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From Tactical Differentiation to Tactical Convergence. Trajectories of Healthcare Direct Social Actions and Their Impact in the Greek Healthcare Arena: 1983-2015

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Abstract. This paper traces the emergence, politicisation and spread of healthcare provision tactics by (contentious) collective actors in Greece between 1990 and 2015. Drawing on participant observation, in-depth interviews with relevant field actors (N=40), and documentary analysis, the paper develops a diachronic typology that analyses and compares; (1) the appearance of those tactics in the Greek context in the 1990s, (2) their appropriation by contentious actors after the December 2008 riots, and (3) their diffusion, and eventual modularisation over the course of the 2010 crisis and the cycle of anti-austerity contention. In so doing, the paper helps disentangle the dynamics of repertoire innovation through an understudied set of tactics. This is achieved through the reconstruction of the genealogy of healthcare Direct Social Actions (DSAs) – pace Bosi and Zamponi (2015) – in Greece, their transmutation from "consenting" to contentious tactics after 2008, and their wide diffusion among contentious milieus after 2010. In addition, the paper discusses the interplay between the contextual and strategic dimensions of those tactical preferences across actors and across time. To be sure, early utilisation of those tactics on the side of marginal players can be understood as attempts to tactically differentiate themselves vis-à-vis those traditional and hegemonic players in the arena who relied on indirect, protest tactics. The crisis, however, disturbed the seeming equilibrium of the healthcare arena thus prompting tactical convergence around healthcare DSAs among contentious actors, on the one hand, while reinforcing strategic convergence among some actors and strategic divergence among others.

Keywords: politicisation, healthcare, actors, tactics.

1. INTRODUCTION

On June 2015, the European Parliament (EP) honoured 47 people across the European Union with the European Citizen's award. Among them were two people from Greece, Dr. Giorgos Vichas from the "Metropolitan Community Clinic of Hellenikon" and Kostas Polichronopoulos from the soup kitchen "The other human", both selected for their exemplary social contribution in the country.

During the award ceremony, the EP vice-president and Citizens' Prize jury president Sylvie Guillaume highlighted that

> *The European Citizen's Prize 2015 jury has honoured the efforts of citizens to provide healthcare for the poorest, food aid, rescue, solidarity, education, the fight against radicalisation and the protection of LGBTI rights [...] European citizens whose daily work is essential to the social cohesion of our countries and I am glad that the Parliament could honour them (European Parliament 2015).*

However, neither of the two accepted the prize. Instead, they used the occasion to exert criticism towards Europe and its institutions. In the words of Dr. Vichas;

> *the austerity policies implemented and imposed in Greece are the result of pressure and blackmails by the IMF, the ECB and the EU. These policies have led more than 3 million impoverished and jobless citizens outside the health care system. […] This Europe, which wants to reward us, does not seem to be bothered by all these data, neither by the thousands of deaths of unsecured fellow citizens. […] It would be hypocritical for us to receive a Prize when Europe closes its eyes to malnourished infants and dead cancer patients, to mothers telling they have to live their families without electricity and water and minimal amount of food (Keep Talking Greece 2015).*

Dr. Vichas' refusal was a collective decision, taken on the side of the broader Social Clinics-Pharmacies movement that emerged in Greece over the course of the most recent cycle of anti-austerity contention in 2010. The movement was a massive instance of self-organisation and a remarkable social action that provided (primary) healthcare services and/ or pharmaceuticals for free to anyone in need.

In the context of the crisis, over 90 such clinics-pharmacies sprang up across the country (Adam and Teloni 2015; Cabot 2016; Evlampidou and Kogevinas 2019). The majority of them formed the Social Clinics-Pharmacies movement, and shared common tactics, goals and principles. More specifically, the clinics-pharmacies combined direct tactics of healthcare and/or pharmaceutical provision with indirect protest tactics against the austerity regime. The movement demanded that the clinics-pharmacies become obsolete through progressive healthcare reform and public investment in the National Healthcare System (NHS).

In this paper I provide a genealogy of those tactics of healthcare and/or pharmaceutical provision in Greece, to unearth their origins, continuities, discontinuities and strategic appropriation by different actors over time. I argue that although initially conceived by marginal actors and used as a strategy for differentiation and distancing from the hegemonic and predominant actors in the Greek healthcare arena, these tactics became diffused and modular over the course of the anti-austerity contentious cycle. I investigate these shifts as an instance of repertoire innovation which can be explained on the basis of 1) the increased demand for healthcare services during the crisis years, 2) the politicisation of the healthcare arena, and 3) the introduction of new and emergent actors therein.

Building on social movement scholarship, this paper opts to bring insights onto this largely overlooked set of tactics by providing a longitudinal perspective to their employment. In addition, it opts to complement existing accounts of these tactics through a specific and clear focus on those tactics of healthcare (and pharmaceutical) provision by contentious actors. As I hope to show, the healthcare arena exhibits some idiosyncrasies and is markedly distinct to the one of welfare. Studying contentious action therein, thus, can shed some light as to the particular dynamics of the arena as an arena of political contestation.

2. TACTICS, STRATEGY AND DIRECT SOCIAL ACTIONS IN HEALTHCARE

Tilly's (1986) elaboration of the repertoire of contention has been foundational to the study of social movements. Capturing the relationship between what people *do*, what they *know* to do and what society *expects* them to do, the repertoire is a relatively hard convention made up of tools at the disposal of contesters to make claims. These tools, their appropriateness and effectiveness are structured and *strictured* 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 said regime and its tactical employment on the ground.

Scholars of social movements (Melucci 1993; Tilly 1986, 1993) have used the repertoire to unearth broad patterns of power and conflict, with tactics reflecting particular socio-economic arrangements. Tactics have been studied for their ability to be innovated (Tarrow 1994) and for their capacity to travel through time and space, both geographically and metaphorically (Bosi e Zamponi 2015; Della Porta and Mattoni 2014; McCammon 2003; Wang and Soule 2016). What is more, tactics are considered important in maintaining movements

through their organisational networks and collective identities, over periods of relative acquiescence and are understood as central to the establishment of social bonds and of ways of being in the world (Futrell and Simi 2004; Glass 2010; Meyer and Whittier 1994; Polletta 1999; Rupp and Taylor, 1990; Staggenborg 1998; Taylor 1989; Yates 2015).

Most studies on tactics, however, have focused either on indirect, protest tactics or tactics of identity formation and, concomitantly, the creation of alternative communities. Very few studies, to date, have looked at the separate category of tactical forms 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 holder» (Bosi and Zamponi 2015: 367, emphasis added). Fuelled by the most recent cycle of anti-austerity contention following the 2008 global financial crisis, the visibility of these tactics increased and so did scholarly attention around them.

Scholars of anti-austerity movements have looked at those characteristics that differentiate them from previous instances of collective action and/or contention. To summarise, anti-austerity contention brought forward issues of socio-economic justice and prompted scholars and students of social movements to reintegrate structural accounts into their analytical approaches (Benski *et al.* 2013; della Porta 2015; Peterson *et al.* 2015). What is more, in most settings, anti-austerity mobilisations combined issues of economic inequality with issues of democratic accountability, democratic responsiveness and the separation of democratic politics from the financial sector (Benski *et al.* 2013; Della Porta 2015; Della Porta *et al.* 2017; Grasso and Giugni 2016).

This intersection of the economic and democratic crises was used to explain the spread and modularisation of tactics of direct intervention among social movement actors, but also among alternative communities, solidarity collectives, resilience groups and NGOs. Relevant literature has stressed the relevance of democratic unaccountability, pauperisation and the fading of the welfare state in this conjuncture as central to informing contentious and/or collective action.

So moving from indirect to direct tactics, scholars have looked at Sustainable Community Movement Organisations, which opt to re-socialise the economic system and re-politicise people towards more direct forms of participation (Forno and Graziano 2014). Others have looked at the spread of Alternative Forms of Resilience (AFR) over the crisis years, understood as the wide repertoire of «nonmainstream/ capitalist economic and non-economic practices through which citizens build community resilience when confronted with hard economic times through austerity policies, decreasing social welfare policies and threatened economic and social rights» (Kousis and Paschou 2017: 148). However, the case studies analysed under the AFR umbrella focus entirely on economic tactics, and do not delineate those from their welfare or healthcare counterparts.

This pitfall was partly bridged by Bosi and Zamponi's (2015) systematic comparison of welfare provision tactics during the 1970s and 2010s crisis-settings in Italy. The authors coin the term Direct Social Actions (DSAs) for this inclusive category of tactics which invites a plethora of actors to their enactment. These include (i) NGOs and voluntary associations, (ii) solidarity economy organisations and informal grassroots groups and (iii) protest activities and social movement milieus who choose to use them «either as a supplement to their claim-making activity or as their primary form of action» (*Ibidem*).

Having these distinct categories in mind, they point to the different trajectories toward the same tactical forms and compare the different spheres each set of actors participates in. They conclude that although social movement actors represent a minority in the overall sample of DSAs in Italy, they make up a third of those providing welfare from below. Their study, thus, highlights that these tactics 1) travel through time, that 2) they become more visible as demand for them rises and that 3) they are strategically, albeit not unproblematically, used by contentious actors to (re)policise their constituencies. As such, DSAs can be understood as a tactical preference among Italian contentious actors that wish to mediate the socio-economic effects of the crisis while affecting political opportunities for themselves.

Similarly, Sotiropoulos and Bourikos (2014) investigate the seemingly unexpected upsurge of DSAs in Greece over the course of the 2010 crisis, to conclude 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» (*Ibidem*). 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 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 (Ibidem).

We understand, thus, that DSAs, at least on the side of contentious actors, have been studied either as economic tactics that wish to create alternative communities socialised in alternative markets or as welfare tactics that wish to mediate as well as politicise the crisis and its effects. As such, Sotiropoulos and Bourikos (*Ibidem*), Zamponi (2019) and Bosi and Zamponi (2015) unearth the contextual as well as strategic dimensions of these tactics and root them in the repertoire of anti-austerity contention. In particular, they all note that social movement milieus experienced a relative failure to extend their constituencies in a period that should have, otherwise, constituted an opportunity for them. For this reason, they shift their strategic orientation, witnessed in their change of tactics towards more direct forms of intervention to affect immediate change. Seen in this light, DSAs are part of political strategies that aim to mediate the "politicisation of the need" and the "social" where neither is implied.

In the remaining of this paper, I shall try to complement the aforementioned accounts by focusing on the healthcare arena, its players and their tactics (Jasper and Duyvendak 2015) from the establishment of the Greek NHS in 1983 and all the way to the closure of the anti-austerity cycle of contention in 2015. As I hope to show, the case study provides us with important insights as to the strategic utilisation of DSA tactics in the healthcare arena, itself markedly different from that of welfare (Carpenter 2012; Christou 2022; Moran 2000). Most importantly for this paper, the healthcare arena is distinguished by the role of the medical professional group, which exhibits a high degree of specialisation and autonomy and has been central in the configuration of health systems and policies (Freidson 1988; Immergut 1991). This makes the arena harder to penetrate and seals it off from broader participation and/or contention (Brown and Zavestoski 2004; Christou 2022). In this paper, I hope to show that healthcare DSAs were proven successful in introducing new and emergent actors in the healthcare arena – whether medical professionals or lay activists. These actors (re)politicised claims and aims in the arena and shifted the agenda in the direction of long-resisted healthcare reform.

3. METHODS

This paper draws from my participant observation of the grassroots clinics(-pharmacies) (2013-2014) and in-depth interviews (n° 40 see appendix) with actors involved in the healthcare arena over two periods of fieldwork (2013-2015 and 2018-2021). The interviews lasted a median of 1h15m. Relevant interlocutors were chosen on the basis of purposive sampling, drawing on my experience of the case, and snowball sampling to enhance my data collection and substantiate my findings (Bryman 2012). Due to the temporal scope covered by the paper, I had to use methods frequented in historical inquiries (Bosi and Reiter 2014) and complement those experiential accounts with primary and secondary sources. More specifically, I have relied on my personal collection of social movement material covering the period 2010-ongoing, together with 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. In addition, I have used secondary sources such as policy and historical analyses of healthcare reform in the country.

4. 1983-2008: HEALTHCARE REFORMS AND THEIR DISCONTENTS

Law 1397/1983 radically transformed the Greek healthcare arena through the establishment of the Greek National Health System (henceforth NHS) 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. Similar to other Southern European counties, Greece at the time was exiting from a period of long and protracted political repression as the military junta of 1967-1974 was replaced by the liberal conservative party of New Democracy. In 1981, however, New Democracy was overturned by the mass victory of PASOK (Panhellenic Socialist Movement) which, upon its election, took on the role of reforming the political system and modernising the country on the basis of redistribution and equality.

By the time of PASOK's victory, the healthcare system had become a topic of intense debate as it was already facing significant pressures. After the military junta, relevant reports had identified regional inequalities in healthcare provision and financing, as well as the existence of illegal, direct payments for healthcare services. The proposals drafted based on these reports centred around the merging of the various sickness funds

and the introduction of family doctors to decentralise care and harmonise service provision in rural settings, as well as facilitate referrals to hospital units.

4.1. Medical syndicalism: Indirect tactics to resist reform

Medical doctors would prove decisive in affecting the Law and its completion. To be sure, established hospital and university doctors were against the reform for the NHS. According to their representatives, the NHS constituted a threat to their status and compensations, as well as to the quality of care delivered. In a contemporary interview President of the Auxiliary Teaching Staff of the Athens Medical School Kaklamanis warned against the principle of universalism, as this would «result not in the advancement but in the degradation of healthcare» (Petritsi 1983).

However, PASOK had the support of junior doctors which, in the period preceding the socialist government, had doubled in numbers and had radicalised over the course of their medical studies, joining the movement against the junta and the uprooting of its allies in universities, the army, and the public sector. These radical junior doctors objected the powerful strata of established hospital and university doctors and resented their privileges. What is more, and by virtue of their mass participation in medical associations, junior doctors shifted the orientation of their trade unions, including the powerful Union of Hospital Doctors in Athens and Piraeus, in a socialist direction for the first time during the 1980s (Davaki and Mossialos 2005).

These professional and political antipathies, therefore, provided the window of opportunity necessary for PASOK to introduce its radical reform onto the national healthcare system. Albeit subscribing to the Beveridge model of healthcare, however, the Greek NHS was not to be funded via general taxation, but through social contributions made to the numerous existing sickness funds, which the Law opted to merge. In a nutshell, then, the newly found NHS was to (1) equalise and universalise access to healthcare, to (2) ensure its quality across the country and across the funds and to (3) develop a system of Primary Care. However, these core items of the Law would remain incomplete since the founding of the NHS, as the medical professional group would soon join forces to defend and expand its interests.

Senior doctors persisted in resisting the individual reform clauses that undermined their status and reduced their compensations, while junior doctors soon found themselves against PASOK, which they perceived as taking advantage of the professional rivalry to undermine the group in its totality. Efforts to complete the reform on the side of the government would thus become the subject of contention across generational and ideological divides, leading to the announcement of a mass strike in 1984, heralded by the, by then, socialist Union of Hospital Doctors in Athens and Piraeus (EINAP). Minister of Health Paraskevas Avgerinos condemned the strike and deemed it illegal as it would affect "the delay, if not the undermining of the implementation of the NHS" (I Kathimerini 1984).

EINAP was swift in responding to the Minister, affirming that

> *it is the hospital doctors that can implement the NHS. For this reason, it is the Minister's action that serves to undermine the NHS. With awareness of our responsibility, we call our members to militant participation in tomorrow's strike and in the general assembly (Ibidem).*

The strong corporatist traditions in the country would foster alliances for this privileged professional group, and the various sickness funds together with their constituencies also found themselves against the completion of the reform. In this climate, Avgerinos' hostile attitude towards doctors and his attempts at litigation led to his isolation, his resignation and replacement by Giorgos Gennimatas, who halted the 1983 reform effort and extended doctors' professional privileges.

This victory marked the beginning of a long history of contention against the NHS reform. Another such occasion was marked by the mobilisations against the second greatest reform effort in 2000-2002, heralded by PASOK's Minister of Health Alekos Papadopoulos. Papadopoulos' plan for the NHS involved its decentralisation in regional authorities, the formation of a Primary Care level and the curbing of informal payments made to hospital doctors in the public healthcare system. Physicians working for the biggest insurance fund in the country (IKA) – which also functioned as a Primary Care provider – commenced a continuous strike for tenure in 2001. A year later, they were joined by hospital and university doctors who interrupted their medical practice and teaching activities. As a commentator for Kathimerini observes

> *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 (I Kathimerini 2002).*

The powerful role of doctors in halting healthcare reform is not confined to Greece, however. Scholars have stressed how medical professionals are central in health

policy and more generally, according to sociologists of professions, among the most powerful professional groups writ large. Building on Freidson (1988), 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).

Greek doctors, however, relied on a wider basis of fragmented interests that converged in their favor. Resistance against the 2000-2002 reform effort was also expressed by bureaucrats for its decentralisation clauses, as well as the national Civil Servants' Confederation (ADEDY) which saw threats to the status of university doctors as extendable to all employees of the public sector. All the above made for a powerful movement resisting the reform, culminating, yet again, in the resignation of Papadopoulos and the halting of healthcare reform (for more see Nikolentzos 2008; Nikolentzos and Mays 2016).

Over time, the solidification of the NHS would reinforce and amplify its internal weaknesses, translating into systemic blindspots for the healthcare system (Davaki and Mossialos 2005; Mossialos and Allin 2005). The underdeveloped Primary Care level in the country would further contribute to the centralisation of care in and around hospitals, which run without a system of referrals. This not only came at the cost of the public healthcare budget, but it also undermined prevention and equality in distant and rural parts of the country.

In addition, geopolitical transformations over the turbulent 1990s, turned Greece from a migration to a destination country, would challenge the principle of "universality" as enacted in the NHS. More specifically, as outlined above, the NHS was offering access on the basis of legal residence in the country and registered, formal employment. Undocumented migrants were denied access unless in the case of an emergency, and asylum seekers were only allowed to use emergency services until their status was recognised by the Greek authorities. As such, these constituencies were covered by the National Centre of Disease Control and the third sector, which thrived on the weaknesses of the NHS and its promotion and funding by mainstream politics (Sotiropoulos 2013; Huliaras 2015).

4.2. Volunteering doctors: DSAs to cover for healthcare needs

These blind spots were also noticed by grassroots civil society actors as early as the 1990s, giving birth to the first instance of self-organisation and grassroots healthcare provision for those people falling outside the purview of the NHS. More specifically, in Chania in the island of Crete, prominent left-wing militant and trade unionist Kostis Nikiforakis established a volunteer clinic to cater for those seasonal migrants living and working on the island. After a series of negotiations with the local authorities, he took over the soup kitchen "Saint Nikolaos Splantzias" from the Church and transformed it into a secular soup kitchen under the name of "Social Intervention- Soup Kitchen Splantzias". It was not long before the initiative added primary and dental care to its activities. Medical students at the University of Crete joined Nikiforakis and offered their services to "Splantzias" which soon began attending not only seasonal migrant workers but also the local poor and the homeless.

The clinic of "Splantzias" was, thus, the first informal civil society actor to engage with healthcare DSAs in the country since the establishment of the NHS. However, and despite their innovative nature, one can approach these DSAs as "consenting" tactics to mediate healthcare needs in the absence of universal care. The clinic closed down after two years but some of its members would mobilise anew and on a new basis in the period analysed below.

5. 2008-2010: POLITICISING HEALTHCARE DSAS

5.1. Volunteering doctors: DSAs to propose alternatives

In 2008 another clinic opened in Crete, this time in Rethymno, under the name "Volunteer Clinic of Social Solidarity in Rethymno" (EIKAR). Similarly to the clinic of "Splantzias", EIKAR was granted a space by the municipality and offered primary care services to migrants without papers.

Starting with only two specialisations -internal medicine and paediatrics- the clinic would soon move to the city centre and expand its services. The stated goals of the clinic were the mediation of healthcare needs for those most vulnerable residents of the island, but also the identification of healthcare needs for the articulation of concrete demands for reform, alongside the promotion of alternative approaches to health – holistic medicine, prevention over treatment etc. – and the facilitation of social change writ large (Tzanakis *et al.* 2018).

This already marks the first attempts to politicise healthcare DSAs. Before long, EIKAR was increasingly visited by uninsured Greek nationals, thus suggesting the first symptoms of austerity onto health and care. EIKAR would provide the seeds for the mushrooming of

the Social Clinics-Pharmacies over the course of the crisis and the anti-austerity cycle of contention discussed in the following section.

5.2. Anarchist-autonomia[1] doctors: DSAs in the Spirit of December

While doctors and grassroots civil society actors in Crete were strategizing around their use of healthcare DSAs, urban centers in the mainland, and Athens in particular, were shook by the assassination of 15-year-old Alexandros Grigoropoulos by policeman Epaminondas Korkoneas on the night of December 6th, 2008. In just a few hours after the assassination, people took to the streets, initiating a short yet intense protest cycle of mass protests and riots (Seferiades and Johnson 2012).

The events following the "December uprising" were spearheaded by the anarchist, *autonomia* and anti-authoritarian movements which are relatively marginal due to the country's strong communist traditions. Momentous mobilisations and clashes with the police were gradually replaced by university occupations and assemblies (Kanellopoulos *et al*. 2012) which covered a range of topics. These included health and care, as a special "Assembly for Health" was established in the occupied Athens University of Economics and Business to then move to the historical occupation of Villa Amalia, over the months of February and March 2009 before it dissolved. In a collective document, participants of the Assembly for Health affirmed that;

> *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 (Health Assembly 2020).*

The events of December, thus, stirred the healthcare arena, introducing a new collective actor therein, which would articulate new stakes and utilise new tactics of intervention. More specifically, the Health Assembly gave birth to two sets of innovative tactics of contention in the national healthcare arena, each brought forward by actors that explicitly stated their intention to "break" from the hegemonic strategies of the trade union movement and its repertoire. The first was the padlocking of the hospital cashier. "Padlocking" was an alternative to the traditional hospital strike that intended to obstruct the collection of money without blocking hospital operations, thus targeting the state and not care delivery. The second was a re-appropriation of healthcare DSAs through the creation of the Social Space for Health. These two innovations were linked to different strategic agendas and visions for change, ultimately causing the Health Assembly to split.

5.3. The Social Space for Health: DSAs for self-organisation

The Social Space for Health (SSH) was established in April 2009 in the occupied building of the abandoned Health Centre in the Athenian neighbourhood of Petralona. Supported by the Neighborhood Assembly of Petralona, Koukaki and Thissio in Athens, the SSH was to provide free primary healthcare services to locals as well as politicise the issues of health, care and wellbeing. The founding members of the SSH clarify their intervention

> *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 (Health Assembly 2020).*

To be sure, the strategy of the SSH can be understood as deriving from the combination of anarchist critiques to the state and Foucauldian critiques to biomedicine and biopolitics. It did not engage with health policy and it outright rejected the NHS as corrupt by virtue of its dependence on the state. In this context, healthcare DSAs were understood as key in prefiguring health autonomy and social emancipation. The politicisation of DSAs by the SSH, then, is radically different from that of EIKAR. As such, we see how new and emergent actors utilised healthcare DSAs as tools to break into the historically sealed arena. With them, they brought new claims and stakes and strategically differentiated themselves from those organised interests in the arena. The effects of these transformations, however, would not be visible until the following period.

[1] Autonomia here refers to the political movement inspired by the Italian *Autonomia Operaia* of the 1970s.

6. 2010-2015: HEALTH CRISIS, HEALTH MOVEMENT, HEALTH REFORM

These transformations in contentious action only foreshadowed the cumulative and combined effects of austerity onto health and care. In 2010the government of PASOK inaugurated a long period of bailouts by signing the first Memorandum of Understanding (MoU) issued by the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) (the so-called Troika). The MoUs prescribed the combination of fiscal consolidation measures, labour market reforms and structural changes(Armingeon and Baccaro 2012; Frangakis 2015) that wrecked the social fabric, leading to the dramatic pauperisation of large social strata and bringing the NHS to its knees. Unemployment levels skyrocketed (Matsaganis and Leventi 2013) while unemployment benefits shrunk both in size and scope (Vaiou and Kalandides 2016). By 2010, a third of the Greek population was officially impoverished (Ifanti *et al.* 2013).

What is more, the MoUs involved direct prescriptions for the NHS, including the reorganization of its funding through the merge of the various sickness funds into one (EOPPY) in 2011. The merge implied the shrinking of the benefits basket for all, further squeezing funding for the NHS and provisions for beneficiaries.

Cuts in personnel, reductions in their compensations and the closure and/or privatisation of hospital units, clinics and beds in the name of cost-containment all formed part of a greater plan to reduce public expenditure onto healthcare. Over the austerity period, the Troika acquired its first-ever control over a national healthcare system by setting a 6% ceiling on public contributions towards health (Karanikolos *et al.* 2013). While health policy experts deemed it arbitrary and extremely low, Health Ministers in the country went beyond Troika's desires and reduced public health expenditure to 4.6% in 2014 (Kentikelenis *et al.* 2014; Kondilis *et al.* 2012; Stuckler and Basu 2013).

The rapid impoverishment of the population led to a sharp increase in the demand for public healthcare options. 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). In addition, and as already mentioned in the beginning of this paper, a third of the population was left without health insurance (Amnesty International 2020).

Cutbacks in prevention and intervention programmes contributed to the (re)appearance of infectious diseases, including malaria (Stuckler and Basu, 2013) and HIV which increased 16fold between 2010-2011 (ECDC 2012; Hatzakis *et al.* 2015). Major depression, suicidal ideation, as well as suicides rose to epidemiological levels as mental health budgets were being dramatically slashed (Economou *et al.* 2013: 20; Kentikelenis *et al.* 2011; Vaiou and Kalandides 2016). The economic crisis was turning into a health crisis.

The economic, social and health outcomes of austerity paved the way for a long and protracted cycle of anti-austerity contention in the country between 2010-2015. Scholars of contention in Greece have all divided the broader cycle of contention into three consecutive waves, each with their own constituencies, tactics and demands. For the purposes of this paper, I follow the periodisation of Kotronaki and Christou (2019) which sees the first wave as beginning with the voting of the first MoU in 2010 and culminating with the Greek Indignados in 2011. This wave was characterised by mass sectoral protests that introduced and established the anti-memorandum and anti-austerity frames characteristic of the whole cycle (Kousis and Kanellopoulos 2014; Serntedakis and Koufidi 2018). The following wave saw the decline of indignation and the upsurge of collective practices of solidarity and self-organisation, through the diffusion and modularisation of DSAs. Finally, the third wave (2014-2015) was distinguished by the domestication of protest forms and solidarity practices, as the emergent party of SYRIZA was preparing for power (Karyotis and Rüdig 2018; Kotronaki 2018).

6.1. Protest wave

The same dynamics were also reflected in the healthcare arena. The first wave was a protest wave proper, involving the mobilisation of healthcare professionals in defence of the NHS, their positions and compensations against the austerity regime. Those mass mobilisations were largely sectoral, called by trade unions and political parties. Protest events were frequent, and they culminated around periods of reform and parliamentary vote on specific bills. The first wave mobilised the arena's hegemonic actors which utilised their usual protest tactics to push for their sectoral demands. Albeit tactical innovation was not yet apparent, new frames and claims entered the scene, addressing austerity and the memoranda.

In May 2011, thousands of people took to the streets following an online call for "Direct Democracy Now!". Following the steps of the Spanish Indignados movement, participants set up tents in major squares across the country and engaged in continuous protest. The encampments saw the formation of citizen assemblies

discussing the causes of the crisis, its effects as well as potential solutions. In addition, and as noted by Marilena Simiti (2014), assemblies were also divided on different themes similar to those following the 2008 riots. Issues of health and care were discussed in the squares, preparing the arena for the next wave of contention.

6.2. Solidarity wave

The first wave spilled into the second one, with the gradual dissolution of the encampments in late 2011 and the decentralisation of contention from squares to neighbourhoods (Malamidis 2020). This decentralisation favoured the diffusion of occupation tactics as well as DSAs around affected domains (housing, food, healthcare, education etc). Meanwhile, the medical trade union movement continued its contentious activities, and strikes and protests witnessed a peak between 2011-2012 before subsiding in 2013 (for more see Tombazos and Serntedakis 2018).

It is during this hybrid wave that we saw the mushrooming of grassroots healthcare initiatives, themselves combining healthcare DSAs with indirect tactics of protest and claims-making. Indicatively, the first clinic-pharmacy established during this period was KIA, the Social Clinic of Solidarity in Thessaloniki. KIA was the by-product of a successful migrants' hunger strike in 2011, where doctors attending to the protesters decided to continue their operations due to the increased demand they perceived for such interventions. According to a participant

> *We were delighted to be the positive outcome of […] 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, on the 7th floor of the Trades' Union Centre, we came to the decision that something ought to be done (Thodoris Zdoukos in Karagkiozidou* et al. *2016).*

Similarly to EIKAR, KIA expanded its constituencies from migrants to impoverished and uninsured nationals, responding to the needs of the time. In so doing, it developed more contentious characteristics than EIKAR, including protest tactics in solidarity with the migrants, against austerity and for healthcare reform. The next clinic-pharmacy established was the Metropolitan Community Clinic in Hellenikon (MKIE) in the Athens metropolitan arena by Dr. Vichas, cited in the prologue to this paper. MKIE traces its establishment to an appeal made by Mikis Theodorakis, a composer and historical figure of anti-fascism in the country, during an event against the privatisation of the abandoned airport in the municipality of Argyroupoli-Hellenikon. As Dr. Vichas recalls

> *In a small group of friends, just before the beginning of his concert at the old airport of Hellenikon, he told us "No Greek should starve, no Greek should be left without a doctor (Zarakovitou 2019).*

This small group of friends were medical professionals and lay, local activists also involved in the Greek Indignados movement. Together they decided to set up a clinic-pharmacy, utilising one of the abandoned buildings in the old airport. As such, MKIE was not only addressing healthcare needs through DSAs; it was also servicing the struggle for the protection of the old airport, proposing an alternative and setting an example of its public repurposing. The more the paradigm of the clinics(-pharmacies) would diffuse, the less tactical options austerity contesters would have. Soon enough, political parties on the (radical) left would set up their own initiatives as part of their greater involvement in the anti-austerity movement. The neo-Nazi party of the Golden Dawn also tried to get involved in healthcare DSAs, namely by launching its own blood donation campaign "only for Greeks". The campaign was as short-lived as it was unsuccessful.

a) Strategic convergence

-The Social Clinics-Pharmacies Movement:

This tactical convergence among anti-austerity actors soon led to strategic convergence and the formulation of an anti-austerity health movement, namely the Social Clinics-Pharmacies Movement, following KIA's call for a national meeting of grassroots clinics in 2013. The movement's code of conduct stressed the clinics-pharmacies' "autonomous, independent, self-organised and self-managed" operations and defined their tactics as oriented to the provision of "services of primary healthcare to all uninsured people, the unemployed and the poor, on a completely volunteer basis".

The clinics-pharmacies were juxtaposing themselves to existing structures and initiatives, mainly NGOs and the Church. Unlike the charitable orientation of formal civil society and the Greek Church, the clinics-pharmacies were to operate under the principle of solidarity, and their DSA tactics formed part of a larger contentious agenda of the "collective struggle for our right to public healthcare" and for "free access to medical and pharmaceutical care for all" (see Kotronaki and Christou 2019).

What is more, the founding document of the movement prescribed the combination of healthcare DSAs with indirect, protest tactics against austerity and for progressive healthcare reform, namely in universal access and primary care. The movement saw itself as part of the greater anti-austerity and anti-fascist movements. Finally, it did not wish to replace the NHS; the clinics-pharmacies would mobilise in its defence, so that they become obsolete.

- Solidarity4All:

Parallel to these cooperative efforts, the emergent party of SYRIZA (Coalition of the Radical Left) also began strengthening its bonds with the numerous grassroots solidarity initiatives, in general, and the clinics-pharmacies, in particular. This leaning of SYRIZA towards civil society has been explained as a strategy to mitigate its failure to penetrate the trade union movement (Karaliotas 2021; Tsakatika and Eleftheriou 2014). In 2012, SYRIZA's leader Alexis Tsipras extended an appeal to his party members prompting them to engage in grassroots solidarity efforts. Tsipras also called for the creation of a strategic document regarding these initiatives, understood as pools for supporters as well as ideas for the most pressing issues stemming from the austerity regime and ways to address them.

The strategic document outlined the main areas of intervention for party members as those (a) health, (b) food, (c) education, (d) culture, (e) solidarity economy and (f) legal support. In less than a year, the party had established its own Social Movement Organisation (SMO) "Solidarity4All", meant to map, promote and facilitate grassroots solidarity initiatives.

b) Strategic divergence

This strategic convergence among emergent actors in the healthcare arena did not remain unnoticed, triggering further differentiation on the part of the anarchist-*autonomia* initiatives which also flourished over this period. In the aftermath of the movement's founding meeting, to which they were invited, the SSH distinguished its position and warned against the movement's tactics and their strategic alignment.

To be sure, the SSH defended itself as the original practitioner of healthcare DSAs and, as such, criticised the movement for supporting the inherently corrupt NHS and the state. The SSH argued that healthcare DSAs can only operate in the name of autonomy and self-organisation, starting from health and spilling over to all domains of social and political life. If DSAs were not to serve the struggle for emancipation, then they were lending themselves to be instrumentalised and coopted by the state.

Thus, the diffusion of healthcare DSAs diversified their strategic utilisation by contentious actors and fuelled competition for their ownership in the arena. The SSH went on to denounce the movement and began organising its own network of cooperation with a number of clinics adhering to its principles. For this network of anarchist-*autonomia* clinics, austerity formed part of a greater biopolitical strategy to exterminate the poorest strata of society. Combined with their commitment to prefiguring self-organisation through health and care, the network only saw the crisis as an opportunity to politicise and expand its constituencies. This clearly sets this network apart from the austerity contesters' camp and their repertoire.

6.3. Domestication wave

The final phase of the cycle of anti-austerity contention was characterised by the plateauing of solidarity DSA initiatives. As mentioned above, this wave saw the gradual domestication of anti-austerity contention through the alignment of the movements' goals with those of the emergent movement-ally part of SYRIZA, facilitated by the party's SMO "Solidarity4All".

By the end of the cycle, segments of the anti-austerity movement transmuted their visions for social change to wishes for parliamentary change in an anti-austerity and anti-memorandum direction (Kotronaki 2018). The Social Clinics-Pharmacies movement was no exception, and their interactions with "Solidarity4All" and SYRIZA led to their involvement in drafting SYRIZA's pre-election plan for health and care. For the first time since the establishment of the Greek NHS the issues of universality and Primary Care were addressed.

The victory of SYRIZA in 2015 marked the end of the cycle of anti-austerity contention. Once in power, however, it continued to consult members of the Social Clinics-Pharmacies' movement and in 2016 and 2017 it announced two interrelated reform clauses for the NHS. First, access was extended to all those with a social security number -that is to everyone but undocumented migrants. Second, a first-ever network of Local Health Units (ToMY) was announced with the intention of promoting prevention and equality and facilitating referrals to other levels of care. This was an instance of paradigmatic healthcare reform, albeit in paper, as core elements of the reforms were not fully realised. Upon the announcement of the reforms the movement of the Social Clinics-Pharmacies was dissolved while most of the component clinics (-pharmacies) retained their oper-

ations and revisited their strategic orientation in the new conjuncture.

7. CONCLUSION

This paper has presented the co-development of the Greek healthcare arena, its actors and their tactics. Departing from the establishment of the Greek NHS in 1983, the paper has followed the medical professional group and its indirect, protest tactics to resist healthcare reform, defend its interests and advance its autonomy. These organised efforts have led to a policy stalemate in the country and have shifted the agenda for the NHS away from universalism in coverage and comprehensiveness in care.

At the same time, the paper traces the entrance of new and/or emergent actors in the arena by virtue of their healthcare Direct Social tactics. More specifically, the 1990s saw the first experiments with healthcare DSAs guided by medical humanitarianism to mediate the blind spots of the NHS. These tactics were soon discontinued, to be picked up again in 2008, this time as part of larger strategies to contest healthcare practices, in general, and the NHS, in particular. A year later, the same healthcare DSAs were (re)appropriated and (re)purposed by the anarchist and *autonomia* milieus, which employed them within their own prefigurative agenda for self-organisation and autonomy. To be sure, until the advent of the economic crisis in 2010, healthcare DSAs represented marginal tactics of marginal actors in the arena, "jockeying for advantage" against their powerful enemies, that is the medical professional group and its trade unions (Fligstein and McAdam 2012: 54). Thus, DSAs were strategically used to open the healthcare arena to new actors and stir it in the direction of new stakes.

The economic crisis of 2010 had direct and cumulative effects onto the Greek NHS, population health as well as individual wellbeing. The political and social disintegration, coupled with the health crisis induced by the austerity regime, paved the way for a strong and impactful anti-austerity contentious cycle that shook the country between 2010-2015. In this environment, healthcare DSAs expanded the, otherwise, closed arena of healthcare as they offered new and/or emergent contentious actors alternative ways of participating therein. Most of them came together and formed the Social Clinics-Pharmacies movement, which combined direct tactics of healthcare and pharmaceutical provision with indirect claims-making tactics for progressive healthcare reform.

As such, I conclude that the same tactics that were initially conceived as indicative and formative of strategic divergence prior to the crisis, prompted strategic convergence upon their diffusion. In line with the relevant scholarship, I argue that healthcare DSAs diffused as demand for (primary) healthcare services and pharmaceuticals increased. This led to the politicisation of issues regarding health and care and the employment of DSAs by different contentious actors. The sum of these transformations affected the arena to such an extent that the emergent party of SYRIZA drafted its healthcare agenda based on the movement's demands and experiences and announced paradigmatic healthcare reform once in power in 2015.

This paper highlights some of the idiosyncrasies of the healthcare arena, and most importantly the centrality of the medical professional group therein. This is in line with the international health policy scholarship, that sees doctors as consequential to the configuration of healthcare systems (see for example Starr 1982; Immergut 1991; Chapin 2010). Contention on the part of less powerful groups, however, has received much less attention. The central role of the medical professional group in the arena has direct and indirect implications for mobilisation therein. To be sure, healthcare DSAs are costlier than their welfare and/or economic counterparts. That is because they rely of the expertise, state licensing and legitimacy of those employing them. Healthcare DSAs imply at least some participation of healthcare professionals. At the same time, and as showcased in the case examined here, healthcare DSAs offer medical professionals opportunities for mobilisation outside their sectoral as well as for collaboration with lay, non-expert activists. The co-operation of medical professionals and non-expert activists in the Greek healthcare arena, rejuvenated the grievances of the former and gave confidence to the claims of the latter, ultimately paving the way to paradigmatic healthcare reform.

The study of healthcare DSAs can be relevant for social movement studies and health policy. Future research should look at the continuities and discontinuities of healthcare DSAs among different (contentious and non-contentious) milieus as well as across different crisis settings (economic crisis and Covid-19 pandemic). This will allow us to better understand the opportunities offered but also the obstacles posed in the mobilisation of these tactics and their utilisation within larger contentious strategies.

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APPENDIX

List of interviews

1. Alex. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
2. Alexis Benos. M.D. at Social Clinic-Pharmacy, Advisor to the Ministry of Health, Professor of Primary Care, General Practice and Health Policies. Thessaloniki, 2015, 2019 and 2020.
3. Antonis. M.D. at Social Clinic-Pharmacy. Athens, 2015.
4. Chris Giovanopoulos. Ex-cadre of Solidarity4All, Researcher. Online, 2019.
5. Dora-Dimitra Teloni. Member of Social Clinic-Pharmacy, Professor of Social Work. Athens, 2019.
6. Eleni. Receptionist at Social Pharmacy. Athens, 2018.
7. Georgia. Receptionist at Social Clinic-Pharmacy. Athens, 2018.
8. Gianna. Member of Social Solidarity Centre. Athens, 2018.
9. Hara Matsouka. M.D. Ex-member of Social Clinic-Pharmacy, Advisor to the Ministry of Health, Ex-President of the National Centre for Blood Donation. Athens, 2019.
10. Hobo (nickname). M.D., Member of Saleu Bellum, Member of Autonomous Doctors' Union. Athens, 2018 and 2019.
11. Katerina. M.D. at Social Clinic-Pharmacy. Athens, 2015.
12. Katerina Matsa. M.D. at Social Clinic-Pharmacy, Founding Member Ψ-Initiative for Mental Health Reform. Athens, 2019.
13. Konstantinos. M.D. Syndicalist. Athens, 2019.
14. Kostas. M.D. at Social Clinic-Pharmacy. Athens, 2015.
15. Lena. Pharmacist at Social Clinic-Pharmacy. Athens, 2018.
16. Manolis. M.D. at Social Clinic-Pharmacy. Online, 2020.
17. Maria. Receptionist at Social Clinic-Pharmacy. Athens, 2014.
18. Maria. Receptionist at Social Clinic-Pharmacy. Athens, 2019.
19. Marianna. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
20. Meri. Receptionist at Social Clinic-Pharmacy. Athens, 2018.
21. Nikos. Syndicalist. Online, 2019.
22. Orestis. M.D. Activist. Athens, 2019.
23. Panagiotis. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
24. Penelope. Member of Workers' Club. Athens, 2018.
25. Petros. Receptionist at Social Clinic-Pharmacy. Athens, 2020.
26. Rea. Receptionist at Social Clinic-Pharmacy. Athens, 2019.
27. Samy. Activist, Social movement expert. Online, 2021.
28. Tatiana. Receptionist at Social Clinic-Pharmacy. Athens, 2019.
29. Thanos. Receptionist at Social Clinic-Pharmacy. Athens, 2014.
30. Thanos. Receptionist at Social Clinic-Pharmacy. Athens, 2019.
31. Thodoris Megalooikonomou. M.D. at Social Clinic-Pharmacy, Founding Member of Ψ-Initiative for Mental Health Reform. Athens, 2019.
32. Thomas. Receptionist at Social Clinic-Pharmacy. Athens, 2015.

33. Vasiliki. Receptionist at Social Clinic-Pharmacy. Athens, 2019.
34. Vaso. M.D. at Social Clinic-Pharmacy. Athens, 2018.
35. Vicky. Ex-member of Social Clinic-Pharmacy. Athens, 2019.
36. Voula. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
37. A. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
38. B. Receptionist at Social Clinic-Pharmacy. Athens, 2015.
39. C. Member of militant antifascist group. Piraeus, 2019.
40. D. Activist in anarchist/autonomia milieu. Athens, 2019.