"As if" but "Not quite" a State: Austerity, Healthcare, and Stateness in Northern Greece[1]

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Abstract

While the Greek economic crisis materialised in sweeping precarity and prolonged deprivation, in certain ways austerity also acted as a locomotive of hopeful transformation. The principles of "solidarity" frame forms of provisioning that seek to contain state retrenchment, ameliorate institutional exclusion, and carve egalitarian spaces. The Social Medical Practice of Xanthi, Northern Greece, accommodates those unable to access public healthcare and constitutes a "solidarity structure". Yet, contrary to dominant iterations of "solidarity", Xanthi's social clinic is firmly embedded in bureaucratic authority and domination. The casting of institutional exclusion into provisional inclusion wields a power that is both modelled on the authority of the state and driven by the logic of the gift. "As if" a state, the clinic provides healthcare, but also generates experiences of exclusion. "Not quite" a state, the clinic occupies a moral high ground that appeals to pity and compassion. I suggest that the clinic's "as if" and "not-quite-a-state" qualities are not incompatible, but rather speak to the heart of governmentality and sovereign power.

Keywords: crisis, provisioning, solidarity, bureaucracy, sovereignty

Introduction

The signing of the first Memorandum of Understanding between the Greek government and the "troika" in early 2010 inaugurated a long period of fiscal consolidation, internal devaluation, and public asset privatisations. Austerity materialised in sweeping precarity and prolonged deprivation. Yet

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in certain ways austerity also acted as a locomotive of hopeful transformation. The view that the grievances caused by austerity occasioned a radical shift in social relatedness resonates with several ethnographers of the Greek economic crisis and is most palpable in the anthropological study of "solidarity" (*allilegii*). While the term had also been in use prior to the onset of the crisis, it was only after 2010 that "solidarity's emic invocation expanded to designate grassroots responses to austerity and later, to be conceived as the "other face" of the crisis (Cabot 2016). The hundreds of "solidarity structures" that sprung up during the crisis include soup kitchens, social clinics, clothing banks, and anti-middleman organisations. In ethnographic representations, the "hidden welfare" (Rakopoulos 2015, p. 98) performed by these provisioning schemes is not only shown to alleviate deprivation, but also to carve spaces of egalitarianism.

Evthymios Papataxiarchis (2016) attaches "solidarity" to three key principles. First, "solidarity" is marked by agonistic relationality and opposes the political establishment. Secondly, "solidarity" is programmatic and overtly oriented towards alternative horizons. Lastly, "solidarity" is mediated by the gift. While earlier anthropological work in Greece documents a pervasive aversion towards the obligations and hierarchies implicated by gifts (e.g. Campbell 1964; Du Boulay 1991; Herzfeld 1992), the abundance of goods distributed in the name of "solidarity" points to a significant revision in culturally dominant principles of autonomy. The transgression of the "gift taboo", as Katerina Rozakou (2016a) puts it, owes to generalised indebtedness and the disruption of social standing, which effectively re-signified notions of obligation and interdependence. In short, while not altogether innocent, the gifts offered amidst crisis transformed into building blocks of largely egalitarian relations. Seen from the vantage point afforded by "solidarity", the Greek economic crisis becomes a "political cosmogony" (Rakopoulos 2016, p.143), while "the society that is reborn in horizontal "solidarity" is an "anti-structure" and stands against the very political and economic forces that assigned society its exclusionary potential" (Papataxiarchis 2016, p. 208).

The implications of this hopeful trope, which reverberates in both emic and etic discourses, are varied and merit attention. Here, I will briefly outline what I consider to be its driving assumptions; namely, the reflexive depreciation of social difference, the denunciation of hierarchy, and lastly, the salience of counter-hegemonic intent. The disruption of social stratification, most evident in the drastic decline of the middle classes, is central in this optic. The assertion of a ubiquitous ordeal that implicates everyone, regardless of socio-economic status, gender, ethnicity, or race, not only destabilised existing "regimes of difference" (Papataxiarchis 2006), but also generated idioms of relatedness that suspend difference altogether (Bakalaki 2015). For instance, while "solidarity" shares an affinity with culturally salient notions

of conditional hospitality (Cabot 2016; Rozakou 2016b), it also marks a departure from them, insofar as it effectuates a programmatic shift from antagonism to disinterestedness. Similarly, while "solidarity's" practitioners are ethnographically shown to be immanently aware of their potential complicity in neoliberal governance (Cabot 2016) and bourgeois philanthropy (Theodossopoulos 2016), this awareness appears to accentuate, rather than question, "solidarity's" distance from its less egalitarian cognates. In short, unlike forms of relatedness that are predicated on hierarchy, "solidarity" champions similarity and inclusion (Cabot 2016). In this capacity, the exogenous collapse of social standing is shown to instigate fields of action that are either blind to social difference or recognise difference as inequality and exclusion.

The principles of "solidarity" find material expression in the distribution of things like food, clothes, and healthcare. As elsewhere, the rise of welfare volunteerism belongs with a broader and markedly neoliberal transition from welfare state to self-governing communities and active citizenship (Rose 2006). Echoing the view that neoliberalism is a "migratory set of practices" that take shape as they enter into place and time-specific assemblages (Ong 2007, p. 4), anthropologists have demonstrated that processes of welfare neoliberalisation take on historically and culturally situated forms (e.g. Sharma 2006; Muehlebach 2012; Ferguson 2015). Katerina Rozakou's (2016a) periodisation of "public sociality" in Greece is particularly illuminating to this end. Rozakou draws a distinction between the "civilising mission" of civil society, which gathered momentum at the turn of the twentieth century, and the informal invocations of relatedness that flourished in the course of the Greek economic crisis. In Rozakou's analysis, the denunciation of hegemonic visions of European modernity is shown to have reshuffled the landscape of public sociality, marking a transition from state-sponsored volunteerism to "spheres of disinterestedness, solidarity, and subversion to the state" (Rozakou 2016a, p. 81).

In related literature, "solidarity's" opposition to the state is shown to be twofold. First, "solidarity" frames forms of provisioning that seek to contain state retrenchment and ameliorate institutional exclusion (Agelopoulos 2015; Rakopoulous 2015; Cabot 2016). Secondly, "solidarity" rejects the state form and, in place of "predictable formalism" (Herzfeld 1992 p. 19), it asserts spontaneity and informality (Dalakoglou 2012; Leontidou 2012; Rozakou 2016a; cf. Henshaw 2019). The question that arises then, according to Theodoros Rakopoulos (2015, p. 95), is whether "solidarity's" agents can be seen as "novel welfare institutions that mark a move from centralised and distributive frameworks of welfare to horizontal and reciprocal ones".

The optic above may also be summarised as follows: if the Greek economic crisis' dominant narratives fixate on fiscal irresponsibility and corrective

discipline, its dominant counter-narratives herald emergent visions that are distant to, if not outright subversive of, political, economic, and cultural hegemonies (see also Streinzer 2018). Although analytically nuanced, ethnographically sustained, and ideologically exhilarating, I suggest that this framing risks selectively revealing certain crisis-related configurations while obscuring others.

My own ethnographic research, carried out in Xanthi, Northern Greece, between March 2014 and February 2015, also belongs with what may be viewed as the "redistributive turn" in the anthropology of the Greek economic crisis. But while I was fortunate to analyse my material at a time when anthropologists were beginning to catch up with the emergent landscape of "solidarity", I also found myself having to account for a series of stark contrasts between our ethnographic findings. The middle-aged female volunteers of the Bank of Love, a soup kitchen that distributes 150 portions of food daily, were not informed by egalitarian principles. Rather, they performed their innately feminine duties as mothers and housewives (Douzina-Bakalaki 2017a). Similarly, the handful of female volunteers of a clothing bank known as the Social Wardrobe were not moved by the principles of disinterestedness. Rather, courtesy of a process that I call "performative commodification", the used objects of the clothing bank transformed into idiosyncratic commodities that mediated relations between customers and store-clerks and allowed disfranchised actors to circumvent stigma and engage autonomous action (Douzina-Bakalaki 2017b). These arrangements, I suggested, were not predicated on the denunciation of hegemonic forms, but rather on their performative upholding, even when this was a delicately ambivalent task.

Here, I address a different austerity-driven arrangement that, similar to Xanthi's soup kitchen and clothing bank, is not oriented towards "alternative" horizons, but rather towards perduring frames of social action and meaning, and more specifically the "language of stateness" (Hansen and Stepputat 2001, p. 5). My ethnographic focus is the Social Medical Practice of Xanthi, Northern Greece, which was established in 2012. Dedicated to the assistance of those unable to access healthcare through the public healthcare system,[2] the Social Medical Practice constitutes a "solidarity structure" and resembles dozens of other healthcare initiatives that sprung up during the crisis (Cabot 2016; Bonanno 2019). Yet, contrary to dominant por-

2 Between 2009 and 2011 Greece witnessed a 28% drop in its health expenditure per capita resulting in a sharp rise in the number of people exempted from public health insurance coverage. According to an OECD report, in 2015 26% of the population was unable to access national health insurance, while 23% of the population reported unmet medical needs.

trayals of "solidarity", the Social Medical Practice of Xanthi is vested in bureaucratic authority and domination. In what follows, I document the social clinic's daily operation, to suggest that the "dissonance" of my ethnographic material owes to the active legitimisation of the state as a regulatory framework of healthcare provision. Drawing on literature that theorises the state as an "effect" that is produced through mimicry and resemblance (Das 2004; Navaro-Yashin 2002; Jansen 2015; Jusionyte 2015), I argue that the social clinic employs the state form and (re)produces its effects.

The Social Medical Practice of Xanthi is premised on a reverse bureaucracy that is closely modelled on the state's symbols, procedures, and artefacts and accommodates those excluded from the public healthcare system. The routinisation of healthcare provisioning, accomplished through things like protocols, documents, a filing system, and a rubber stamp, vests the social clinic in bureaucratic formality and **turns actors into state-like agents and dependents**. Removed from the semantic field of "solidarity", patients' claims to healthcare are conditional on bureaucratic legibility and meticulous inspection. Thus, contrary to dominant iterations of "solidarity", which abandon social difference in favour of shared humanity (Kirtsoglou 2018), the social clinic's volunteers advocate bureaucratic indifference, pertinently described by Michael Herzfeld (1992, p. 1) as "the rejection of shared humanity". The social clinic's state-like qualities are both a function of neutrality and its routine violation. Bureaucratic authority, laden with the power of the unreciprocated gift, imbues the social clinic with excess power and enfolds its actors in arbitrariness. "As if" a state, the clinic provides healthcare, but also generates experiences of marginalisation and exclusion. "Not quite" a state, the clinic occupies a moral high ground that appeals to pity and compassion and allows volunteers both to surmount the authority of the state, as well as to establish a selective economy of favours that is couched in discriminatory conceptions of class, religion, and ethnicity.

I suggest that the "as if" and "not-quite-a-state" qualities of the social clinic are not incompatible, but rather speak to the heart of what authors have variably referred to as "informal sovereignty" (Hansen and Stepputat 2005, p. 297), "petty sovereignty" (Butler 2004, p. 56), and "micro-sovereignty" (Humphrey 2004, p. 435). In this body of work, sovereign power is not theorised as a prerogative of the nation-state, but rather as fragmentary and dispersed, "a tentative and always emergent form of authority grounded in violence that is performed and designed to generate loyalty, fear, and legitimacy from the neighbourhood to the summit of the state" (Hansen and Steputtat 2006, p. 297). The casting of institutional exclusion into provisional inclusion wields a power that is at once modelled on and supersedes the authority of the state, driven by and withholding the logic of the gift. The simultaneous legitimisation of authority by resort to and suspension of the state turns the social clinic into a peculiar space of exception that resides

both inside and outside the law. Caught between the "as-if" and the "not-quite", the social clinic is thus nested in tensions between protection and domination, empathy and indifference, compassion and hostility. In this regard, akin to the "real" state, the social clinic is at once menacing and caring.

The Seal of the Social Medical Practice

The Northern Greek town of Xanthi borders Bulgaria and approximately half of its seventy-thousand residents belong to what is known in official Greek terminology as the "Greek Muslim minority", which consists of people of Turkish origins, Roma, and Pomaks, a population often described as Bulgarian or Slav speaking Muslims. The broader region of Thrace, to which Xanthi belongs, has consistently occupied low positions in national economic indexes. The implementation of regional development policies in the 1980s transformed the region into a hub of medium and large-scale manufacturing, specialising in textile production, wood, and food processing. Despite improvements in local economic conditions, Thrace continued to be one of the poorest regions in Greece. The onset of crisis in 2010 further amplified regional disparities. Tellingly, the second largest economic contraction in the European Union between 2012 and 2015 was recorded in the administrative region of Eastern Macedonia and Thrace. Unable to sustain production, the majority of Thrace's manufacturing firms either closed down or migrated. In the striking words of Aggelos Bebekidis, head of Xanthi's trade union, the town became "a vast cemetery of sweatshops". Xanthi's unemployment in 2014 was estimated to be 39%, while youth unemployment in 2015 was speculated to be as high as 65%. It is against this backdrop that the Social Medical Practice was established in October 2012. According to its brochure,

> The Social Medical Practice provides primary medical and pharmaceutical services to the uninsured and the destitute. It constitutes a collaboration between the Holy Cathedral of Xanthi, the Medical Association of Xanthi, and the Pharmaceutical Association of Xanthi. The Social Medical Practice engages 34 doctors, 20 pharmacists, 17 nurses, 3 social workers, 3 psychologists, 2 physiotherapists, 3 technicians, and 10 secretaries, all of whom are volunteers.

Although these numbers are exaggerated, the clinic was supported by an impressive number of volunteers, the majority of whom were retired doctors and nurses, middle aged or older. Between May 2014 and February 2015, I volunteered as a secretary, spending most of my Monday, Tuesday, and Thursday afternoons at the Social Medical Practice. My role was to ensure that visitors were indeed uninsured, and hence eligible to receive the

services of the clinic. Additionally, my role was to register patients' details, diagnoses, and treatments. I performed my secretarial duties with the aid of a protocol, the meticulous details of which I found almost impossible to follow without error. But even then, there were invariable deviations in its application, for there were always cases that had not been accounted for, exceptions to the rule, and attempts to bypass it.

On Monday 7 July 2014, however, everything ran smoothly. I arrived at the clinic at quarter to three and hurriedly walked past the few people who were queuing in the yard. I entered the cool, dark building and greeted Mrs Yianna, a retired nurse in her mid-fifties, and Mrs Myrto, an insurance agent and dedicated volunteer. I also exchanged a few words with Mr and Mrs Papadopoulou, both in their late sixties and the unofficial heads of the social clinic, she a retired anaesthesiologist, and he a retired orthopaedic surgeon. I then made my way to the narrow wooden desk located at the rear of the room, labelled Reception. At three o'clock sharp, the door of the clinic opened. One by one, the patients approached the reception desk. I greeted them and located their entry cards in the alphabetical database. I then recorded their details in the large hardbound Patient Logbook: name, patronym, age and reason of visit, all attached to a unique number. I also updated the entry cards, to include the date and allocated number. I arranged the cards in successive order and handed them to the volunteering dermatologist, who summoned the patients into the Examination Room one by one.

Featuring a scarred medical couch, a gynaecological chair with broken arms, and a flickering medical lamp, the state of the Examination Room was rather ramshackle. This, however, did not seem to interfere with its function. While the patients were being examined, Mrs Papadopoulou and Mrs Myrto, remained in the small room known as the Pharmacy. Stored there, in all sorts of jugs, crates and cartons, were the pharmaceuticals donated to the Social Medical Practice. Mrs Papadopoulou occupied herself with the spreadsheet accounting for shortages in pharmaceuticals and other necessities. Mrs Myrto performed the tedious task of disposing of the expired medicine.

It would have been an entirely unexceptional afternoon had the quarterly donation of powdered milk from the Union of Greek Ship-Owners not arrived. At quarter past four, while the dermatologist was examining her last patient, the afternoon quiet was interrupted by a honking lorry. Mrs Yianna went outside and soon returned to inform us that, "The milk has arrived! Come, come!" I joined her to find dozens of cardboard boxes by the pavement and many more still stacked in the lorry trailer. The powdered milk was to be offered to uninsured parents of children up to 18 months old. Demand for it was extremely high and many people sought for it over

the previous months, only to discover that the milk had run out. Together with Mrs Yianna we started packing the boxes in large garbage bags, which we then carried to the kitchen. It took us around twenty minutes to store all the boxes. When we eventually finished, the driver handed Mrs Yianna a delivery note that needed to be signed. She gave it a brief look and decided that "It is better that Mr or Mrs Papadopoulou sign it".

I passed the Delivery Note to Mr Papadopoulos, who was comfortably seated on the couch. He scribbled his initials and then ordered me to "Bring the stamp". I went to the secretarial desk, opened the first drawer and removed a small plastic bag. Contained within it was a crimson ink pad and the rubber stamp of the Social Medical Practice. Mr Papadopoulos removed the stamp, opened the ink pad, and pressed one against the other multiple times. He then placed the stamp on the lower right corner of the delivery note and held it there for several seconds. I returned the note to the driver and placed the stamp back in the plastic bag and into the drawer. "It's nearly five, time to get moving", said Mr Papadopoulos. I stored the logbook and card database in the Secretarial Armoire and sealed it. Mrs Yianna locked the door to the Pharmacy and the Examination Room. We exited the building and Mrs Papadopoulou triple locked the door. We bid each other a warm farewell and left.

The following day, however, the mood had shifted. Greetings were reserved and the customary small talk was omitted. Unable to decipher the reasons behind this change, I simply carried on with my usual tasks. It was only much later that I was informed that the stamp had gone missing. More importantly, the stamp had last been handled by me. I recounted the steps that I had followed the day before and I repeated that I had returned the stamp back in the drawer. "Then why is it not there?" Mrs Papadopoulou asked. I started looking for the stamp and Mrs Yianna soon joined me. Together we turned the drawer upside down, looked under the secretarial desk, emptied the garbage bins, scanned the Pharmacy and the Examination Room, and searched in the kitchen. The stamp, however, was nowhere to be found. Perplexed by the anxiety caused by the incident, and the implication that I was somehow responsible for it, I asked why anyone would want to take hold of the social clinic's stamp. Mr Papadopoulos responded,

> Do you know what will happen if someone forges a prescription, seals it with the stamp of the Social Medical Practice and takes it to any pharmacy? He will get whatever he wants, whether it is painkillers, drugs or poison — for free. And do you know why? Because everyone knows that the Social Medical Practice is a last resort. No one is obliged to fulfil the Social Medical Practice's prescriptions, but who dares to leave a diabetic without insulin? This stamp has more power (*ischis*) than you can imagine — even more than those of the Public Hospital. The stamps of the Hospital can only do so many things. The stamp of the Social Medical Practice can do everything.

No warm farewells were exchanged that afternoon. Dominated by worry, I spent the rest of the day searching my apartment, looking for the stamp of the social clinic — in vain. But as it turned out, the stamp was found the following day. "The Bishop needed to notarise some documents and sent his assistant to pick the stamp on Monday evening", Mrs Papadopoulou informed me in a rather unrepentant phone call. The following day there was no talk of the incident, apologies, or regrets. With the stamp back in place, order had finally been restored.

In his ethnography of a besieged Sarajevo suburb, Stef Jansen (2015) reflects on the value of a different rubber stamp, used in the emergency "staircase schools" that operated during the Bosnian war. Originally spontaneous, the educational activities organised in the apartment complex of Dobrinja gradually developed into a schooling system that was accessed by thousands of students and allowed a relative sense of meaningful routine during the siege's extraordinary times. The "staircase schools" featured curricula, contractual arrangements, diploma accreditation procedures, and even an official stamp, invested with hopes for the "ratification of the Gimnazija as a 'real' school, by standards of 'normal' life" (Jansen 2015, p. 113). Dobrinja's make-shift schools were part of a broader constellation whereby, exposed to the absence of a "normal" state, the Dobrinji engaged in an "intricate gridding exercise that mimicked stateness as much as it could" (2015, p. 109). In this analysis, the libertarian framing of the state as a source of oppression is abandoned in favour of an understanding that treats statecraft as an object of hope and intimate investment. The gridding processes Jansen documents, which took forms as varied as armed defence, census taking, and food distribution, invoked the state as an ordering framework and, insofar as they afforded experiences of "vertical encompassment" (Ferguson and Gupta 2002), exerted the state's effects.

The view that the state's assumed transcendental abstraction and ideological unity is sustained through material realities and mundane practices has been expressed in an extensive body of anthropological work (e.g. Krohn-Hansen and Nustad 2005; Mitchell 1991; Navaro-Yashin 2000; Reeves 2013). Crucial to this framing is the idea that the state does not entail a palpable and conspicuous entity, but rather the "powerful metaphysical effect of practices that make [the state] appear to exist" (Mitchell 1991, p. 94). This approach has variously qualified the state as an "illusion" (Abrams 1988, p. 5), a "fictional reality" (Aretxaga 2003, p. 400), and a "magical presence" (Das 2004, p. 226). Attention to the performative underpinnings of the state has allowed scholars to conceive of the state as an effect that bleeds into areas of life that ostensibly exist outside its scope. In this body of work, material artefacts, such as stamps and documents, are shown to

often be conductive of state-like effects, which upset clear-cut distinctions between the real and the fake, legality and illegality, and state and non-state (e.g. Das 2004; Hull 2012; Navaro-Yashin 2007; Riles 2008).

Here, I want to return to the cherished stamp of the Social Medical Practice. Its seal certifies the authority of the social clinic and facilitates iterative performances of routine validation. These functions do not necessarily turn the clinic into a state-like entity. Yet, Mr Papadopoulos' remark that "the stamp of the social clinic can do everything" entails an unmistakeable analogy between the social clinic and the state, as well as a pithy admission that the stamp's power emanates from beyond the legally sanctioned authority of the state. The tension between officialism and provisionality that I understand to be embodied in the stamp, imbues the social clinic with surplus power. On the one hand, immersed in bureaucratic formality, the social clinic attaches its gratuitous services to the logic of the state. On the other hand, vested in pity and compassion, the social clinic administers disentitlement through the binding logic of the gift, manifest in voluntary labour and pharmaceutical donations. The casting of institutional exclusion into regulated entitlement yields a peculiar space of exception, whereby the state is both retrenched, dismantled, and absent, as well as fortuitously present. The concurrent withdrawal and protraction of the state allows the social clinics' authorities to invoke its rules at will, and inserts beneficiaries into a volatile landscape of discretionary inclusion and exclusion. Sovereignty, Judith Butler (2004, p. 83) explains, operates "in the variable application, contortion, and suspension of the law; it is, in its current form, a relation to law: exploitative, instrumental, disdainful, preemptory, arbitrary". I argue that the power of the social clinic, cogently objectified in the seal of its stamp, is indeed sovereign, for as Michael Herzfeld remarks of the state, "symbols of hope may always become instruments of despair" (1992, p. 6).

"As If" But "Not Quite" a State

Unlike Mr and Mrs Papadopoulou, who were responsible for medical matters, Mr Kazakos was the administrator of the Church's philanthropic enterprises, General Secretary of the Social Medical Practice, and therefore the clinic's "real" authority. Commonly referred to as the "Bishop's right hand", Mr Kazakos was a retired military officer and, in the eyes of Mr and Mrs Papadopoulou, entirely unfit to oversee the social clinic. This, however, did not stop him from displaying his administrative power through acts as varied as an unsolicited new filing system, an unannounced meeting with the President of Xanthi's Medical Association, and an undisclosed shipping of pharmaceuticals to the monasteries of Mount Athos. By contrast, Mr and Mrs Papadopoulou demonstrated their own authority by invoking their

medical expertise: Mr Kazakos' new filing system was not fit for medical purposes, his meeting with the President of the Medical Association was a travesty, and the shipping of medicines to Mount Athos had resulted in substantial shortages at the expense of local patients. "The Enlightenment never came here", Mr and Mrs Papadopoulou would often comment to condemn the exercise of religious authority in medical contexts. Or, as a common joke of theirs had it, "We are committed to the ideal of Church and State separation!" The joke never failed to cause laughter. Its success stemmed from the well-acknowledged facts that first, the Social Medical Practice operated *courtesy* of the Church, and secondly, that the Social Medical Practice was no state, but had rather been established with the purpose of counteracting the defects of an increasingly debilitated public healthcare system marked by pharmaceutical shortages, excessive waiting times, and reduced insurance coverage.

Yet echoing scholars who insist that anthropologists "take seriously" people's investment in boundary work (Candea 2011; Gershon 2019), and that much of the state's power is exerted through its assumed separation from the rest of social life (Mitchell 1991; Navaro-Yashin 2002), I suggest that Mr and Mrs Papadopoulou's joke should not be dismissed as inconsequential. Rather, if as Mary Douglas (1999, p. 154) asserts, the joke's resultant "disturbed bodily control mirrors both the joke structure and the social structure", then in addition to offering a good occasion for laughter, the "Church-State separation" advocated by the couple is also telling of the limits to which the idea of the state can be stretched. The view that neoliberal state withdrawal does not necessarily erode the state form, but rather disperses governmental regulation among non-state actors, who often operate in state-like ways, has been expressed by several authors (Aretxaga 2003; Das and Poole 2004; Ferguson and Gupta 2002; Sharma and Gupta 2006). However, in asserting that, "the state is everywhere" (Dunn 2008, p. 245), this Foucauldian approach risks obscuring critical differences between divergent instantiations of "stateness", as well as actors' common insistence that the state is absent.

Among the volunteers of the social clinic, the historically resilient phrase "we have no state" (Herzfeld 1992, p. 10) was interchanged with phrases such as "this is no state", "[the patients] think we are the state" and "we are like the state". On a few occasions the volunteers went as far as to declare that "we are the state!". If any of these utterances are to be treated as reflexive admissions of governmentality, then their gradations require attention. Here, Yael Navaro-Yashin's remark that "contemporary governmentality requires (is based on upholding) this 'as if' quality" (2002, p. 179), which frames certain agents and practices as being of, or related to, the state, is particularly illuminating, because it allows an analytical reconciliation between the two extremes available at the social clinic; the "as if" and "as not".

These coexisting potentialities point to important differences in the social positions available at the social clinic. At times, volunteers and beneficiaries united against the receding state. At others they emerged as unequal parties of philanthropic relations. Most commonly, they transformed into state-like agents and dependents. These subtle differences offer insights into how the noble task of assisting the "destitute and the uninsured" was heavily couched in contempt, indifference and occasionally, hostility.

In her ethnography of two Athenian solidarity clinics similar to the one addressed here, Heath Cabot (2016) observes that while the horizontal paradigm of "solidarity" often blurred distinctions between healthcare givers and receivers, it did not eradicate feelings of ambivalence brought by the recognition that, "solidarity" both contained and aided state withdrawal. The tension between precarity and "solidarity" described by Cabot, manifest in her interlocutors' awareness that their ethically inflected practices were partly sustained by neoliberal politics, was not entirely absent from Xanthi' social clinic. For instance, Mr Kazakos would frequently urge me to hurry up finishing my research, because "Soon the Social Medical Practice will close! Woe if it doesn't! Woe if people continue living in such terrible conditions, unemployed, uninsured, abandoned… We are no state here, this is no state!". The framing of the social clinic as a temporary proxy for the welfare state made room for compassion, while the pronounced deficits of the state generated disdain. At closing time, it was not uncommon for volunteers to assemble and deliberate medical-related developments, including changes in hospital fees, updates in the pharmaceuticals covered by the national healthcare fund, and increases in prescription charges. "Solidarity" in these discussions emerged as an obstacle-ridden undertaking, while the state transformed into the object of a critique that, although not as explicit as among Cabot's interlocutors, drew a clear line between the state and the social clinic.

Yet the complaint that the beneficiaries mistook the social clinic for the state was much more common. "The [patients] think we are the state!" (*mas pernane yia kratos*), Mr Papadopoulos would frequently exclaim with a look of exaggerated despair on his face. Usually, this was the first clause of his sentence, to be followed by several possible options: "they think we are the state and they come here full of demands"; "they think they are entitled to whatever it is they want"; "they treat us like servants"; "they ask for a plastic surgeon". As a retired volunteering doctor once told me in the context of a formal interview,

> They come here and ask: "What are we entitled to (*ti dikeoume*)?" What they don't understand is that they are entitled to absolutely nothing. And this is because the Social Medical Practice was made for those who are entitled to absolutely nothing. Those who come here have no entitlements whatsoever.

In light of the above, any pretence of empowering "solidarity" becomes obscene. Rather, the doctor's cynical remark appears to situate the social clinic within the realms of "philanthropy" and to endow its services with the silencing implications that unreciprocated gifts have for those at the receiving end (see also Theodossopoulos, 2016). Because the social clinic's entitling practices are conditioned on public healthcare disentitlement, any claims on behalf of the patients are entirely unwarranted. Here, however, it is worth considering work that frames the state in precisely this guise, thus grasping it as a composite site of excessive absence and presence (Jansen 2015, p. 135), distance and penetration (Das and Poole 2004, p. 15), hope and despair (Herzfeld 1992, p. 6). The state in this dialectical framing occupies the "highly mobile, tangible, and embodied space through which the power of the state is felt as the slippage between threat and guarantee" (Poole 2004, p. 36). I argue that this tension was particularly pronounced at the social clinic, for despite emerging as a safeguard against welfare state disentitlement and exclusion, the social clinic practiced its own rejections and exclusions.

Bureaucratic Authority in Reverse

The second page of the Social Medical Practice's brochure is dedicated to Frequently Asked Questions:

> Who is entitled to healthcare?
> Any citizen who is a resident of Xanthi and is uninsured and destitute.
>
> What documents should I bring with me?
> Your national health insurance booklet, which indicates that your insurance has been interrupted.
>
> How do I prove that I am destitute?
> Through a copy of your tax statement. Alternatively, through a formal document, validated by the Citizens' Service Centre, indicating that you do not submit a tax statement.

In short, as a volunteer secretary I had to attend to documented interruption and invalidation. By the end of my stay in Xanthi, their symbols were known to me. Usually, prospective patients would arrive with their national health insurance booklets rather than their tax statements. Sometimes dirty and frayed, but most often enclosed in protective cases, the booklets would be placed on the desk with a certain reverence. I would open them with

the gentlest of gestures, making sure not to rumple them, and I would turn the pages one by one, until I reached page five. There I would find all necessary details: name, surname, father's or husband's name, profession, and address. And if the booklet's owner had been fortunate, on basis of their misfortune, I would also find an imprint reading "invalid", accompanied by the date on which the booklet had been invalidated. This imprint did not only invalidate the booklet under inspection, but also a certain life, defined by employment and welfare protection. Having lost their potency, these invalid booklets served as reminders of a more prosperous, or at least less troubled, past. But as they entered the social clinic, these booklets regained their potency — albeit in reverse terms. This reverse bureaucracy, closely modelled on the state's symbols, procedures, and artefacts, turned the state's "invalidation" into the social clinic's "validation" and cast institutional exclusion as provisional and thoroughly regulated entitlement.

Akin to documentation "through which the state claims to secure identities, but which in practice often circulates in ways that undermine these same identities and assurances" (Das and Poole 2004, p. 15), the documents presented at the social clinic were often vested with illegibility and hence fell short of granting their owners access to free healthcare. During my fieldwork I saw many people be rejected by the social clinic and, under the attentive eyes of my superiors, I rejected many people myself. Among them were people who had insurance but could not afford the co-payment required for their treatment; people whose booklets were valid, but whose treatment was not covered by their insurance; people whose treatment was covered by their insurance but was unavailable at the public hospital. Although insured, these patients could not rely on the state, and neither could they rely on the social clinic, because their health insurance booklets were valid. Those unregistered or lacking the necessary documents would also be rejected. Finally, request for pharmaceuticals would not be granted unless an existing prescription was presented or a doctor of related medical expertise happened to be volunteering on that day. According to Herzfeld (1992), one of the most palpable embodiments of bureaucratic power is the timelessness of conduct, condensed in the phrase "come back next week". At the social clinic phrases like "Please return with your insurance booklet" or "Come back on such and such date when a cardiologist will be available" usually caused no major turmoil other than a certain inconvenience. There were, however, cases, where volunteers' meticulous observance of the regulation caused major distress.

"Can you not give us a painkiller? Are they yours? We are poor, respect that and give him a painkiller". These words were uttered by an evidently agitated man, holding a boy with a swollen cheek and shivering jaw, possibly due to an abscessed tooth. The man had registered in the past, and it only took me a moment to locate his card in the database. But no paedi-

atrician was available on that day and as a result, the painkillers could not be prescribed. "It is only a painkiller! Don't you see him? He is in pain!" shouted the man, and a couple of tears rolled down the boy's cheek. "No sir, I told you. No prescription, no medicine" responded Mr Papadopoulos in a cold tone. As it turned out, the man had come from the Roma settlement of Drosero, where the local doctor was nowhere to be seen. He mentioned that painkillers do not require any special prescription — "you can even buy them at a mini market"— and that they are cheap — "How much? Three-four euros per pack?" He explained that he would have gone to the pharmacy to "get the kid some medicines, Panadol or Depon, and maybe some mouthwash, as instructed by the pharmacist". But as it turned out, the man had no money. Whispering words of compassion to his son, he eventually left. Later a volunteering nurse explained to me that,

> Just because we aren't a proper hospital doesn't mean that we don't have to act like one. We do things as they do at the hospital. No one would be admitted without registration, no one would be given medicine without a proper prescription, no matter how poor they were.

Unlike urgency, which had no power vis-a-vis the bureaucracy of the social clinic, phone calls asking for accommodations most certainly did. In this regard, the social clinic was state-like also in its ability to create its own selective economy of corruption and to frame itself as needing to be shielded from corruption. The contention that the social clinic was not only visited by those in need, but also by free-riders (*tzabatzithes),* meaning people who could afford private insurance, was widely shared. When in April 2014, the volunteering paediatrician cancelled her shift at the last minute, Mrs Papadopoulou contacted Mr Poulios, also a paediatrician, and asked him to cover the shift. Mr Poulios declined the request and explained that the majority of the clinic's patients could afford the services of a private practice, but chose instead to take the "easy path". As a result, Xanthi's young practitioners trying to make a living under the harsh conditions of austerity were running out of business. Mr Poulios added that he did not want to become complicit in the encouragement of fraudulence on behalf of the "common suspects", by which, I learnt, he referred to members of the so-called "Muslim minority".

Olga Demetriou (2013) explains that the "minority condition" in Western Thrace is produced by a biopolitical governmentality that draws on law, statistics, demography, education, and medical discourses, among others, to naturalise otherness, cast particular populations as "problematic", and determine aspects of life and subjectivity. At the social clinic, the intersectional mapping of religious affinity, ethnicity, language, and place of residence served as an indicator of moral stature and deservingness. Additionally, it

framed certain individuals as more delinquent than others. The stereotyping of Roma into deceitful, Turks into fake-poor, and Pomaks into passive and withdrawn, was common (see also Davis 2012, p. 150), and was frequently invoked to justify both the ruthless application of the regulation, as well as certain individuals' exemption from preferential treatment. Yet this discriminatory classification also emerged as a form of common knowledge that had no authority vis-à-vis the official scripts of the state. When I asked Mr Papadopoulos whether he would stop serving those he discovered to be able to afford private healthcare, or to be entitled to public health insurance, he responded with a question:

> Would the state ever reject someone because he is of a different religion, a *Yiftos* or a *Pomakos*? We will continue to serve anyone whose booklets is invalid. Just as the state does with all those whose booklets are valid. Just like the state… Maybe we are the state (*isos na imaste emis to kratos*).

Conclusion

The "epistemic proposition of hope", which owes much to the legacies of Ernst Bloch and Gilles Deleuze, treats futurity as a quintessential response to radical change and distils hope into quests for alternative horizons (Ringel 2014, p. 52; Jansen 2015). Emerging against a backdrop of debilitating austerity, "solidarity" firmly confirms the "epistemic proposition of hope" and aligns anthropologists and informants over shared visions of brighter futures. In this reading, the temporal split induced by the Greek economic crisis, which divides social time into "before" and "after" (Knight and Stewart 2016), is also reflected in "solidarity". Mobilised in times of rupture and change, "solidarity" is understood to embody hopeful rupture and remoralising change. What happens, however, when our interlocutors are not concerned with bringing alternative horizons into being, but rather perform the dismantled orders of the past? And related to this, what happens when our informants do not find solace in visions of egalitarianism and horizontality, but rather strive to restore the social positions and hierarchies that once made institutional dependence possible?

The Social Medical Practice of Xanthi may offer some insights. Xanthi's social clinic identifies itself as a "solidarity structure". Yet, the path to free healthcare, laden with bureaucratic formality, is premised on the "language of stateness". Echoing the view that the state "emerges as an affective force in the ambivalent slippages between the stable certainties promised by regulatory frameworks, and the doubts generated by the ambiguities they pose" (Harvey and Pinker 2015, p. 15), I have argued that Xanthi's social clinic employs the state form and (re)produces its effects. Within the reverse bu-

reaucracy of the Social Medical Practice, which turns the state's "invalidation" into the social clinic's "validation", volunteers transform into state-like agents and beneficiaries into state dependents. Acting as a proxy for the failing welfare state, the social clinic couples bureaucratic authority with the power of the unreciprocated gift and casts institutional exclusion into provisional inclusion. The results, as we saw, are often despairing. During my fieldwork, people needing life-saving doses of insulin were rejected, others injured were thrown out, and parents of sick children were referred to the public hospital. The rejection of patients was often justified through invocations of bureaucratic rationality combined with claims of authoritative expertise.

The social clinic however most often emerged as the last resort for an ever-increasing number of people who had been excluded from conventional avenues to healthcare. Having become irreparably complicit in the enforcement of a menacing bureaucracy, I often found solace in the fact that "good days" far exceeded bad ones. According to the social clinic's brochure, "More than 1200 uninsured fellow-citizens received healthcare in 2013, many of whom were children who were vaccinated for free", while "In 2014 the number of patients treated at the Social Medical Practice nearly doubled". Russel Henshaw (2019) in his illuminating ethnography of Athens' "Solidarity Network", observes that, faced with scant resources and logistical problems, the volunteers resorted to administrative procedures that implicated volunteers and beneficiaries in power relations. Henshaw (2019, p. 53) asks: "Is this solidarity or governmentality, have volunteers radicalised the state or has the state de-politicised the volunteers?" I share Henshaw's question, but I would like to pose a different one: Could the invocation of state authority at a time of rampant welfare neoliberalisation be as meaningful an act as its resistance? The Social Medical Practice of Xanthi does not offer egalitarian and counter-hegemonic alternatives. "As if" but "not quite" a state, at its worst, it embeds actors within a volatile landscape of sovereign power. At its best, the social clinic offers a field of action where the "uninsured and the destitute" can continue to experience the state's indifference and receive its care.

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