central to the party and/or the movement, that were quickly replaced by more traditional social-democratic actors. On the other, the resultant configuration of the party *vis-à-vis* its remaining social movement basis compelled those constituencies to the ever-greater support and defense of SYRIZA from critique. This created hostilities and polarization within the solidarity movement, Solidarity4All as well as the Social Clinics-Pharmacies movement, as we will see below.

The Social Clinics-Pharmacies' movement is an excellent lens from which to study SYRIZA's transformation upon coming to power, as well as its strategy and agenda upon signing the third MoU. Following its pre-election slogans, frames and promises, Healthcare Reform soon gained center stage, especially with regards to the two thorny issues of the ESY that mobilized the Social Clinics-Pharmacies in the previous period. As such, SYRIZA committed to extending coverage to the uninsured and to improving and enhancing Primary Care.

To that end, the second SYRIZA-ANEL government appointed Andreas Xanthos, a physician and activist at the Social Clinic-Pharmacy of Rethymno, Crete, as Minister of Health and responsible for drafting and implementing progressive reform in these two directions. The inclusion of the Social Clinics-Pharmacies in policymaking, however, did not stop there, as the Ministry of Health extended the invitation to the reform effort as unpaid policy advisors to representatives of the various clinics. As we will see below all the Social Clinics-Pharmacies

discussed in this thesis that belonged to the movement participated in the drafting of the reform. Their participation, however, was different both in terms of degree and outcomes, and was guided by the various interpretations attached to the reform, themselves informed by each distinct trajectory to healthcare DSAs discussed in the previous chapter.

This chapter then aims to shed light onto the processes and interactions that shaped and informed trajectories to and from certain forms of action, and provide a relational perspective onto the strategic dilemmas and tactical paradoxes the social clinics were faced with during this period. More specifically, we observe four tendencies; (1) certain clinics affiliated to Solidarity4All underwent institutionalization –if not cooptation- by the party of SYRIZA. This is understood as a process initiated already at the third wave of contention and culminating over the period the SYRIZA-ANEL coalition. Some others, (2) became hostile towards the reform and continued their operations, elevating solidarity from a tactic to the sum of their strategic goals concerning socio-cultural change. Some others, still, (3) distanced themselves from the government to critically support or condemn individual reform clauses and make claims for the extension of the reform effort, while using their activities to pursue political projects with more pronounced class orientation. Finally, (4) those clinics subscribing to the project of health autonomy continued pursuing on their vision of social change from below, through their paradigm of self-organisation in health and care and upon the confirmation of the coopting certainty of the state’s intervention in self-organised healthcare.

Institutionalisation is thus, at least in part, a process that involves the array of heterogeneous actors employing healthcare DSAs, SYRIZA and Solidarity4All. In attempting to sketch the clinics’ trajectories following the movement’s institutionalization, thus, I wish to examine its impact not only on the actors themselves seen as isolated and homogenous players, but in the sum of their interactions, in affecting change to each other and impacting the healthcare arena. I therefore also converse with the literature on strategic (inter)action as well as pose some reflections upon the limits of DSAs in healthcare, as seen and discussed in the cases of other movements worldwide. In so doing, I try to infuse post-mobilisation literature with more agentic accounts of movement continuity and change, abeyance and the doldrums.

What I hope to show, ultimately, is that in the case of the Social Clinics-Pharmacies’ movement, institutionalization was a strategic choice, reached after the prolonged co-development and interaction between the solidarity movement, Solidarity4All and SYRIZA. This process had “open-ended” and “context-based” implications for the movement, made evident by the various trajectories carved in the period presented here (Suh, 2011). As we will see, following the closure

of the cycle of contention and movement institutionalization, some of the actors discussed here maintained their contentious characteristics and expanded their interventions and constituencies to appeal to broader social movement milieus. Others yet lost their contentious characteristics (tactics and frames) and in so doing contributed to the solidification of the post-welfare landscape in the country and minimized those reversibility points for change through DSAs.

I hope that this chapter is generalizable so much for what concerns the healthcare arena and the opportunities and limitations it affords for DSAs in other countries and settings. In addition, I anticipate that results of this analysis also shed light onto the broader dynamics of contention in the post-welfare and post-democratic era and, more specifically, onto the potential and unintended spilling of contention into “ethopolitics” (Rose, 2000). Ethopolitics in the context of the neoliberal order represents a shift in governmentality that displaces responsibility from the state and its representatives to those (ethical) citizens that assume responsibility for sustaining their own communities. A critical discussion on this issue is much needed and long overdue, it can help disentangle the literature on resilience vis-à-vis solidarity tactics it is a subject and inform larger political reflections. I shall reserve my contemplation on this issue for the concluding remarks of this thesis.

#### 7.4.2. Movement institutionalization as an outcome

For the purposes of our analysis here, I propose a definition of Healthcare Reform as the combination of two interrelated laws taken by the second coalition of SYRIZA-ANEL. The first is Law 4368/2016 which extended the admission criteria for the ESY to all those in possession of a Social Security Number- that is to everyone but those without papers. Law 4486/2017 that followed announced the effective restructuring of the Primary Care level of the ESY through the establishment of a new Primary Care System (PFY). Later that year, the law was embellished with yet another clause that saw to the gradual establishment of Local Health Units (henceforth ToMYs) responsible for the provision of welfare and healthcare services on the local level, oriented to “health promotion, prevention, diagnosis, therapy and a holistic conception of health” (Law 4486/ 2017; for original analysis of this law see Kotronaki and Christou, 2019: 337).

It is worth mentioning here that although usually going unacknowledged by analysts and activists alike, these reforms also constituted recommendations attached to the third MoU signed by the coalition of SYRIZA-ANEL. These recommendations- commitments were driven by troika’s logic of improving efficiency in the healthcare system and securing cost-containment, as dictated

by the politics of debt chosen over the course of the recent global financial crisis. I provide here some extracts of the MoU pertaining to healthcare as presented on August 19<sup>th</sup>, 2015;

“The authorities have committed to continue reforming the health care sector, controlling public expenditure, managing prices of pharmaceuticals, improve hospital management, increased centralized procurement of hospital supplies, manage demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commission private sector health care providers in a cost effective manner, modernize IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients” (2015: 15).

“The authorities will closely monitor and fully implement *universal coverage of health care* and inform citizens of their rights in that regard and they will proceed with the roll out of *the new Primary Health Care system*, and the issuing of an MD as envisaged in Law 4238 by December 2015. To this end, they will make use of the available Technical Assistance support” (ibid: 16; *emphasis added*).

As we will see in the subsequent analysis of my empirical data, only a handful of my interlocutors were aware of the policy recommendations made by the troika in the direction of the ESY reform, and neither has there thus far been any analysis of the convergence between the agendas of SYRIZA, the troika and the Social Clinics'-Pharmacies movement. Most of my interlocutors, including those aware of the above recommendations, see the reform as the successful outcome of their mobilization in the previous period- even if partial, incomplete or distorted.

For the purposes of this thesis I only provide this as factual data, as the reconstruction of the negotiation process and/or any examination of the impact of the movement on the drafting of the Memorandum by the European patrons is beyond the scope of this thesis. Instead, we turn our attention to the interpretation of the Reform by our clinics-pharmacies discussed in the previous chapter, and its repercussions onto the emergent Health Social Movement in the country.

### **7.5. KIA: class struggle trajectory**

As we saw in the previous chapter, KIA was the first clinic to appear in the context of the anti-austerity contentious cycle. KIA emerged as the outcome of the successful mobilization in defense of the migrant hunger strikers in the city of Thessaloniki. Its composite members were activists coming from a range of local social movement milieus and radical left-wing parties. Many of the healthcare professionals involved in KIA had a militant background and some had strong connections to SYRIZA. For this reason, a number of its activists were involved in the reform effort, and some of them saw it to its completion.

KIA was probably the most outspoken clinic encouraging public participation in the drafting of the healthcare reform. In its official website, it posted updates of the discussions and announcements pertaining to the reform effort and called for people to become involved in the dialogue by submitting their opinions and grievances to the Ministry of Health. In addition, they exerted critique on the initial drafts of the reform, and helped stir it in their desired direction. In so doing, KIA broke down the laws into their composite elements, analysed them through justice and rights' frames and *vis-à-vis* their ideological orientation and acquired experience in healthcare DSAs.

One such example is the sharp critique they published concerning the initial discussions over the law for the uninsured. More specifically, KIA stated that the law was reaffirming the connection between employment status and the right to health, a right that is and should be recognized as universal and should be irrespective of employment status. In addition, KIA was clarifying its role as being;

“[n]ot that of government allies nor that of the opposition to this or any government [...] [our role lies in] our everyday interventions. Those are taking care of the uninsured and the excluded residents of our city, [securing] the self-organisation and direct democratic running of our clinic and supporting of all those solidarity networks that contribute to the preservation of the social fabric, [while] fighting against individualism and any form of human exploitation”.

This document concluded with the reiteration that members of KIA;

“[a]re determined to continue to contribute, with the experience we have earned over these 3,5 years of our operations, our knowledge as well as our politics towards the development of a social movement that fights to establish healthcare as a human right.<sup>46</sup>”

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<sup>46</sup> KIA. 23/09/2013. *Press Release: For all the workers at the hospitals and health centers.* [in Greek]. «Για όλους τους εργαζόμενους στα νοσοκομεία και κέντρα υγείας».

**Αντιδρώντας** έμπρακτα σε πολιτικές που εξαθλιώνουν τον άνθρωπο, κατασκευάζουν στρατιές ανέργων, δημιουργούν χιλιάδες ανασφάλιστων, καταργούν τη δημόσια υγεία, **Απαντάμε** υλοποιώντας στην πράξη, την αλληλεγγύη, τη συλλογικότητα, την αυτοδιαχείριση στο κοινωνικό πεδίο. Από **7 Νοεμβρίου 2011** λειτουργεί το **Κοινωνικό Ιατρείο Αλληλεγγύης** προσφέροντας δωρεάν ιατροφαρμακευτική & οδοντιατρική περίθαλψη σε Έλληνες & αλλοδαπούς ανασφάλιστους.



Picture 10: KIA poster

“**Reacting** in practice to the policies of human pauperization, that create armies of unemployed, thousands of uninsured, eliminate public health, **We Respond** by realising in practice, solidarity, the collective, self-organisation on the social field. The **Social Clinic of Solidarity** is in operation since **November 7, 2011**, offering free medico-pharmaceutical and dental care to the uninsured Greeks and non-nationals.”

On May 11<sup>th</sup>, 2015 KIA published an analysis of the updated version of the law concerning the admission of the uninsured into the ESY, co-signed by sixteen social clinics-pharmacies. These included clinics that were close to SYRIZA, such as KIFA, as well as those closer to the Class Clinics’ paradigm presented in the previous chapter. The analysis broke down the draft, itself the product of public deliberations that also incorporated the earlier critiques of KIA, into positive and negative outcomes. According to KIA and the rest of the clinics signing the document, this version marked advances in two directions. It removed income criteria for the uninsured and it expanded their benefits’ basket to include a number of diagnostic tests, orthopedic products and other services such as physiotherapy and speech therapy. The points of critique were more extensive and technical but they all threatened the “distortion [of] what we call free and universal access to all the people residing in the country, [that sees] no form of exclusion, no bureaucratic obstacles and exceptions <sup>47</sup>”.

Upon the announcement of the reform in admissions in 2016, KIA decided to reduce its doctors and regular appointments held within its space, redirect people to the ESY and cater only for those without papers that the law did not cover. This was in line with their original strategic employment of DSAs to address migrants and their stated refusal to substitute the national

<sup>47</sup> KIA. Press Release on the announcement concerning the uninsured. [in Greek]. «Δελτίο Τύπου για εξαγγελίες σχετικά με τους ανασφάλιστους.

healthcare system. KIA's strategic integrity, however, was neither granted nor guaranteed. According to my interlocutors, the period following the reform presented the clinic with a series of dilemmas concerning their operations, that ultimately shaped their strategy for the period discussed here. More specifically, Alexis Benos, medical doctor, professor of health policy and activist at KIA who acted as a policy advisor for SYRIZA during the reform effort recounted in our interview;

“[A]t that point we had a serious talk [in the clinic]. We had a serious talk and one of our founding members [...] she stood up and said “Ok guys, I think we ought to close down, everything has its beginning and its end”. And we all reacted, emotionally mainly. I mean, how is it possible, this is our child... And the realistic argument that prevailed was that the needs covered by the Law are not necessarily going to be covered after a change in government. So, maybe we ought to keep it [the clinic], albeit in hibernation, sure, but in case of adversity... so that we can go straight in, roll up our sleeves and get to work.”

Alexis Benos' words bring us back to our discussion on periods of latency, as they provide an insight onto their agentic dimension. More specifically, we can understand KIA's decision to continue its DSA interventions as corresponding to those latent dynamics of repertoire preservation. This period, then, is dialectically linked to the previous cycle of contention and to future struggles, as it “sews” resistance to the fabric of everyday life (Melucci, 1989). By exposing the strategic quality of KIA's decision to continue its operations, then, I argue that we advance existing accounts on those abeyance structures that capture (and suspend) activist momentum, circles and repertoires in periods of latency (Taylor, 1989). The approach proposed here, therefore, acknowledges the preservation of movement characteristics for a later stage of struggle, anticipated in the context of great fluidity and uncertainty, as a strategic goal of those actors involved in healthcare DSAs in KIA.

All in all, the two interrelated laws of the Reform were seen positively by KIA, whose members believed it to be a product of their struggles over the past years. However, clauses and configurations of the laws were scrutinized *vis-à-vis* KIA's vision for the ESY. This was more evident concerning the law on the development of PC, which became subject to more nuanced criticisms. Alexis Benos told me about this latter reform;

“It is an application of some right ideas, I mean the concept of the Local Health Unit (ToMY) is very good. But nothing is incidental, these things are ideologically loaded, they are marked by ideology... In the proposal for the reform made by us [at KIA] we put forward the so-called Neighborhood Groups. Something which was not entirely rhetorical, nor etymological. Neighborhood... A more social approach to care. [...] It allows you to demarcate your population,

the environmental conditions in which they live, delineate their sociological profile. And much more... Well, they turned them into ToMYs. So the outcome was somehow... more technical. A unit, an office, a service. Something administrative... Not something of the neighbourhood. [...] This was a struggle ... and we lost it!"

Further critiques involved the very funding of the ToMYs as overwhelmingly precarious, based, at least in the short term on National Strategic Reference Frameworks (NSRF) programs provided for by the European Union. This insecurity in funding was understood as the main reason behind SYRIZA's failed appeals to staff the ToMYs, a failure that the government was using to justify delays in implementation. The criticism made by KIA, then, extended to SYRIZA's attempted shortcuts to recruiting that inadvertently derailed the reform effort from KIA's vision. One such shortcut was identified in the introduction of the concept of the family doctor that needs not necessarily be specialized as a GP and can be contracted by the ToMYs even if practicing privately. KIA expressed concerns about this arrangement, deeming it costly and at the expense of their proposals for an interdisciplinary medical team. According to KIA, this team should comprise of healthcare employees on permanent contracts which would secure better quality and more holistic care to the local population.

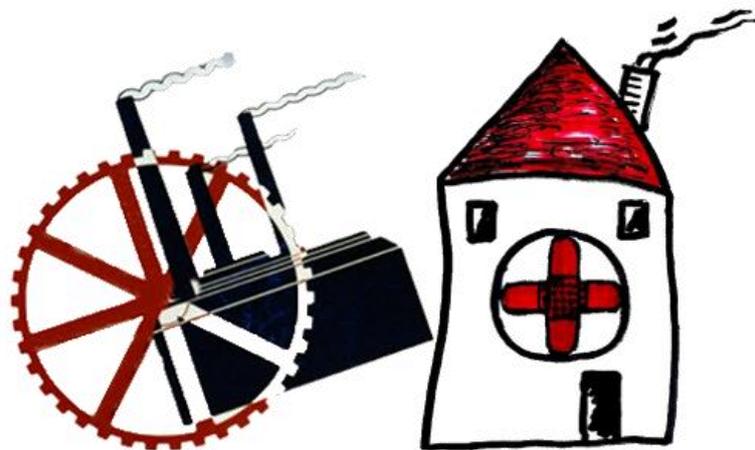
As such, the sum of these distortions to KIA's vision of an effective PC were scrutinized as an attempt not for better and more equitable care, but for more effective gatekeeping sloppily designed to take pressure off hospitals and reduce the inflated expenses of secondary and tertiary care. Moreover, Benos who was among those few aware of the healthcare policy prescriptions of the third MoU criticised these developments as reflective of troika's cost-containment logic infused in the reform through the Memorandum.

KIA therefore, not only participated in the drafting of the reform, but utilized this instance to mobilise its constituencies, discuss and analyse healthcare policy. As such, I argue that it applauded and welcomed Healthcare Reform, but reserved a number of criticisms. These pertained to the incompleteness of the reform, so much in terms of coverage as well as in terms of implementation. In addition, given the country's "epidemic" of short-lived healthcare reforms (Stambolovic, 2003) already discussed in this thesis, activists at KIA were not confident concerning the continuity of these reforms by another government. It was for these reasons that KIA decided to continue its interventions in the provision of primary care services in Thessaloniki, albeit with less medical appointments than in the previous period.

KIA's latent activities, however, did not stop there. Over the same period of movement decline, following the closure of the contentious cycle and movement institutionalization, KIA added a

new clinic to its operations. This clinic marks an innovation in KIA's profile and a change in the tactical alignment of DSAs within its broader strategy. Already on January 2016, KIA announced the establishment of the Workers' Clinic inside the factory of VIO.ME (Industrial Mining). The factory was occupied by its workers after its owners declared bankruptcy and abandoned it in 2011. Since, the occupied factory has turned towards the production of eco-friendly detergents, as agreed by the members-workers of the occupation. To this day, VIO.ME stands as a symbol of workers' struggles in the city, if not the entire country. KIA's invitation for participation in the efforts of establishing the Workers' Clinic reads as follows;

“The Workers' Clinic starts its operations in the space of the self-organised factory of VIO.ME [...]. The clinic was established through the meeting and collaboration of the workers at VIO.ME and KIA and provides free healthcare and prevention [services] to the workers, the unemployed and the uninsured residents of the Patriarchiko Pyleas area. **It is automomous, self-organised and is not funded by the state, the parties, the market or the church. It operates without hierarchy, through a general assembly where all decisions are taken** <sup>48</sup>.”



Picture 11: Workers' Clinic poster

[The symbol on the left is the logo of the VIO.ME occupation and the symbol on the right is the logo of KIA. The two combined make up the symbol for the Workers' Clinic indicating the collaboration between the two initiatives.]

This is a very important point for KIA as, upon the announcement of the reform for the uninsured, it reduced its constituencies to those without papers, to soon extend them again to include workers and connect to other radical local milieus. This shift also corresponds to a

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<sup>48</sup> KIA. Opening of the WORKERS' CLINIC in VIO.ME. [in Greek]. «Εναρξη του ΕΡΓΑΤΙΚΟΥ ΙΑΤΡΕΙΟΥ στη ΒΙΟ.ΜΕ».

change in the profile of KIA, that is, to the solidification of its social movement profile, evident in its commitment to strengthen its bonds with and actively promote local struggles. The Workers' Clinic was set up quickly and remains in operation, catering for the healthcare and pharmaceutical needs of any incoming patient. In addition, KIA continued its contentious activities in the realm of health and healthcare, but extended its focus to other spheres including labour, migration, and ecological issues.

In addition to local social movement milieus during this first and challenging period of the SYRIZA-ANEL coalition, KIA appears as spearheading the collaboration and coordination between the members of the Panhellenic Network of Social Clinics-Pharmacies in their attempts to build and promote a Health Social Movement, as suggested in their announcement above. It is to this end that KIA organized what was going to be the fifth and last Panhellenic Meeting of Social Clinics-Pharmacies in Thessaloniki in 2016. The meeting was almost exclusively focusing on migrants and refugees, their living and containment conditions in Greece and, relatedly, the impact of those conditions on their health and access to healthcare.

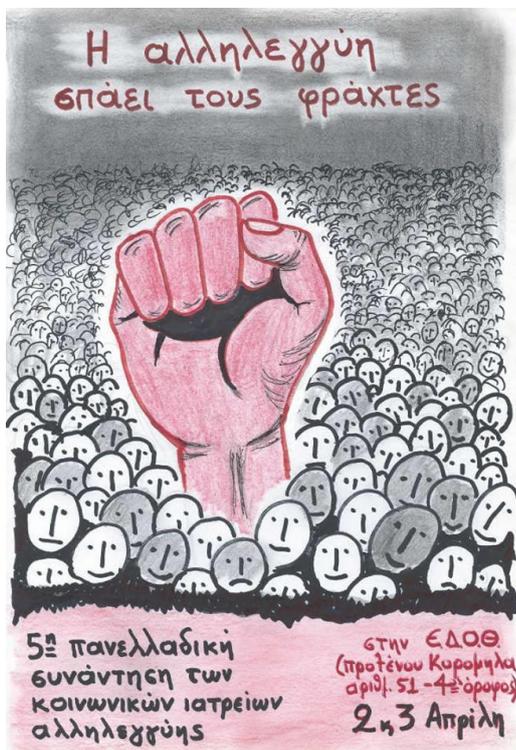
Called soon after the signing of the contentious EU-Turkey Deal, KIA drafted a resolution condemning it for “legitimising the closure of borders, creating a zone of protection for the center of Europe and turning Greece into an ever-growing ghetto of refugees and migrants, and a space for the reinforcement of repression against refugees”. An overwhelming majority of the clinics attending the meeting voted in favour of the resolution against the EU-Turkey Deal. In addition, KIA put forward two resolutions that were less applauded but nonetheless passed. Both those resolutions are indicative of KIA's strategic orientation in this period.

The first had to do with the defence of VIO.ME against plans for its re-privatisation. The resolution stated that by virtue of VIO.ME's recent collaboration with KIA, any attempts to sell the factory and/or evict it would imply the ceasing of their medical activities therein, at the expense of the health and social-emancipatory benefits reaped from their interventions. As such KIA used its interventions with healthcare DSAs in the occupied factory as a defence to the whole project of VIO.ME. KIA also put forward a resolution against the plans for the expansion of mining activities in the Halkidiki region in northern Greece. The resolution stressed that KIA stood in opposition to the profit-driven model of development that involves locals and workers in ecological destruction and declared its solidarity with struggles against the toxic exploitation of the region.

We understand, therefore, that KIA entered into this period of latency without interrupting or ceasing its contentious DSA tactics. In tracing and tracking its strategy over this period, I argue

that KIA was faced with a dilemma. The clinic-pharmacy wanted to continue covering for needs on the ground whilst preserving its characteristics, momentum and human resources. This, however, could risk their instrumentalisation and substitution of the ESY. In navigating this tenuous period, then, KIA decided to reduce its doctors and constituencies to cover only those without papers. Soon enough, however, it would expand both its activities and targeted constituencies by extending its healthcare DSAs to the labour and environmental movements that offered a fertile ground for the tactical employment of DSAs. As such, KIA fostered alliances with local struggles and hubs of resistance and broadened its potent healthcare frames and claims to include appeals to a healthful existence.

What is more, I would argue that movement institutionalisation was consequential for KIA but it was neither inevitable nor decisive for it. To be sure, KIA made a strategic choice to cooperate with SYRIZA in the reform effort and invited its constituencies to participate therein. Despite the convergence of both the clinics and the MoU in the reform clauses, members of KIA acknowledged those advances marked by the Healthcare Reform and criticized its weaknesses. Upon institutionalisation, KIA neither radicalized nor become coopted, but shifted its strategic orientation in the context of the new political environment.



Picture 12: Fifth Panhellenic meeting of Social Clinics-Pharmacies poster



Picture 13: NO to gold mining- SOS Halkidiki campaign poster

## 7.6. Fifth Panhellenic Meeting of Social Clinics-Pharmacies

The fifth Panhellenic Meeting briefly presented above was riddled with tensions and dilemmas over the role of Social Clinics-Pharmacies under the new coalition and in light of the upcoming Healthcare Reform. The meeting was well-attended and produced a common Press Release upon its conclusion, with the bold title “The need that birthed us still persists”. The document, signed by all the social clinics-pharmacies in attendance declared that those clinics-pharmacies continuing their operations do so as grassroots initiatives that fight for their vision of a public, free healthcare system without exclusions, thus pushing further than the limitations identified in the Healthcare Reform. The document reiterated their autonomous and self-organised profile and direct democratic and anti-hierarchical organisation and highlighted that they will not remain silent in this period nor will they allow their instrumentalization by this or any other government. In addition, the clinics-pharmacies committed to continue providing free services and pharmaceuticals to all those migrants overlooked by the reform, whilst fighting against the exclusionary policies and practices in the ESY. In so doing, they would become “the eye” and “the ear” of society against any instance of healthcare exclusion and/or obstruction to access, through witnessing and reporting. Their healthcare DSAs would also promote their attempts to foster a Health Social Movement that can challenge the dominant medical model and stir it in an alternative, more holistic direction, rooted in the socio-economic determinants of health<sup>49</sup> (see also, Kotronaki and Christou, 2019: 338).

This was the last common document indicating cooperation between the clinics-pharmacies to date. Following my operationalization of the Social Clinics-Pharmacies’ movement, then, I argue that the dissolution of the Network marks the end of the emergent Health Social Movement in the country. The trajectories to healthcare DSAs sketched in the previous chapter, thus, become solidified as distinct and divergent trajectories of action over this period; a differentiation that is propelled by the diffused strategic employment of healthcare DSAs. In what remains I propose a relational and dynamic (re)construction of the different trajectories that affected and were affected by movement institutionalization.

## 7.8. MKIE: reactionary trajectory

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<sup>49</sup> Self-Organised Social Clinic Pharmacy of Nea Filadelfia, Nea Chalkidona, Nea Ionia and surrounding areas. 06/04/2016. 5<sup>th</sup> Panhellenic meeting of Social Clinics-Pharmacies: The need that birthed us still persists. [in Greek]. «5<sup>η</sup> Πανελλαδική Συνάντηση ΚΙΦΑ: Η ανάγκη που μας γέννησε εξακολουθεί να υπάρχει».

MKIE also participated in the deliberations for the drafting of the Healthcare Reform to then denounce the reform altogether. MKIE continued with its operations, although the low attendance of patients necessitated the reduction of its opening hours. This need was further reinforced by the exodus of many of its volunteers during and after the reform effort, for reasons that we will see below.

To be sure, MKIE's approach to the Healthcare Reform as well as SYRIZA follows its more general personality-centered profile around MKIE's "founder" Vichas. Dr. Vichas ran as a candidate for SYRIZA in the first elections of January 2015, to leave after the signing of the MoU and align himself with other political forces of the nationalist Left. Similarly, and despite MKIE's apolitical stance- relative to the other social clinics discussed in this thesis- the clinic started as friendly towards SYRIZA only to turn to its critique, if not aversion, during the second coalition. As we will see, MKIE's acquired characteristics in this period, alongside its perception of the SYRIZA-ANEL coalition and interpretation of the Healthcare Reform are key in understanding the continuation of its operations and the direction it chose to move forward.

Unlike the rest of the clinics discussed here, MKIE underwent serious polarization within its ranks, mainly with regards (and due) to its tumultuous relationship to SYRIZA and the reform. To be sure, volunteers that had since left MKIE told me of this period as being particularly disappointing and demoralizing, and had remained very skeptical of the way that MKIE had evolved since. In an interview conducted in 2019, my interlocutor Vicky Kouloura recounted the activists that left MKIE over the course of the reform to exclaim that "many, many people left then, damning and cursing... a mess, a real mess. [Cites names] all of them, I mean they were all very central to the clinic. Those that were pivotal to its running, those few with activist experience, they all left ... enraged." Vicky continued to remark on the decay of MKIE as patients also started to leave. She presented me with another discussion volunteers at MKIE had during the announcement of the Healthcare Reform, which led to her decision to leave. She remembered that;

"Ever since the healthcare system reopened, those [patients] that could go to the hospitals to get PC left. They could be served there. So they left from us. This immediately lowered the number of our patients from 1,200 per month to... say 480 patients [...] The system opened and people, well, people feel more comfortable in the hospital, let's not kid ourselves! The hospitals have more equipment, more experience... more doctors. We were small, we might had been doing an extraordinary job but we never had- never *could* have- the infrastructure of a hospital! [...] And that's when volunteers started complaining. They were disappointed, if you can believe it, they were saying "we lost the patients". I said to them, we did not lose them, they went to the hospitals,

just like we wanted them to! This was the beginning of the fight... they tried to convince me that the hospitals were dangerous. Whereas us? We, a volunteer clinic, can speak of safety? They were out of their minds... and that's when they started talking of how to bring them [the patients] BACK!?"

MKIE's insistence to remain put, continue its operations despite the reform and, in a way, compete with the ESY was heavily criticised by the rest of the clinics, which exerted pressure onto MKIE to start redirecting people back to the public healthcare system. This led to disputes and tensions with other clinics and culminated to MKIE's erratic departure from the coordinating committee of the Attica clinics and, eventually, the Network. This was going to be the first and only formal departure before the Network dissolves altogether, while the hostility exhibited by MKIE upon its exit effectively isolated it from the rest of the clinics- pharmacies still in operation.

As we saw in the previous chapter, MKIE's development was heavily influenced by its participation in the Network. More specifically, MKIE expanded its constituencies from Greeks to all those uninsured and its agenda from anti-austerity claims to broader challenges to the biomedical model through its exposure to the agenda of the Network. In addition, the Network was prompting MKIE in a more contentious direction, motivating and mobilizing it to collective action through the coordination of joint public events and demonstrations. This disassociation of the MKIE from the other clinics therefore only reinforced its self-involved and inward-looking profile and pushed it into the direction of uncritical organizational path-dependency. Through my data analysis, I have identified the following indicators suggesting MKIE's transformation into an organization, removed from the Health Social Movement or other movement milieus, and preoccupied, first and foremost, with its own survival and reproduction.

First, MKIE rarely provided a critique to the Healthcare Reform, apart from a few instances of radio shows where Vichas would discuss some of its implications onto the system of admissions. Instead, and in line with the discourse and practices MKIE had adopted since its founding, it would confine its critique to the publication of dramatic stories of illness, exclusion and, at times, death. This tactic was frowned upon by other clinics; many of my interlocutors accused Vichas – and by extension MKIE- for producing “yellow press” propaganda, while those closer to SYRIZA for explicitly and intentionally spreading lies.

Secondly, the assembly would be almost entirely hollowed out due to the extremely low attendance of volunteers therein. This internal undermining of direct democratic procedures in

the clinic, led to the routinization of the assembly as low attendance was redressed with the appointment of non-rotating representatives for each line of work.

Thirdly MKIE made frivolous attempts at expanding in the realm of psychological care. As we will see, many clinics retained their mental health services, even when they interrupted all other healthcare DSAs. This was justified on the basis of securing continuity of care with the same specialist, whilst advancing mental health in a less medicalized and more socially mindful direction. MKIE, however, never made efforts to challenge mainstream mental health practices. During this period, it lost a number of its specialists in this area of care, and instead attempted to recruit new volunteers. All the above showcase that MKIE's investment in mental health was driven by concerns about its own continuity, uncritically lending what they perceived to be a successful (survival) strategy on the side of other clinics during this period.

In addition, MKIE intensified its activities around pharmaceuticals. SYRIZA-ANEL did not reduce contributions for a series of pharmaceuticals and as years of austerity had depleted people's savings, the demand for free pharmaceuticals was ever-increasing under the coalition. According to a volunteer at MKIE, the pharmacy was servicing this growing need for pharmaceuticals, distributing them to other clinics-pharmacies, not least because they were "underfunctioning", hospitals, health centers and other public institutions such as prisons and the KEELPNO because they were "mismanaged" and NGOs because they were "underfunded". This suggests MKIE's self-perception as a patron of formal and informal pharmaceutical providers due to its greater functional, managerial and resource collection capacities.

What is more, my interlocutors were explicit -and proud- in saying that their cooperation with hospitals had become formalized and routinized. In the words of Vasiliki, a volunteer at MKIE since its early days, "hospitals have now established a list of all the social pharmacies, they give it to the patients and say 'go there to take your meds'. Unfortunately the list is not updated and many-a-times people lose time in going around knocking on the doors of closed [social] pharmacies". The role of the pharmacies as voluntary -yet more capable- assistants of the state is thus going uncriticized and celebrated.

The deletion of the contentious characteristics of the MKIE and its transformation into a formal volunteer organization is also made evident in their understanding of their role. Vasiliki added that;

“When there’s state mismanagement, everyone needs to assume their own role and responsibilities. Those who are in position of control need to control it, journalists need to expose it... We ourselves cannot do everything, this we have realized. What *can* we do? We can collect and distribute those [pharmaceuticals] that would otherwise end up in waste, take them somewhere where they’ll be utilized. We utilize them.”

The collection and distribution of pharmaceuticals, thus, is not treated as a strategic choice- it becomes the normalized, naturalized and decontextualized *raison d’être* of MKIE. To reiterate, this relationship with state institutions and NGOs is discussed in strictly technical terms, and goes largely unproblematized. To my questions concerning the nature of their cooperation with these actors, Vasiliki insisted on the bureaucratic elaboration of the transactions;

“Whatever we give to hospitals as a donation is accompanied by a detailed registration up to the single last pill. For example, we gave out fifty-five Augmentin [antibiotic] pills, with such-and-such expiration date. Then, those responsible in the hospital take them from the Management Board as a donation, they enter the hospital as a donation. [...] Of course there is legislation [on this]! In this way, we give them away with their accompanying paper, we ask them to sign for the collection [...]. This allows us to distribute many pharmaceuticals that are needed or are in scarcity.”

This marks MKIE’s tendency to become a formal organization, through the charting of a third sector-mediator in the healthcare arena. This formalization is made ever more evident in the way MKIE chose to address the dilemmas of the period. As tensions led to disagreements and disagreements to departures, the assembly was weakened and dilemmas over tactics and overarching strategies could not be addressed. It is for this reason that a team of three volunteers took it upon themselves to construct a questionnaire examining the motivations for and levels of satisfaction of the 109 remaining volunteers therein. This research conducted in 2018 is exhaustive and particularly instructive, both as a study and as an artifact in and of itself.

The questionnaire, among other items, was asking the remaining volunteers whether the clinic-pharmacy should remain in operation, a critical question that appears to remain unresolved three years into the coalition. Notwithstanding the numerous departures of the period – or exactly due to those- the remaining volunteers overwhelmingly applauded the continuation of MKIE’s interventions, with 96,8% of them agreeing to stay put. The reasons for MKIE’s continuation, however, were not examined- instead, the team turned its attention to the examination of the personal reasons for (1) deciding to participate in MKIE in the first place and (2) deciding to continue participating to date. The structured format of the questionnaire suggests that the great majority of volunteers joined (64,6%) and continued participating (69,6%) in MKIE to spend free time that they had to their disposal. Meeting new people ranked as second most popular

motivation, while resistance to the crisis and the feeling of social responsibility and solidarity were much less cited reasons for participation in MKIE. At this point it is important to note that, by then at least, the overwhelming majority of volunteers were between 51-70 years of age (73,9) and most were pensioners or unemployed. Following the organisational transformation of MKIE, then, the questionnaire attempts to measure volunteers' levels of satisfaction with the clinic – interpersonal, practical etc.- and suggestions to improve its effectiveness.

The mere existence, design and circulation of this questionnaire among the volunteers on the side of the MKIE cannot be overlooked as it serves to highlight its transformation into a formal and bureaucratic organisation. This research-report resembles Human Resources Departments' attempts to improve workplace satisfaction and outputs, where questions are distributed and answers are collected to be analysed and presented to the volunteers, and not discussed in the assembly. All the above highlight MKIE's tendency towards uncritical self-preservation.

Moreover, and in analyzing the results of the questionnaire, I argue that they represent a remarkable finding that takes us to the discussion on ethical subjectivation during times of welfare retrenchment. Anthropologist Andrea Muehlebach (2012) writing about the development and establishment of the third sector in Lombardy, Italy, during a period of neoliberal welfare reform, cites feelings of loneliness and alienation as primary drivers behind the rocketing of volunteering in the region. After following a range of different actors engaged in the third sector over the period, from Catholic milieus to trade unions rooted in the traditions of the Italian left, Muehlebach makes a compelling argument as to how neoliberal governmentality creates its ethical subjects and concomitant “postwelfare morality” that paves the way to further marketization. This is achieved through the configuration of a new type of labour, that is relational labour, animated by the dependent populations of those retired and unemployed in their attempts to “purchase some sort of social belonging at a moment when their citizenship rights and duties are being reconfigured in the profoundest of ways” (ibid: 7). As such, the state redresses citizens as active and ethical, to then outsource solidarity to them as it withdraws.

Viewed in this light, the exit of MKIE from the Panhellenic Network further pushes it into the direction of the third sector paradigm. The last confirmation of this solidification of MKIE into a formal voluntary organization is the ceasing of their contentious activities. MKIE in this period did not publicize marches and strikes and neither did it participate in collective contentious events against austerity and/or its implications onto the ESY. The one instance when MKIE launched a contentious event was upon the eventual selling of the Elliniko airport. As we saw in the previous chapter, MKIE was founded by members of the anti-privatisation campaign in the

area, who decided to set up the clinic-pharmacy in the old airport's space as a means of uniting, symbolically and practically, the two struggles.

The privatization of the old airport to the large corporation Lamda Development for the construction of a luxurious park was a prerequisite for the signing of the third memorandum, and a pending development project for twenty years. Three years after its auction, MKIE was sent an eviction notice to which it responded with a mass visibility campaign, inside Greece as well as outside of Greece, and the circulation of a statement around medical communities, activist circles, journalists and universities, including my own. The English version of the statement reads as follows;

### **“Sudden Death for Metropolitan Community Clinic at Helliniko**

We say NO and “we will not go quietly into the night....”

On 31 May 2018 Elliniko A.E. [S.A.](a quasi-governmental agency) sent us an eviction notice. The Metropolitan Community Clinic Helliniko [here Elliniko] must vacate its premises by 30 June 2018, so that Elliniko A.E. can transfer the land to its ultimate buyer.

Our eviction notice was copied to Minister of Finance, Mr. Tsakolotos, the Minister of State, Mr. Flavouraris, the Secretary General Government Coordinator Mr. Papayannakos, as well as other leading government ministers and heads of private property development.

To date no alternative solution or proposal for re-location has been offered. We're supposed to pack up and go home on 30 June. They have simply told us to close our doors and immediately stop this massive social action.

Since December of 2011 we have treated 7,366 patients and conducted 64,025 patient visits. We pioneered recycling of medicine in this country and because of medicines we have gathered, hundreds of organizations and agencies throughout Greece have asked for and received support from us. Besides our own patients, we have sent medicines and materials to community clinics [here social], public hospitals, social services and organizations serving people with disabilities, child care facilities, refugee centers, and many many more. The list is long, but all who came to us found open doors and immediate support from the volunteers at MCCH [here MKIE] and those who support us. There are thousands of those who have donated medicines, supplies or their labor both in Greece and from other nations.

Because of this, journalists from every corner of the planet have visited us, as well as university groups and groups wanting to establish something similar to our free clinic. They all want to know how we do what we do.

MCCH has supported – and make no mistake – will continue to support those individuals who need us in the spirit of solidarity and respect for our fellow human beings.

At an urgently called General Assembly of volunteers yesterday, the volunteers resolved that we would not gently give up. None of us would be able to look any of the patients in the eye if we simply accepted defeat.

We declare that we will not leave the premises and we will resist any measures taken to deny us access until a suitable alternative is found. Our first duty has been and will always be to our patients. We will not stand idly by and see the destruction of seven years of effort. We have gathered medicines and medical supplies worth hundreds of thousands of Euro. It is to be distributed to patients to insure their health, not left to be turned into rubbish.

On 14 June 2018 there will be a press conference on the operation of the clinic, and the need to continue.”



Picture 14: Snapshot from National Broadcasting Company (ERT)- Eviction for the Social Clinic from Elliniko

Interview with Dr. Vichas at National Broadcasting Company [ERT].

This statement delineates MKIE’s trajectory. As already mentioned, the clinic was set up in the space of the part (old airport) to reinforce the campaign against its privatisation. In the end, however, all MKIE’s powers were to concentrate upon the survival of the clinic, even if this dictated its relocation by public authorities. The continuation of MKIE’s operations, thus, became prioritized even to those of its last ally. What is more, the state is portrayed as obligated to intervene in the eviction of the clinic-pharmacy, and as the airport had already been sold, the state needs to find another place to host it. According to MKIE, the state bears this responsibility due to its contribution over the past seven years, a contribution to the health and care of thousands of people that amounted to a “massive social action”. MKIE’s tendency to

appeal for legitimacy is also made apparent in its citation of the help it has delivered to formal organisations caring for vulnerable groups.

Once again, the clinic-pharmacy posed as the founder of healthcare DSAs and a social innovator in the domain of health and care, which is why the state should be incentivised to preserve its operations. If not, “hundreds of thousands of Euro” worth of pharmaceuticals and medical supplies are going to be “left to be turned into trash”. I argue that this routinization and naturalization of the operations of MKIE reinforce its organizational path-dependency mentioned above. The more pharmaceuticals they collect, the more patients they treat, the greater this social action becomes. This is the only justification for the continuation of their operations.

All the above culminate in a particular amalgam of characteristics defining MKIE’s trajectory. On the one hand, and in line with early movement institutionalization literature, MKIE does seem to become a rigid organisation, following the “iron law of oligarchy” (Seippel, 2001; Michels, 1991). This, however, is not inherent in MKIE’s organizational form. Moreover, MKIE’s routinization and bureaucratization following institutionalisation is not due to its organizational incompatibility with the state, nor due to the latter’s coopting tendencies and powers. Rather, what we see here is a more dialogical picture of MKIE’s distinct trajectory, itself product of a series of interactions between the clinic and the movement, the coalition and, especially, SYRIZA, formal organisations as well as tensions and splits between its very members. In addition, MKIE’s involvement in the reform effort to reject it altogether, advances the clinic’s survival as an ultimate strategic goal foreclosing any possibilities or aspirations of larger change. This pushes considerations concerning its operations, cooperations and role as subsidiary and secondary.

MKIE’s trajectory is, thus, moving towards bureaucratization and de-radicalisation and serves as a potent example of the unintended spilling of contentious DSAs into the expansion of the third sector in healthcare. We already see, then, the differential outcomes of institutionalization onto the different clinics-pharmacies discussed here. Interestingly, KIFA shares some characteristics and tendencies with MKIE in this period, although for different reasons and to distinct outcomes.

### **7.9. KIFA: reformist trajectory**

KIFA’s trajectory is particularly interesting due to its close connections to SYRIZA. More specifically, the clinic-pharmacy’s decision to continue its operations is a lens to analyse those

ongoing contradictions and unresolved dilemmas between the solidarity movement, Solidarity4All and SYRIZA already made apparent in the previous period. Dimitris Parthenis, a medical doctor, member of KIFA and SYRIZA's Healthcare Secretariat spoke of these interactions and their outcomes on the field of formal politics and collective action in an article published by the SYRIZA-affiliated newspaper Avgi. Indicatively, he argued that;

“The contribution of the solidarity movement in the emancipation of broader social forces from the traditional ‘political traps’ (New Democracy- PASOK) is evident as it is undeniable. [...] However, the reality of a left-wing government has startled many, causing a certain political awkwardness [for the social clinics]. Some, not understanding the concept of movement autonomy, are searching for the slightest opportunity to stand in opposition [to SYRIZA]. [...] They continuously and invariably demand that solidarity should claim everything, here and now: pay rises, new positions for doctors and nurses, improvement of infrastructure and equipment, acquisition of reagents, pipettes, and so on, the list goes on forever. Some others still, are weary that their discourse might appear oppositional <sup>50</sup>.”

The tension described by Parthenis here was nothing short of the product of the established affinities between the movement and the government. It is a tension that became apparent over the course of my fieldwork and extended beyond the clinics-pharmacies. KIFA was probably the social clinic that intervened the most in the reform effort with a number of its activists -medical professionals or not- involved therein. They since saw the Healthcare Reform as the successful outcome of their mobilization and the targeted proposals for healthcare deriving from their experiences. However, as activist Lena told me, KIFA as well as other social clinics, decided not to sign the reform proposal, as and “even though they [Ministry of Health] included everything we were asking for, those without papers were left outside.” Having said that, Lena urged to reassure me that Health Minister Xanthos promised this to be the coalition's next priority.

Lena's points deserve greater scrutiny, as they are of theoretical and analytical importance. First, the abstinence of KIFA from signing the proposal appears as curious, due to both its relations to SYRIZA as well as its interpretation of the reform as an achievement on its behalf. This poses definitional questions to the concept of institutionalization as at once a process and an outcome. KIFA was actively and intensely involved in the reform effort, which resulted in two laws that saw to the (at least partial) vindication of their demands, to be implemented by Andreas Xanthos, which members of KIFA saw as one of their own.

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<sup>50</sup> I Avgi. 20/11/15. Parthenis, D. The political movement of solidarity. [in Greek]. «Το πολιτικό κίνημα αλληλεγγύης».

The interpretation of the Reform as being “in the right direction” and, indeed, a product of their collective efforts, results from KIFA’s commitment to SYRIZA enabling its direct instrumentalisation by the party and ultimately affecting its institutionalisation. As such, I would argue that KIA’s refusal to sign the proposal was exactly due to its trust in SYRIZA. In line with Solidarity4All then, KIFA saw itself as the party’s social movement counterpart, responsible of pushing it forward and ensuring the realization of the reform, in good faith. Viewed in this light, KIFA’s refusal to sign the proposal was a strategic decision, aiming to advocate for undocumented migrants’ inclusion in the law for admissions. This strategic orientation was in line with the clinic’s appreciation of and optimism over the Healthcare Reform and contingent on the promise of their comrade, Minister of Health Xanthos, to soon lift restrictions for this population group.

In attributing the reform in admissions to the coordinated efforts between the social clinics and SYRIZA, Dr. Vaso Vasiliou appeared even more enthusiastic about it;

“[SYRIZA] proved it was possible. It made it. It just made it. It was no miracle, but I think that the social clinics were very helpful, especially those that were in urban centers, where people were more politicized. They had developed the experience to collect grievances and the confidence to propose suggestions on how to reform the system of admissions. And of course, the Minister is also a doctor, he knew, he was also [involved] in a social clinic before. But it’s obvious, they satisfied most of what we envisioned. And it was impressive, [they did it] as soon as they could. Nothing, we solved our problem. Our problem is solved”.

Vasiliou’s comment further illustrates the clinics’ optimism regarding the (intentions of the) coalition. My interlocutor Hara Matsouka presented in the previous chapter was personally invited by the Ministry of Health to present and propagate SYRIZA’s agenda for healthcare to other policy advisors, social clinics as well as international audiences. In our interview in 2019, Matsouka argued that the reform was rectifying the existing infrastructural problems of the ESY, as pointed out by the social clinics. She also exclaimed that this effort would not had been possible had it not been for the clinics’ stirring of the healthcare arena and its stakes. Matsouka drew a direct link between the clinics-pharmacies and the Healthcare Reform. She argued that the former helped overcome decades of resistance in improving the ESY in a more comprehensive and equitable direction. Matsouka takes us back to the discussion in Chapter Five. In her words;

“There is connection to be pointed out [between the clinics and the Reform]. Greece in this regard acted in a very innovative way, you probably know this already, but I don’t think that many

countries established social clinics as a response to the economic crisis. This was mostly because we did not have PC, until now people were buying healthcare services by specialized doctors on their own. [...] In Greece, we always had a powerful doctors' lobby that held strong and prevented its establishment. [...] The first time this was attempted was under [Health Minister] Doxiades, in the Karamanlis government [of New Democracy], straight after the junta, which failed as you know, and drove Doxiades out of office. Then there was another attempt under Andreas Papandreou [PASOK], in the very beginning where they decided to prioritise funding for clinics and health centers but soon changed their minds and turned to the hospitals. [...] I think that the first serious attempt is now, [the one] of Andreas Xanthos. And he's doing it right [...] All these things were first done by the social clinics, because there was the need, there was a gap there to be covered... a gap that did not exist in other countries.'

Despite their celebration of the two interrelated laws on healthcare, KIFA remained open and active in the field of healthcare DSAs. This seeming paradox can be explained through the tensions outlined above. In an internal document drafted by Hara Matsouka -who left KIFA upon the reform in admissions but still endorsed the continuation of its activities- she outlined the role of Social Clinics-Pharmacies in anticipation of the Reform. The document reads as follows;

“The role of Social Clinics-Pharmacies under the SYRIZA government and the efforts towards restructuring the Public Healthcare System [in the direction of] universal access, is definitely altered but we are sadly far from ceasing to exist. Unfortunately, the malaises of the public healthcare system are so pronounced that it will take years to overturn its dysfunctions, [while] the economic situation and the memorandum commitments add to the delay in the application of our policies in Health.”

At this point, it becomes apparent that KIFA conflates the historical weaknesses of the ESY that SYRIZA was to correct, not least with the help of the clinics, with the recession and the commitments of the third MoU signed by the coalition. In equating all the three factors to justify the delay in the implementation of “their” shared reforms, SYRIZA’s economic policy and its impact on healthcare become explicitly depoliticised, uncontested and taken for granted.

The document went to further explain this new role of the clinics-pharmacies under the coalition. According to Matsouka, and many people involved in both the clinics and the Reform effort, social clinics should serve as an “educational-preparatory space”. This meant that their role was to introduce the culture of Primary Care to patients and mediate information between ESY and its constituencies while reform is underway. We understand, therefore, that although KIFA retains its logic of non-substitution with regards to the ESY, it is now allowing for its

direct instrumentalisation by the Ministry of Health and opts for its absorption by the ToMYs. More specifically, Matsouka explained;

“Which can be the contribution of the Social Clinics-Pharmacies today?

They continue overseeing patients not covered by Law 4368 (migrants with no legal documents, and those vulnerable categories not covered by the Law).

They inform incomers over the rights offered by the Law. It would be good to produce a document in Greek and translated in other languages. Recently, comrade Alexandra [...] of the Patissia Solidarity Pharmacy, forwarded a good document concerning patients’ rights after Law 4368 to the group. [...]

The new role of Social Clinics-Pharmacies as par excellence primary clinics can be the education of patient populations over the regulations of the new Primary Care system, emphasising prevention. For example:

Screening tests: how often and which diagnostic tests are needed, with the assistance of printed instructions that we will devise centrally.

Recording of population groups that have limited access to screening tests [...] and their systematised promotion.

Maintenance of our database to be integrated into the formal system.

Guidelines for prevention- health promotion: accident prevention, driving behaviour, dietary suggestions.

Mobile dentist team: Dental care in the country is overwhelmingly private. The ESY as much as the National Primary Care Network [PEDY] has very little infrastructure to cover for their respective populations.”

Albeit opposite to MKIE in its interpretation of the reform and support of the coalition, KIFA too feeds into the development of the third sector as it not only allowed for its instrumentalisation by the coalition while reform was underway, but it also helped justified its delay. Instrumentalisation in this period was a strategy to intervene in what KIFA considered to be a transitory period for both the coalition and the Reform, both KIFA’s main strategic goals in the previous period. This period of transition, however, was understood as being impinged by the economic and political pressures that SYRIZA was facing, pressures that dictated the patience and understanding on the side of its constituencies.

Another line of healthcare DSA work done by KIFA not mentioned in the document above was its heightened emphasis on pharmaceutical distribution. In line with their original strategy, KIFA reduced the number of its volunteer doctors and specialists and redirected people back to the ESY. In so doing, it also intervened in public institutions, including hospitals, to press for a faster and wider update of patients and administrative staff on the new admission criteria. It retained a small network of specialists to attend the health needs of those still uncovered by the public healthcare system. In a Press Release produced by KIFA in 13/05/2017, they suggested that;

“The total number of incoming patients for medical care at KIFA is smaller, due to the direct and free access to the public healthcare units for all those in possession of a Fiscal Code or Residence Permit. More people have been notified recently [of the change in the system of admissions] than in the previous months. It should also be noted that the PEDY and the hospitals have by now been more responsive to the needs of the patients. However, we are noticing a **growing need for pharmaceuticals** due to the closure of NGO’s pharmacies in Athens that in the previous period covered for some needs, and the irregular functioning of the Municipal pharmacy. [my translation; emphasis in the original]”

The question of pharmaceuticals and their intensified distribution, notably from 2,611 in 2014 to 4,044 in 2016, was explained to me with regards to two things. Activists at KIFA acknowledged the pending pharmaceutical reform as yet another critical priority of SYRIZA. This, however, is approached empathetically, as pharmaceutical reform, unlike the reform in the system of admissions, is inherently complicated and escapes the strict purview of the state, to include corporations and supranational regulatory agencies. It was for this reason that DSAs in the direction of pharmaceutical collection and distribution was framed as escaping the realm of the political to that of necessity, at least for the foreseeable future.

The other explanation was the expansion of KIFA’s beneficiaries, to include prisons, the KEELPNO and established NGOs intervening in refugee camps, detention centres and hot spots. This expansion did not occur naturally, however. Although going unacknowledged, it corresponded to the blurring of those boundaries previously upheld between the social clinics and formal civil society actors. The activists I interviewed recounted a number of occasions where tensions arose between KIFA and its institutional beneficiaries –mostly due to the paternalism exhibited by the latter. The overall cooperation, however, went largely unproblematised. This shift in KIFA’s approach to institutional actors stems from KIFA’s renewed understanding of itself as an ally of the government, and further reinforces the

unintended yet increasing formalisation and institutionalisation of those tactics of mediation and intervention employed by the clinics-pharmacies.

These two points can also explain the curtailment of KIFA's contentious activities, which had effectively ceased by the time of my fieldwork. The sum of these transformations constitute a trajectory of a clinic-pharmacy that assists its party-ally through tactics of mediation until the successful completion of the Reform. To be sure, this trajectory can be analysed as another instance of ethical subjectivation which involves the strategic cooperation of both the movement initiative and the state. I argue that an analysis of KIFA's trajectory following movement institutionalisation can advance our understanding of the transformative dynamics involved in the process, as it compels us to think beyond co-optation arguments found in the relevant literature.

In so doing, KIFA's trajectory can also be used as a lens to understand the unintended strengthening of the third sector by a social movement milieu. I would argue that albeit their marked differences, MKIE and KIFA are the two clinics that converge in the depoliticisation of healthcare DSAs and, thus, in the transmutation of social movement energies into institutionalised efforts to mediate the retrenchment of the welfare and healthcare systems. Institutionalisation in this context works as a catalyst to KIFA's strategic decision to allow its instrumentalisation by SYRIZA by means of mediation between the coalition and patients' constituencies while Reform is under way. Viewed in this light, both institutionalisation and the resultant transition of KIFA into a formal civil society organisation constitute strategic decisions of both KIFA and SYRIZA.

To help showcase the strategic capacities afforded to both players, I juxtapose KIFA's dilemmas that informed its strategic orientation in this period to those shared among the *Llaret* health group in Santiago, Chile, as presented in Julia Paley's (2001) book "Marketing Democracy: Power and Social Movements in Post-Dictatorship Chile". In her book, Paley follows the community health group during the military junta of Augusto Pinochet to put forward the "paradox of participation" it faced over the course of the neoliberal democratisation in the early 1990s.

The author paints a vivid picture of the ways in which periods of transition and collective expectations attached to them can act as catalysts in the transformation of contentious collective action into collective efforts to institutionalise and assert the third sector paradigm. More specifically, Paley shows how the democratically elected government attempted to involve (militant) grassroots groups in the delivery of healthcare and welfare services, as a means of

advancing both “citizen participation” in symbolic terms, and the coverage of social and health needs, in concrete terms. She points out that;

“[g]roups that had been created for survival and amidst the poverty generated by neoliberalism and organisations that had been networked in a struggle against the dictatorship could become permanent vehicles for delivering social services at a time when the state could do “so much” because of limited public resources. In the post-dictatorship and postwelfare period, local organisations would provide services that a downsized welfare state could no longer afford (ibid: 169)”.

Notwithstanding the obvious limitations of a comparison between the two cases, I would argue that Paley’s analysis can bring some insights onto the relational dynamics and unintended outcomes of movement institutionalisation. More precisely, I argue that what advances as central from the comparison between the two cases is each group’s framing of and relationship to each respective government. The Llaretà health group was sceptical about the intentions of the post-dictatorship government and as such faced the dilemma to intervene with healthcare DSAs to mediate health needs with reservations. More specifically, the state’s attempts to involve the group in the delivery of healthcare DSAs was understood as a strategy to grant legitimacy to the democratic façade of the new government while assisting the neoliberal restructuring of the welfare and healthcare systems by outsourcing them to citizens. As a result of this, the Llaretà health group was mindful of the risks inherent in their instrumentalisation by the government and dedicated itself to its resistance in the new period. This strategy of resistance to the co-opting tendencies of the state involved a combination of healthcare DSAs with contentious tactics, as “action needed to be directed not only toward daily survival but also toward keeping social organisations autonomous and independent and toward pressuring the state to meet social demands (ibid: 170)”.

KIFA, on the other hand was sympathetic to the coalition, saw SYRIZA as an ally, and by extension, interpreted the Healthcare Reform as the product of the coordinated efforts between them. For this reason, the strategic decision to continue their operations was aiming at assisting both the implementation of the Reform as well as the government, seen as the only actor that could and would bring it forward. As such, opposition is a priori excluded, and KIFA rationalises SYRIZA’s delays and budgetary limitations not only as logical and natural, but as necessitating its cooperation in overcoming. The sum of these considerations informed KIFA’s decisions (1) to continue with its tactics of intervention, (2) to extend its cooperations to formal civil society

actors, (3) to assume responsibility in training and educating citizens about the new laws and (4) to advance the new culture that Primary Care reform would introduce in the country.

### **7.10. SSH: prefigurative trajectory**

As we already saw in the previous chapter, the Social Space for Health, hosted in the old PIKPA occupation in Petralona had maintained its distance from the Panhellenic Network and was prompt to warn the clinics involved of the dangers of co-optation implied in the interaction with state authorities. Instead, the SSH kept its distance, and in line with its original strategic framework, never mobilised towards making claims to the government and/or the Health Ministry. We understand, therefore, that the SSH was not involved- if at all interested- in the Healthcare Reform. If anything, the Reform and participation of the social clinics therein, confirmed their suspicions over the instrumentalising tendencies implied in the state's involvement with "horizontal struggles".

Their perceived irreconcilability between the state and movements is further highlighted by the lack of any relevant documents discussing SYRIZA's coming to power and/ or the Healthcare Reform. If anything, SSH refrained from targeting the coalition. In all its documents "the government" is treated as this and any other government, affirming the essential conformity of all parties involved in the state apparatus. To this end, SSH in this period solidified its profile as an experiment with self-organisation in health, to then extend to other social realms. It was for this reason that the reform went unacknowledged and its interventions were unaffected by its advent.

What the SSH did in this period was extend its networking with other collectives and/or clinics operating by the principle of "true self-organisation", belonging to anarchist and/or autonomist milieus. This was mostly achieved through their collaborations with either self-organised clinics across the country, or with the coordination of anti-fascist and anti-racist demonstrations in their own neighbourhood.

Through material published on its Blogspot, SSH appears to have maintained its interventions as those were taking place prior to the election of the SYRIZA-ANEL coalition, with primary healthcare provision, pharmaceuticals and the organisation of a series of talks and debates that reflected upon their experiences with self-organisation in healthcare. In addition, they continued with self-help seminars and educational talks aiming at the emancipation of people from medical expertise and the acquisition of their health(care) "into their own hands".

## ΕΡΓΑΣΤΗΡΙ ΑΥΤΟΜΟΡΦΩΣΗΣ ΠΡΩΤΕΣ ΒΟΗΘΕΙΕΣ

Self-educational Worksop: First Aid



Στα πλαίσια της αυτοργάνωσης και της διάχυσης της γνώσης, οργανώνουμε ένα εργαστήριο - παρουσίαση κάποιων χρήσιμων τεχνικών που πρέπει να γνωρίζουμε προκειμένου να παράσχουμε τις πρώτες βοήθειες σε έκτακτες περιπτώσεις, όπως την φροντίδα ενός τραύματος, το φιλί της ζωής, κ.ά.

In the context of self-organisation and knowledge diffusion, we organise a workshop- presentation of some useful techniques that we should know in order to provide First Aid in emergency situations, such as caring for a wound, giving the kiss of life etc. [...]

ΠΑΡΑΣΚΕΥΗ 14 ΔΕΚΕΜΒΡΗ 2018 στις 7 μ.μ., στην κατάληψη του πρώην ΠΙΚΠΑ στα Άνω Πετράλωνα (Τιμοδήμου και Αντωνιάδου, στο συνοικισμό του Ασύρματου)

**Κοινωνικός Χώρος για την Υγεία**

εγχείρημα της λαϊκής συνέλευσης Πετραλώνων-Θησείου-Κουκακίου

Social Space for Health initiative of the popular assembly of Petralona- Thissio- Koukaki

Picture 15: SSH First Aid poster

Over the period of the coalition discussed here, the SSH publicised two main interventions. The first was a public appeal made in defence of occupations facing eviction during this period. In their call, made in 2017, they accused the “state mechanism” of trying to uproot occupations that constituted means of struggle and attempts for self-organisation. The document charted their terrain of struggle and resistance *vis-à-vis* the undifferentiated entities of the state, the government and the police. In this way, they outlined their interventions as follows;

“As a Social Space for Health we have chosen to host our collective desires and organise the ways in which we can take our lives and health into our own hands in practice in the space of the Occupation of the old ΠΙΚΠΑ. Through this choice of ours we conceive occupations as the living cells of the struggle, as cells of a culture that attacks the organised world of everyday boredom and indifference. In a time when individualism is expanding, and an ever greater segment of the population is led to resignation, while migrants are being restricted in closed units and excluded, we understand that such initiatives are bothersome. As we have mentioned in earlier attempts of repression from another government “in reality what is being attempted is not the evacuation of occupied buildings (for the purposes of their supposed repurposing) but more so to strike the threatening, for powerholders, bolstering of those efforts for self-organisation that are surfacing ever more pluralistically in the last years”.

This was a particularly telling instance of differentiation of the SSH from the rest of the clinics presented and discussed in this thesis. The SSH did not differentiate between the government, the state and the elites, and neither between different governments. In this way, it avoided the “awkwardness” inherent in left-wing governmentality, as expressed by Dr. Parthenis above. It remained consistent with its strategy in prefiguring an alternative mode of social organisation.

What is more, a few months later the SSH organised an anti-fascist demonstration in Petralona, after the “failed attack against the occupation by a gang of fifty neo-Nazis”. The attack that took place during an assembly resulted in the injury of one of SSH’s members and the subsequent “chasing out of the neo-Nazis” by the participants and neighbours. The report also pointed to the adversarial role of the police, as it not only secured the fleeing of the perpetrators, but also arrested six locals.

The SSH called a local protest in response to the attack where it did not fail to remind neighbours of their interventions. Those were summarised as follows;

“The Social Space for Health is now completing nine years of interventions in the occupied old PIKPA, nine years of interactions, meetings and vivid discussions. In this period, about two thousand people have visited our clinic. We have done hundreds of discussions, events, lessons, updates, assemblies and film-screenings. We have been visited by patients whom we welcomed as equals, and tried to explain to them that any illness can oftentimes have social roots, as it is directly related to what we eat, what we breathe, how long and if we are working, on how toxic our relationship to our family and our circles might be <sup>51</sup>”.

In line with its initial strategy, SSH insists that “[t]he only licencing that self-organised projects require is the sense of responsibility of the people who build them and grant them their social legitimacy”. This becomes apparent in their second intervention prompted by the lived experience of one of the members of the Popular Assembly of Petralona- Thissio- Koukaki. More specifically, the incident pertained to the grave mistreatment of an impoverished patient, i.e. fiscally declared as “most deprived” and eligible for free hospitalisation, rehabilitation and provision of necessary medical equipment. On this occasion, the SSH launched a harsh critique against the public healthcare system that further highlighted its perception of the state and its role in the provision of healthcare. The member of the assembly produced a letter appealing for

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<sup>51</sup> Social Space for Health. (28/06/2018). Salute! (In the time of the beast)- Call to antifascist rally. [in Greek]. Την υγεία μας να χουμε (στον καιρό του κτήνους) – Κάλεσμα στην αντιφασιστική συγκέντρωση.

support which was later published by SSH in its call to a demonstration. The letter reads as follows;

“The mishandling of this particular incident by the public services does not strike us as new. We do notice, however, [...] the state’s abandonment, if not its aggression, especially towards those populations that are deemed unproductive. In this moment, the intension for the extermination of these people on the side of the public services becomes apparent. The abandonment and mocking of these people, apart from going against any feeling of social responsibility, a responsibility that the state “takes on” in its own terms-laws through which it exercises its authority, by claiming to commit to the constitution and cater to its basic commitments to respect and protect human life and dignity <sup>52</sup>”.

The Assembly, together with the SSH then called for an intervention in the National Rehabilitation Centre. The intervention started with a protest to later turn into a discussion between the protesters and members of the Centre’s personnel and management. This was the first instance of mediation tactics on the side of SSH. In a relevant report, the SSH claimed to having received no explanation by the Centre concerning the difficulties for admission and grave delays in the provision of necessary equipment for the patient. Instead, the management is said to accuse the Ministry of Health for underfunding while, and at the same time, virtually inflating its budget. The resolution for future action on the side of the SSH was the continuation of the discussions with the employees and patients of the Centre in order to better comprehend and expose the inner workings of the institution and, by extension, those of the Health Ministry. The SSH invited people to its weekly assembly to deliberate and organise a more targeted intervention in both the Centre and the Ministry of Health.

This mediation, pursued through contentious tactics, in the Rehabilitation Centre and the Ministry of Health not only helped speed up the admission and treatment of this patient; it also marked a tactical innovation and strategic re-orientation, even if partial, on the side of the SSH. This corresponded to the group’s investment in a more local, neighbourhood profile of close relationships, strong solidarities and affects. Instead of expecting people within its space, then, the SSH went on to secure patients’ quick admission to emergency care, as well as to investigate the workings of these public healthcare institutions that, until now, were deemed as too predictable, monolithic and inelastic by virtue of their affiliation to the state.

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<sup>52</sup> Social Space for Health. (22/06/2019). Call for intervention in disability rehabilitation center. Κάλεισμα για παρέμβαση στο κέντρο αποκατάστασης αναπήρων.

Last, it is interesting to note here that the SSH made no comments on the other clinics-pharmacies over this period. This might suggest that the dissolution of the Social Clinics-Pharmacies” movement undermined them in the arena, and the SSH no longer felt its need to define and defend self-organisation as the original strategic habitus of healthcare DSAs.

### **7.11. Nea Smirni: class struggle trajectory**

The Clinic of Class Solidarity in Nea Smirni also participated in the reform effort, especially through its main spokespeople who, as we saw in the previous chapter, had long been activists in the mental health, healthcare and labour movements in the country. Similarly to KIA discussed above, the clinic expressed reservations concerning the Reform, usually in a highly articulate fashion. One such example was their understanding of the law concerning the change in the system of admissions. As Katerina Matsa told me;

“SYRIZA’s decision concerning the admission of the uninsured into the ESY played a positive role. In the sense that they now had access to the hospitals, to tests and stuff. But this was not consistent... The healthcare system could not respond to people’s immediate needs. When the social clinics started... in 2011-2012, austerity was terrifying, there was grave economic disruption... bankruptcies. All this pauperisation, the sudden pauperisation of people. So the social clinics... yes, after the reform and upon the possibility of patients getting access to the ESY, there has been a reduction in attendance but, according to me, they still have a reason to exist. They did [then] as they do [now].”

Katerina’s comment reveals the strategic orientation of the Class Clinic, which had remained largely unaffected by the reform. The clinic persisted to highlight the primacy of the ESY and stress its refusal to substitute it, and so it oriented itself to the provision of healthcare services, when those were needed, while intensifying attempts to foster alliances and solidarities with workers in the area. These tactics were understood as parts of a broader political project in the neighbourhood, where the clinic would serve as a meeting point, a point of education, politicisation and mobilisation and an entry into the Workers’ Club and/or the trade union movement. Moreover, the robust presence of psy-specialists, discussed already in the previous chapter, gave the clinic a competitive advantage in this period that most remaining clinics emphasised their mental health services. This advantage allowed the clinic to explore the politically and diagnostically fertile terrain of social alienation and the socio-economic determinants of (mental) health, and relate those to the class struggle and the need for class solidarity underlining their ideology and strategic orientation.

As Thodoros Megalooikonou told me in our latest discussion;

“Class solidarity was among our main points of departure. [...] And for this reason, there is no prospect of us closing. [...] There is not. There might not be the momentum that there was in the beginning, when we first started, but we will keep on pushing. [...] Indeed, we made the clinic during the health crisis, but this crisis has not been resolved- it’s deepening. And this is the paradox. That while the situation has gotten worse, the movement is withdrawing, instead of fighting against what is happening”.

We understand, thus, that the Class Clinics sees no dilemma in the continuation of its healthcare DSAs upon institutionalisation, movement dissolution and the closure of the cycle of contention. The “paradox” that Megalooikonou identified, then, pertains to the curtailment of contentious collective action in the face of adverse socio-economic conditions. This is not a “paradox of participation” on the part of the clinics-pharmacies, but a paradox of non-participation on the part of the working class that the clinic attempts to address and correct.

The other line of tactical continuity on the side of the class clinic was the retention of its contentious profile. According to activists therein, this loss of contentious characteristics on the side of clinics-pharmacies such as MKIE and KIFA was not a product of their institutionalisation and/or instrumentalization by SYRIZA- intentional or unintentional- but symptomatic of the routinisation of those clinics’ activities. More specifically, in our discussions, they insisted in the causal link between the impact the reform on admissions had on the attendance and functioning of those clinics and the attendance, regularity and quality of their assemblies. This decay was understood as decisive for these clinics’ depoliticization, institutionalisation and eventual instrumentalization by SYRIZA and other actors. It becomes apparent, then, that for the Class Clinic, at least, the antidote to what those clinics were experiencing over the period of the coalition and reform, was the existence of a larger political project of class emancipation guiding the employment of healthcare DSAs. The Class Clinic, therefore, saw itself as one of the few remaining clinics retaining its original strategies, tactics and organisational forms.

The strategic orientation of the Class Clinic in this period can be said to have direct affinities to their strategies over the contentious cycle, a continuation which only solidified and enhanced their tactics. The composite elements of their strategy can summarised as follows.

First, and much like KIA, it wished to foster a Health Social Movement in the country. This was regularly spoken about in their Assembly and stated in their various documents. The Health Social Movement envisioned distilled all those claims expressed and collected over the contentious cycle as its goals captured the demand for universal coverage as well as for an alternative to the predominant medical paradigm. This alternative would be configured through the introduction of the socio-economic determinants of health in guiding medical practice away from the medico-centric and pharmaceutical model of healthcare.

The Class Clinic, however, was not only propagating this need for a Health Social Movement. Already in 2016 and upon the dissolution of the Panhellenic Network, the Class Clinic attempted the regrouping of a new network made up of the radical social clinics we saw in the previous chapter. The profile of the network and logic of their cooperation and interventions can be captured in the Class Clinic's first call which was subsequently signed by a number of social clinics.

The call begun by demarcating those "Social Clinics-Pharmacies of Solidarity" that constituted a "grassroots movement response" to the destruction of the ESY by the politics of austerity through the promotion of a radically alternative paradigm in healthcare. Made shortly after the announcement of the reform in the system of admissions, the document called it a "joke, mocking any idea of health policy", "an aspirin" to the systematic destruction of healthcare caused by the government's agenda which centred around the implementation of the memoranda. The call stated that in addition to the reform, the coalition was attempting to instrumentalise and use the clinics-pharmacies by transforming the solidarity put forward by the movement into charity and voluntary unpaid labour to cover for the ever-growing insufficiencies it (re)produced in healthcare.

The newly found network stood against the "compliance of the willing" that saw to the utilisation of the clinics as supportive utensils of a collapsing healthcare system. In the same call, the network appealed to other initiatives to engage with healthcare DSAs and mobilise contention against those (health) policies that led to the extinction of broad popular strata. Summarising, the network;

"Fights against any form of privatisation and commercialisation of healthcare, which is a social good.

Fights for an alternative system that moves away from the dichotomy between illness and health and into that of people's needs and values.

Fights against the commercialisation of pharmaceuticals and the industry writ large.

Stands against any cooperation with or co-optation by the state, local authorities, the church and NGOs.

Supports all those migrants and refugees that 'fortress Europe' has detained in Greece in any way possible.

Promotes and involves itself in activities that pertain to the whole spectrum of life and wellbeing, with other collectives, self-organised initiatives, trade unions, labour and social movements.

And works towards the creation of a network of cooperation between social clinics and workers of the ESY, that fight the system from within and can grant immediate access to all those excluded<sup>53</sup>.”

This document is here used to show the strategic orientation of the Class Clinic in this period. Unfortunately, this network did not amount to forming a Health Social Movement in the country, as tensions and differences therein led to a looser collaboration than initially envisaged.

In addition, and as mentioned above, the Class Clinic opted to foster class solidarities on the neighbourhood level for explicitly political projects aiming at class emancipation. This implied the utilisation of those tactics of education and agitation for and recruitment in the class struggle rooted in the traditions of the labour movement. In addition, this political struggle for health and care would need to unite itself to the trade union movement, not be used as an alternative to it.

As a result of the weakening of the network and the aspirations for a Health Social Movement through the paradigm of the social clinics, the Class Clinic redirected its contentious energies in fostering the mental health movement in the country. This was made evident through the double memberships of the clinic's activists, which often co-authored documents and calls for the emergent mental health movement “Psy- Initiative for a pluralistic movement in mental health”.

The Primary Care reform was not extensively discussed by activists at the Class Clinic, who in our discussions admitted that they would wait to see how the new system would operate and expressed suspicion over delays in its implementation. They were unsure as to whether the

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<sup>53</sup> Leaflet for ‘Call for coordination between self-organised social clinics-pharmacies’ produced on 10/11/2016 and signed by five social clinics-pharmacies around the country.

reform would be completed and contemplated that poor planning and execution will be used as an excuse for the privatisation and/or NGOisation of the ToMYs- either by the coalition or the next government that will be voted in parliament. Such considerations were stemming from the historical experience of the “epidemic” of short-lived healthcare reforms in the country.

The Class Clinic of Nea Smirni, thus, continued along its militant trajectory through the maintenance of healthcare DSAs following institutionalisation, movement dissolution and decline. Its strategic use of healthcare DSAs was oriented towards reviving contentious collective action, in any of the realms of healthcare, mental health and the class struggle, that they had connected in the recent years. In so doing, the Class Clinic attempted the fostering of a new health movement of radical clinics, through its networking with other milieus and initiatives sharing a similar understanding of the implications of capitalism and austerity onto health, healthcare and wellbeing. Together with other movements and initiatives, the clinic worked towards establishing solidarities on the basis of class consciousness and in so doing, it articulated refined and targeted criticisms to the government, the reform as well as the ESY and the medical establishment writ large. The utilisation of healthcare DSAs in this context was largely unaffected by the reform, as it constituted an integral part of a strategy of recruitment to both the mental health and labour movements on the local, neighbourhood level.

**Table 2: Trajectories fro Healthcare DSAs 2015-2019**

	View of reform on admissions	View of PC reform	Tactics after Healthcare Reform	Strategic use of healthcare DSAs
Class Struggle Trajectory (KIA + Class Clinic)	Overall positive but critical of exclusion of migrants	Sceptical/ Critical for either deformation of PC or NGOisation of PC	Healthcare DSAs addressing working-class and local milieus  Contentious, indirect tactics	Advancement of labour movement  Advancement of social struggles  Maintenance of momentum for present and future contention  Fostering solidarities on local level
Reactionary Trajectory (MKIE)	Negative	Negative	Healthcare DSAs  Reduced specialties  Increased mental health services  Increased pharmaceutical distribution  Collaboration with formal actors	Organisational path-dependency  Survival of the clinic-pharmacy  Culture of solidarity
Reformist Trajectory (KIFA)	Positive (but critical of exclusion of migrants)	Positive	Healthcare DSAs  Reduced specialties  Increased pharmaceutical distribution  Collaboration with formal actors  Distribution of information and updates on reform	Mediation of needs until reform is complete  Education/preparation of citizens on changes in ESY  Culture of solidarity  Pressing for and overseeing reform
Prefigurative Trajectory (SSH)	N/A	N/A	Healthcare DSAs  Contentious, indirect tactics  Mediation for admission of locals in care	Prefiguring autonomy through healthcare  Experiment with self-organisation from below

## 7.12. Conclusion

This chapter has completed the longitudinal overview of healthcare DSAs, their actors and strategic alignments, analysed through the prism of the institutionalisation of the Social Clinics-Pharmacies' movement, the closure of the cycle of contention and the advent of Healthcare Reform. In this chapter I have attempted to show how the dynamics of the contentious cycle propelled a major political transformation in Greece, effectively disrupting the historically rooted bipartisanship and advancing the party of SYRIZA into the leading party of an anti-austerity and anti-memorandum coalition.

These transformations have been exhibited through the healthcare arena. In particular, the previous period was characterised by the stirring of the arena by those actors employing healthcare DSAs, and most notably, the Social Clinics-Pharmacies' movement which developed links and affinities with the emergent party of SYRIZA. In this chapter, we saw how the election of SYRIZA into government, prompted the coalition in introducing Healthcare Reform, in at least two directions that had advanced as central claims to the movement. First, the coalition extended the admission criteria for the ESY to all those in possession of a fiscal security code. After a year, SYRIZA-ANEL also announced the restructuring of the Primary Care level in the country, through the establishment of local health units, ToMYs.

The two interrelated laws were the product of long deliberations to which members of the Social Clinics-Pharmacies movement were invited as unpaid advisors to the reform effort. More specifically, the movement drafted proposals for and negotiated with the Ministry of Health, seeing to the optimisation of reform in healthcare. In addition, the coalition appointed Andreas Xanthos, an ex-activist at the Volunteer Clinic of Social Solidarity in Rethymno, Crete, introduced in Chapter Five, as Minister of Health and responsible of overseeing the completion of the Healthcare Reform.

I argue that all the above amounted to the institutionalisation of the Social Clinics-Pharmacies movement, which is here discussed as at once a process and an outcome of prolonged and strategic interactions in the healthcare arena. As I hope to have shown, movement institutionalisation was a process that was contingent on those dynamics and relationships that developed over the course of the cycle of contention. In addition, movement institutionalisation led to the dissolution of the emergent Health Social Movement in the country, without, however, halting those healthcare DSAs on the side of the individual clinics. What we observe over the course of this period is that movement institutionalisation led to the tactical convergence around and strategic divergence in the employment of healthcare DSAs between the different clinics-pharmacies discussed in this thesis.

Building on those trajectories to healthcare DSAs presented in the previous chapter, this period provides a diachronic, relational and dynamic account of each clinic-pharmacy's decision to continue to intervene with healthcare services and pharmaceuticals despite of and/or due to the Healthcare Reform. I argue that this approach advances existing perspectives on institutionalisation, through a more nuanced exposition and analysis of the different strategic uses of healthcare DSAs, the contingency of each strategy and the outcomes, both intended and unintended, of these tactics.

Namely, we see different trajectories to and fro DSAs as configured around the origins of the collective actor employing DSAs, their relationship to the state and their interpretation of the crisis, which ultimately shapes their interpretation of the Healthcare Reform. Upon institutionalisation, movement latency and dissolution, tactics of healthcare DSAs have solidified in four strategic configurations, carving distinct trajectories.

The first trajectory identified here is that of social and political struggles, that saw the strategic convergence between KIA and the Class Clinic in Nea Smirni. These two clinics applauded the Healthcare Reform, albeit reserving some considerations and criticisms, which they communicated to both the Health Ministry and their constituencies, in a highly articulate fashion. What is more, they retained their healthcare DSAs, but realigned those as a tactic to appeal to broader contentious milieus with the intention of breeding solidarities with other struggles and sustaining contentious momentum for a later moment of contention. In doing so, we see that both those clinics oriented themselves towards the labour movement and reinforced their local profile. This strategic orientation was the original approach of the Class Clinic, a relative latecomer in the employment of DSAs, but we see that it was also adopted by KIA, the first clinic created during the cycle of contention. Instead of interrupting its healthcare DSAs, KIA established its own Workers' Clinic, in this period, hosted in the occupied factory of VIO.ME. Both clinics-pharmacies in this period opted to use the frame of health and care to support local social struggles and pursue larger political projects, and, thus, utilised healthcare DSAs to appeal to broader audiences.

The second trajectory is one of organisational path-dependency as exemplified by MKIE. MKIE's relative apolitical framing of the crisis and attention to "clinical" outputs, created complications and disorientation upon movement institutionalisation. As such, and upon participating in its drafting, the clinic-pharmacy resented the Healthcare Reform, without providing, however, a coherent criticism to it. What we see, instead, is that MKIE approached the reform as a threat to its own existence, and the ESY as an antagonist to its interventions and activities. Following their logic of "best practices", MKIE continued to consider itself to be a better alternative to the public healthcare system, tried to obstruct patients' reorientation to it, and elevated its self-preservation into its main project. This was met with

criticism within its ranks, leading to the departure of many of its members and its alienation from other clinics-pharmacies and social movement milieus. These processes and their cumulative effects, propelled MKIE in the direction of its uncritical bureaucratisation, the routinisation of its activities and the hollowing-out of its direct democratic and prefigurative characteristics. As such healthcare DSAs utilised by MKIE unintentionally spilt over to the third sector, and gave life to yet another actor in the realm of healthcare provision. MKIE stood away from both the Social Clinics-Pharmacies movement and NGOs and was now competing for advantage in the healthcare arena, on the basis of its (cost) efficiency and achievements.

The third trajectory also moved in the direction of the third sector paradigm, albeit for different reasons and through different processes. To be sure, this trajectory, here seen through the example of KIFA, was one of mediation to assist the completion of the Reform. As we saw in the previous chapter, KIFA was created by SYRIZA and had since sustained close relationships and affiliations to the party. The advent of SYRIZA into government was, then, interpreted as an opportunity to affect reform in the desired direction of the movement. As such, a number of the clinics' members participated in the reform effort and, upon institutionalisation, were called upon to propagate SYRIZA's healthcare agenda. The confusion and disorientation found within MKIE's ranks was also prevalent in KIFA during this period, but it did not derive from the hostile approach to the Healthcare Reform. Rather, the tensions and contradictions faced by KIFA in this period stemmed from the unresolved and unclear role of movements under the new coalition, echoing the ambiguous strategies of Solidarity4All and SYRIZA in the previous period. Upon discussions and deliberations KIFA decided to reduce, yet retain, its healthcare DSAs to cover for those that were left outside of the ESY. In addition, it curtailed its contentious tactics and extended those tactics of mediation to assist institutional actors in the provision of pharmaceuticals, to acculturate patients to the new Primary Care level, as well as inform them about changes in the ESY. KIFA, thus, allowed its instrumentalization by the new government and in so doing it refrained from exerting criticism onto SYRIZA's healthcare agenda. In contrast to most existing accounts that see institutionalisation as leading to co-optation, KIFA's instrumentalization by SYRIZA cannot be understood as anything else but a strategic choice, informed by its perception of SYRIZA as its close ally. More precisely both KIFA and Solidarity4All saw themselves as the movement extension of the party, not least in the absence of a trade union basis. In this configuration, social movements were understood as sharing the party's goals and as pursuing them reciprocally. Their strategic interaction would, then, consist of the former prompting the latter, and the latter satisfying the claims of the former. The trajectory carved by KIFA, thus, was that of mediation between civil society and the state, with the intention of addressing pressing needs, pushing for social reforms and encouraging communication between the two. It is for this reason that KIFA

also helped shape a new third sector actor which would stand between SYRIZA and its constituencies and utilise healthcare DSAs until the Healthcare Reform would deem them unnecessary.

The last trajectory carved by the SSH was the one least affected by these political changes and transformations. The SSH did not belong to the Social Clinics-Pharmacies' movement and did not go through institutionalisation, as it did not intervene in the reform effort. As we see in this period, the SSH did not position itself with regards to the announced Healthcare Reform and neither did it ponder over its role after it. Instead, it reached out and forged a network of clinics and initiatives subscribing to its own ideology of and strategy for autonomy and self-organisation from below. Following the warnings it had warranted regarding the co-opting certainties of the state, the SSH continued to employ healthcare DSAs in the area it intervened. In doing so, it continued with its project, as outlined already before the advent of the austerity crisis and the cycle of contention, to prefigure autonomy, starting from health to then spill over to other domains of social life. Moreover, and in the absence of any affiliation to the movement of the clinics and/ or political parties, the SSH continued in drawing its legitimacy from the local milieus that it addressed. It is for this reason that in the period discussed in the chapter, the SSH decided to also employ mediation tactics to ensure its constituents' access to care. Throughout the years discussed in this thesis, the SSH continued to pursue its paradigm of an anti-hierarchical and holistic care that would serve as an example of the possibilities of self-organisation. For this reason, the institutionalisation and subsequent dissolution of the movement of the Social Clinics-Pharmacies, served as a confirmation of the impossibilities of collaboration with the state and its representatives. In this period, the SSH defended its tactics from their (mis)appropriation by other collective actors, and became convinced that the only coherent and original use of healthcare DSAs would be in the struggle for self-organisation and autonomy.

The trajectories outlined here are used to explain the various processes and outcomes entailed in the institutionalisation of a movement defined by its use of healthcare DSAs. As I hope to have shown, relational, dynamic and longitudinal account is paramount in reconstructing and understanding those different paths to and from healthcare DSAs. Viewed in this light, we can start developing more refined theories concerning institutionalisation as a strategy for both contentious collective actors and the state. In addition, we can begin to analyse institutionalisation and its layered outcomes as a series of steps that reconfigure the healthcare arena and reposition the actors and their tactics involved therein.

## 8. Concluding Remarks

### 8.1. Epilogue

This thesis began with my political and scholarly puzzlement over the development and course of the Social Clinics-Pharmacies' movement in Greece during the period of the austerity crisis in the country. More precisely, it was an attempt to understand and account for the “strange” flourishing of Direct Social Actions among informal and contentious civil society actors in healthcare which, in turn, fed into the creation and establishment of a dynamic Health Social Movement capable of involving itself in paradigmatic change in healthcare policy. Following from empirical observations and keen curiosity, this thesis also set out to analyse and explicate the “paradoxical” continuation of those tactics of intervention in healthcare and pharmaceutical provision following movement institutionalization and the announcement of Healthcare Reform. Through iterations of theory and data, I have used the case of the Social Clinics-Pharmacies' movement to advance existing scholarship in at least three directions.

First, over the course of this work I have attempted to contribute to the literature on the repertoire of (contentious) collective, through the inclusion, systematic examination and critical analysis of those tactics intending to affect immediate and direct change. As I have argued, existing scholarship on the dynamics of the repertoire has focused on sets of tactics that opt for change through mediation, either by appealing to third parties- most often than not the state- or by changing oneself and one's community.

Research conducted in either of these directions has shed light onto the dynamic, contextual and relational properties of tactics which account for repertoire transformation on the macro level, innovation and diffusion on the meso level and preservation on the micro level, during “moments of madness” as well as periods of relative acquiescence. Using the case of the Social Clinics-Pharmacies' movement, I have strived to account for these processes through the lens of DSAs which I approach as a distinct set of tactics that “focus upon directly transforming some specific aspects of society by means of the *very action itself* (Bosi and Zamponi, 2015: 367; emphasis added)”.

I have argued that those tactics have been largely overlooked in social movement studies as they are shared among a multitude of collective actors, including non-contentions, formal and institutional actors. In addition, these tactics are often understood as apolitical, opposite or even contradictory to antagonistic agendas, thus deeming them uninteresting for scholars of contentious politics. My case study has rooted those tactics to the repertoire of (anti-austerity) contention and has clarified their

potential alignment within broader strategies of contention, complemented by indirect and/or other forms of direct tactics.

What is more, through this work I have attempted to enrich the existing scholarship on DSAs, which usually focuses on welfare, through a close inspection of those tactics centring on healthcare. Notwithstanding their obvious overlaps, I have suggested that welfare DSAs are distinct from healthcare DSAs. In proposing a dynamic and relational approach to collective action, this thesis has proceeded to discuss those differences as reflective of the different arenas in which DSAs are employed. To this end, I attempted a brief presentation of and comparison between welfare and healthcare systems, albeit implicit. This was complemented by my bibliographical overview of DSA tactics in healthcare more broadly, used to induce those contours of the healthcare arena as an arena of strategic interaction.

The characteristics that advanced as most distinctive of and central to the healthcare arena were structural and institutional. More specifically, these pertained to (1) the high economic costs and (2) the political and cultural stakes implied in the arena and (3) the paternalism of the state, (4) the strong and, relative to other professional groups, autonomous role doctors and the (5) dynamic penetration of the market therein. Last, the arena is understood as structured and *structured* around a specific (6) material infrastructure and (7) an immaterial bioethical- legal nexus. As I hope to have shown, all the above shape opportunities and threats for mobilisation in the healthcare arena, they provide particular incentives for and pose limitations to the employment of healthcare DSA tactics therein.

Having sketched the contours of the healthcare arena, I proceeded with the processual exploration of the dialectic between context and agency in affecting change in the players, their tactics and the arena as a whole. Departing from the case of the Social Clinics-Pharmacies, this thesis has provided a longitudinal account of the Greek healthcare arena, its players and their tactics since the establishment of the National Healthcare System in 1983 to 2019. This was a choice that advanced as pivotal to the development of this study as well as an opportunity to embellish existing accounts on DSAs by introducing a longitudinal and dynamic dimension to their analysis.

The historical reconstruction of the arena served to highlight its institutional and structural characteristics and delineate those collective actors animating it, thus configuring it into an arena of competition for advantage. In line with the relevant bibliography, my findings pointed to the co-development of the Greek ESY and the medical profession as consequential for the arena. The interactions between the two cemented fragmentation and reinforced the convergence of multiple interests leading to path-dependency in healthcare reform. The sum of players involved in the arena over this period included medical professionals, their associations and trade unions, insurance funds

and their constituencies, bureaucrats as well as broader parts of the trade union movement that successfully united to affect and/or halt healthcare reform.

In looking at the relevant actors and their interactions, I have argued that the repertoire of the healthcare arena during the period preceding the austerity crisis and the cycle of anti-austerity contention composed mostly of indirect contentious tactics, including protests and strikes in defence of sectoral interests, that is compensations and privileges. The main actors animating the arena during this period and the tactics they used moulded the foundational stakes of the Greek healthcare arena prior to the crisis, notably crystallising them away from concerns over the quality and equity of public healthcare.

Despite the hegemony of these actors, their fragmented yet converging interests and shared tactics to pursue them, however, the arena cannot be understood as homogeneous, even during this period of relative stability. Through my close historical inspection of the arena I have identified some actors, albeit marginal, which mobilised on the basis of different grievances and claims through the development and utilisation of different tactics. As I hope to have shown, these actors were the predecessors of the clinics-pharmacies. We can begin to see, thus, that tactical departures and innovations stem from strategic decisions on the part of those actors; decisions that at once reflect different agendas and demarcate between different camps and positions in the arena.

The advent of the crisis and its effects on all levels of political, social and biological life, as well as on the healthcare system, triggered the clustering of collective actors around healthcare DSAs and within the healthcare arena. These actors, old and new, massively infiltrated the healthcare arena, thus shifting its configuration, its players, their tactics and stakes. More specifically, those players constituted on the basis of DSAs displaced previously hegemonic players, innovated the repertoire in the direction of healthcare DSAs and reoriented the arena's main stakes towards universal and comprehensive healthcare.

Building on the literature on tactical diffusion and modularisation and their effects on repertoire innovation, I have argued that the amplified appropriation of those tactics by different compound players in the national healthcare arena over the course of the contentious cycle was contingent to the context induced by the crisis and the players' strategic positioning therein. More specifically, I have linked the diffusion of these tactics to the health crisis, understood as the compound effect of the various ways in which austerity, healthcare policy and population health interacted, and the disintegration of the formal political scene in the country. In so doing, I have embedded the diffusion of those tactics within the dynamics of contention and at the heart of the cycle. What is more, I have made a case for the (partial) substitution of indirect tactical forms by DSAs which I then used to

account for the displacement of formal actors by informal, contentious actors in their enactment. I have argued that this diffusion and eventual modularisation of DSAs in the anti-austerity repertoire of contention was the result of proliferation of health and care claims related to rights' discourses that were brought (back) with the advent of anti-austerity contention. All the above led to the convergent employment of those tactics by an array of contentious actors.

The dynamic transformation of the healthcare arena over this period favoured this set of tactics over others, and affected opportunities for those actors employing them. As such, (healthcare) DSAs became modular and popular, proving to be at once an effective tactic for intervening in the growing healthcare needs of the population, as well as part of a successful strategy of mobilisation and recruitment. This tactical concurrence, in turn, augmented the dynamics of the contentious cycle, which saw the diffusion and proliferation of welfare and healthcare DSAs across actors, contentious or not, ultimately substituting direct tactics, marking the closure of the protest cycle and extending the cycle of contention in the country. In addition, and for what concerns the healthcare arena, the bolstering of those tactics across emergent actors created incentives for their strategic interactions with the intention of advancing their positions. To be sure, the assembling of contentious actors around healthcare DSAs created opportunities for cooperation for the establishment of common strategies that would prove transformational for healthcare arena.

More specifically, in this thesis I have discussed SYRIZA's turn towards the grassroots Solidarity Movement and strategic reorientation to appeal to and benefit from its members and constituencies as well as to inform its political agenda. SYRIZA created its own SMO, Solidarity4All, responsible for coordinating the movement's activities, promoting the collaboration among its various parts and aligning visions of social change propagated by the movement, with visions of parliamentary change pursued by the party. This attempt for alignment was followed by the formation of the Panhellenic Network of Social Clinics-Pharmacies, which amounted to a Health Social Movement mobilising on the basis of shared tactics in and goals for the healthcare arena. As we have seen, the movement of the Social Clinics-Pharmacies intervened with healthcare DSAs to cover for medical and pharmaceutical needs, as well as to propose and prefigure alternatives to the established practices of healthcare provision and pharmaceutical distribution. Healthcare DSAs constituted tactical priorities for the movement but were also complemented by indirect contentious tactics targeting the state and its officials, in order to make demands for the end of austerity -at least in healthcare- and for the need to reform the ESY in a more universal and complete direction.

Last, the relational, dynamic and longitudinal perspective on the healthcare arena was used to disentangle the "paradox" of the persistence of healthcare DSAs upon movement institutionalisation and the announcement of Healthcare Reform. This analysis opted to complement existing accounts on

movement institutionalisation through the proposal of a more refined and nuanced approach. Moving away from normative and unilateral accounts that see either the state or the movement as the main strategic agent affecting institutionalisation my perspective affords the benefit of strategy to the state, the movement, as well as third-party actors involved in and affecting the interaction.

As such, I have used the institutionalisation of the movement of the Social Clinics-Pharmacies as a lens to discuss institutionalisation as at once a process and an outcome of strategic interactions in the healthcare arena. More specifically, and by rooting those interactions in the context of the crisis, its effects on health and care, and the dynamics of the cycle of contention, I have attempted to provide a strategic account of the processual weaving of relations between the Social Clinics-Pharmacies movement, Solidarity4All and SYRIZA and their effects for the healthcare arena over the course of contentious cycle. In so doing, I have reconstructed trajectories to healthcare DSAs over the period of the diffusion of the paradigm carved through the different alignment of tactics within broader strategies, used to infer the orientation of healthcare DSA tactics by each of the clinics-pharmacies discussed. I have deciphered five trajectories of tactical convergence among five ideal-typical clinics-(pharmacies), four of which were members of the movement. These trajectories were configured around (1) the milieu behind each clinic(-pharmacy), (2) the diagnostic framing of the crisis and its impact on health, (3) the sum of tactics used, (4) the prognostic frames guiding action and (5) the relationship to the state, and by extension, the ESY.

Analysed as such, the formation of the Social Clinics-Pharmacies' movement advances as an instance of strategic and contingent collaboration among clinics-pharmacies that derived from a range of backgrounds but shared an understanding of austerity as detrimental for health and mobilized against it. In addition, these initiatives were aware of the limitations of their own interventions in the domain of healthcare, acknowledged the supremacy of the ESY, exhibited affective tendencies towards its preservation and employed indirect tactics to demand reform in their desired direction. The sum of these characteristics, in turn, reinforced links and relations with the emergent movement-ally of SYRIZA and the mediation of Solidarity4All therein, thus paving the way to movement institutionalisation already during the contentious cycle.

In considering movement institutionalization as a process and an outcome of strategic interaction between players in the arena, one can begin to inspect the different interactions, their strategic orientation and cumulative outcomes for the arena. As such, I have concluded that movement institutionalization was a highly contingent and consequential process that can be traced back to the cycle of contention and its transformative dynamics both in the realm of contentious action as well as formal politics. This perspective, thus, sees movement institutionalization as the consequential and processual co-development of the Social Clinics-Pharmacies' movement, SYRIZA and Solidarity4All.

The exposition of the various trajectories towards the same form of action, thus, accounts for instances of strategic cooperation between the relevant clinics-pharmacies against a dynamically shifting political environment.

In addition, the same approach serves to highlight the contingency of cooperation strategies and resist tendencies of homogenization among compound players. The differences exemplified in the various trajectories, thus, can be used to disentangle the seeming paradox of the retainment of healthcare DSAs upon movement institutionalization, explain movement dissolution and decipher strategic divergence after the announcement of Healthcare Reform. As such, the decision of each clinic-pharmacy to continue their operations can be understood as a strategic reorientation stemming from different interpretations of SYRIZA's Healthcare Reform and the reconfiguration and realignment of healthcare DSAs within larger strategies.

## **8.2. Future contributions**

### **8.2.1. Healthcare Neoliberalism, DSAs and the Third Sector**

The findings presented in this thesis would benefit from a larger comparative study with at least one more country. Indeed, one of the guiding purposes of this work was to report on and expose the adverse effect of austerity onto health, healthcare and wellbeing. The thesis puts together the effects of the crisis onto the social fabric, the political system, and people's lives. This serves as more than a background to understanding collective responses to "health system neoliberalism"; it is a testament to the detrimental impact of austerity in modern societies, and a lesson to learn for future times.

Over the course of this PhD, I entertained the idea of such a comparison, but eventually decided to focus on the case of Greece alone, if I were to make the most out of my longitudinal approach and within-case comparison. The case of Spain, however, was the first obvious example due to the similarities its shares with Greece. The two countries of the European South shared a number of developmental and institutional similarities. Coming out of dictatorships in the 1970s, Greece and Spain established bipartisan political systems, they constructed similar welfare regimes as well as converged in their "atypical" Southern Healthcare Systems configuration. As such, shifts and turns between the Health Social Insurance model and the NHS (both in terms of financing and coverage), the emergence of new actors in the political scene in the post-dictatorship period of the two countries (either in the form of parties or regions) and the presence of a strong private-public mix have been historically central to the development and evolution of the two healthcare systems (ESY and SNS).

In addition, both countries had been severely hit by the most recent economic crisis of 2008 –albeit in different ways and to different degrees and outcomes. Within this economic context, Greece and Spain saw the implementation of harsh austerity measures onto their National Health Systems that undermined their operations and quality of services, on the one hand, and intensified plans for their privatization on the other. The combination of austerity with such attacks onto the NHS sparked political contestation in both settings. Following similar trajectories of collective action in their contentious cycles, this serves to highlight the importance of public healthcare in those contexts. More specifically, both countries saw the specialization of their square occupations into sectoral mobilisations in defense of public healthcare –among others. In Spain, this formulated a distinct movement called *Marea Blancas*, the white tides that among other collective actors protesting in defense of public goods, mobilized healthcare practitioners and patients in defense of the Spanish Health System (SNS).

Similarly to Greece, Spain also saw a radical change in the system of admissions through the imposition of the Royal Decree-Law 16/2012 that saw to the exclusion of people without residence permit, precariously employed EU citizens as well as Spanish citizens living abroad. This led to the weakening of the sectoral mobilisations of the *Mareas* and their substitution with campaigns and “civil disobedience movements” such as the *Yo Si, Sanidad Universal* [Yes, Universal Healthcare] and the *Coordinadora de Hospitales y Centros de Salud* [Coordination of Hospitals and Health Centers], advocating for the reversal of the exclusionary law. Albeit refraining from using direct mediation tactics, the *Yo Si* soon realized the primacy of healthcare provision for those left outside of the National Health System and started engaging with tactics of mediation to ensure people’s admission into hospital structures. The taking over of the right-wing government of Rajoy (People’s Party) by socialist Sanchez (Spanish Workers’ Party) in 2018, also saw the invitation of *Yo Si* activists in the reform process, to revert the exclusionary law of 2012. Upon the passing of the reform (RDL 7/2018) activists soon realized that although it opened up access to some constituents who had lost it during the crisis, it nonetheless made criteria for admissions more rigid, disallowing activists to manipulate loopholes, as they once did, in order to ensure and secure admission of excluded persons. This triggered a shift in collective action tactics, to more direct tactics of legal support and advocacy (such as contesting exclusion on legal grounds) and fostered collaboration with large NGOs in the name of human rights.

In line with the findings of this thesis, then, one can observe the partial and unintentional spilling of contentious energies into energies to substitute for the collapsing healthcare, welfare and, ultimately democratic systems. These considerations also invite a comparison across arenas, and most importantly for the case of anti-austerity DSAs, the arena of welfare. Welfare DSAs have been predominant and as such have received most of scholarly attention. That is because the arena of welfare is the second largest consumer of public resources, albeit in cash benefits and pensions. A closer examination onto

those institutional characteristics of those arenas and their impact onto tactics of contention to defend and expand them would, thus, be of great analytical and political value. Finally, movements that mobilise on the basis of healthcare DSAs can be analysed, compared and contrasted with the recently discovered -at least for scholars- universe of Health Social Movements. As I have argued elsewhere (Christou, forthcoming), scholarship on Health Social Movements derives almost exclusively from the U.S. and thus approaches collective action in health and care as an instance of consumer activism. Anti-austerity healthcare DSAs give us the opportunity to examine those movements that react to the retrenchment of established, albeit feeble, public systems of healthcare provision. This should allow for more nuanced conceptualisations of those institutional characteristics affecting the tactical and strategic use of DSAs. As such, I would argue that a critical but sensitive approach to the diffusion and modularization of DSAs in the time of healthcare retrenchment and marketization, thus, is important as a future goal, as it is overdue in the present day, especially in light of the COVID-19 pandemic.

#### 8.2.2. Studying healthcare activism in health crisis setting(s)

This particular study set out to investigate healthcare activism in the (health) crisis setting of the dismantlement of the Greek National Healthcare System. Over its course, however, the global health crisis of COVID-19 enclosed and overshadowed it. I close this thesis with a brief discussion on the interactions between this research, its particular topic and the pandemic to point to the relevance of future research of healthcare DSAs.

First, on a political level, the pandemic served to lay bare the historical weaknesses of healthcare systems, most of which stemming from their internal undermining and gradual privatization. At the time of writing, we are witnessing massive shifts in the public discourse around health and care, as politicians, experts and activists all converge in declarations about the necessity of high quality health and healthcare. Activists and movements are lending health(care) frames and claims, politicians make promises concerning the expansion of the public sector onto healthcare, and sidelined organisations, such as the WHO, become radicalized and demand greater decision-making powers. Refraining from presumptions, we await for developments to see the impact of this period onto healthcare systems as well as activism around them.

As the pandemic revealed long-standing problems of health and care, however, it overshadowed the clinics-pharmacies discussed here. During the period of the lockdowns in Greece the clinics-pharmacies closed. Most of those justified this by their limited capacity to guarantee safety, although concerns of extra-legality that surfaced for the first time over this period cannot be excluded. These considerations were complimented by a severe reduction in the capacities of doctors to participate in the clinics. As in

most countries, the pandemic exposed the severe shortage of hospital doctors and personnel, implying the intensification of their work for public sector doctors and the forced requisition of private doctors in urban settings. This placed severe limitations for the operations of the clinics, as key participants were devoting their energies elsewhere.

This thesis, therefore, took place in the overlap between two major health crises- one national and one international- and it only serves to highlight the pressures placed on the healthcare system of Greece both in those moments and cumulatively. Healthcare DSA tactics in this context reach their ultimate “ceiling” as, on the one hand the human resources they are contingent upon become exhausted, and their physical presence as clinical settings becomes problematic on the basis of extra-legality and concomitant disease prevention preoccupations. In addition, one can start to explore the differences in each crisis setting- as the advent of the economic crisis fostered healthcare DSAs, while the pandemic halted them. This pertains mostly to the involvement of the state in the organisation and management of the pandemic and its decision to pool most- if not all- its resources to its service.

To be sure, health movements in this period are particularly relevant as they are important, both politically and analytically. From healthcare, to public and population health, from epidemiology to policies of prevention and health promotion, the pandemic saw the dynamic reappearance of health into the political spotlight. It triggered the dialogue between the political and scientific communities, closely watched and followed by a large share of the population that lives with the pandemic and faces the concomitant reforms, decisions and technologies meant to control and contain it.

At the same time, in this period we have also seen the development and consolidation of critiques against medical and state authority and arbitrage, against the medicalisation and the depoliticisation of the pandemic as well as criticisms to the desocialisation of public policy in the name of public health. As a response to those shifts and transformations in the public and political spheres, we notice the formation of new campaigns around health, as well as the adoption of innovative tactics on the side of existing movements and their communities, which utilise health as trope to extend their constituencies, articulate and push for their demands.

All the above developments make the study of health movements and healthcare activism more interesting than ever. More data and research on health movements in Europe along these axes could provide the basis for systematic comparison among and across cases and countries, as well as inform larger debates on social movements, medical sociology and public policy as well as the ever-pressing future of public healthcare.

## Appendix

### 1. List of clinics(-pharmacies) studied

- 1990 Chania CLOSED
- Voluntary Clinic of Social Solidarity in Rethymno
- Social Clinic-Pharmacy in Heraklion, Crete
- KIA
- MKIE
- KIFA
- N. SMIRNI KIFA
- Class Sol N. Smirni
- Clinic of Social Solidarity in Ilion
- Clinic of Solidarity in Patissia-Acharnes
- Patissia Solidarity Pharmacy
- Self-organised Social Clinic/Pharmacy in New Philadelphia, New Chalkidona, New Ionia
- SSH
- ADYE: Self-organised Health Structure in Exarchia
- Neighborhood solidarity clinic in Aghios Nektarios, Volos
- Social Clinic of Solidarity in Thermi
- Social Pharmacy/ Clinic in Vyronas
- KIFA Piraeus
- Workers' Clinic in VIO.ME (E.I. VIO.ME)
- Social Clinic-Pharmacy "Solidarity Space" in Larisa CLOSED
- KIFA Salaminas
- KIFA Patras CLOSED

## 2. List of interviews

Interviews conducted for the purposes of my MSc thesis in Medical Anthropology, UCL. (2014-2015).

- Alex. Receptionist at Social Clinic-Pharmacy. 2015.
- Antonis. Doctor at Social Clinic-Pharmacy. 2015.
- Katerina. Doctor at Social Clinic-Pharmacy. 2015.
- Kostas. Doctor at Social Clinic-Pharmacy. 2015.
- Maria. Receptionist at Social Clinic-Pharmacy. 2014.
- Marianna. Receptionist at Social Clinic-Pharmacy. 2015.
- Panagiotis. Receptionist at Social Clinic-Pharmacy. 2015.
- Thanos. Receptionist at Social Clinic-Pharmacy. 2014.
- Thomas. Receptionist at Social Clinic-Pharmacy 2015.
- Voula. Receptionist at Social Clinic-Pharmacy. 2015.
- A. Receptionist at Social Clinic-Pharmacy. 2015.
- B. Receptionist at Social Clinic-Pharmacy, 2015.

Interviews conducted for the purposes of my PhD in Sociology and Political Science, SNS. (2018-2020).

- Alexis Benos. M.D., Member of KIA, Advisor to the Ministry of Health, Professor of Primary Care, General Practice and Health Policies. 16/02/19 and 21/10/20.
- Chris Giovanopoulos. Ex-cadre of Solidarity4All, Researcher. 16/10/19.
- Dora-Dimitra Teloni. Member of Social Clinic-Pharmacy of Solidarity in Patra, Professor of Social Work. 31/10/19.
- Eleni. Member of Solidarity Pharmacy in Patissia. 08/11/18.
- Georgia. Member of Clinic of Social Solidarity in Peristeri. 14/11/18.
- Gianna. Member of Solidarity Hub in Pallini. 12/11/18.
- Kostas Veniotis. Member of Solidarity4All Organising Committee. 16/10/18.
- Hara Matsouka. M.D. Ex-member of KIFA, Advisor to the Ministry of Health, President of the National Center for Blood Donation. 15/02/19
- Hobo. M.D., Member of Saleu Bellum, Syndicalist in Autonomous Doctors' Union. 30/11/18 and 02/02/19
- Katerina Matsa. M.D. Member of Clinic Pharmacy of Class Solidarity in Nea Smirni, Member of Class Clinic of Ilion, Member of Psy-Initiative for Mental Health Reform. 07/01/19.
- Konstantinos. M.D. Syndicalist, 21/06/19.
- Lena. Member of KIFA. 22/11/18.
- Manolis. M.D. Member of Social Clinic-Pharmacy of Solidarity in Chania. 05/11/20.
- Maria. Member of Social Clinic of Solidarity in Chalandri. 15/03/19.
- Meri. Member of Solidarity Pharmacy in Patissia. 08/11/18.
- Nikos Giannopoulos. Member of Solidarity4All, Ex-syndicalist in Aghia Sofia Hospital. 10/02/19.

- Nikos. Activist in anarchist/autonomia milieu. 26/01/19.
- Orestis. M.D. Activist. 28/01/19.
- Penelope. Member of Nea Smirni Workers' Club. 28/11/18.
- Petros. Member of MKIE. 21/03/20.
- Rea. Member of MKIE. 06/02/19.
- Samy. Activist, Social movement expert. 16/05/21.
- Tatiana. Member of MKIE. 30/01/19.
- Thanos. Member of MKIE. 29/01/19.
- Thodoris Megalooikonomou. M.D. Class Clinic of Ilion, Psy-Initiative for Mental Health Reform. 01/11/19.
- Vasiliki. Member of MKIE. 29/01/19
- Vaso Vasiliou. M.D. Member of KIFA. 5/12/18 and 11/12/18.
- Vicky. Ex-member of MKIE. 03/02/19.
- C: Member of militant antifascist group in Piraeus. 03/03/19.

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