



FIGHT LIKE HELL FOR THE LIVING



A HEALTH AUTONOMY READER

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CONTENTS

TOWARDS HEALTH AUTONOMY4

AUTONOMOUS HEALTHCARE:

 IN CHICAGO16

 IN THE BRONX26

 IN CHIAPAS41

 IN ROJAVA46

 IN GREECE52

CREATING THE IRREVERSIBLE70

TOWARDS HEALTH AUTONOMY:

AN INTERVIEW WITH DR. FRANK

Name the materials necessary for the common good, or how about just your top three. Health is an arguable front-runner, no? It should be way up there, alongside things like freedom and the environment.

Medical care's active role in healing denotes its intrinsic value to our common human experience, and for that our communities have a real dependence on Healthcare. Please note its capital 'h'. The medical industrial complex touts both material and nonmaterial forces in its ranks. Knowledge, profit, and taste keep us under the authority of Health. Yet there could be hope. According to my friend and comrade Dr. Frank, we may be living through a time of immense change in the way health services function.

Frank and I met at Woodbine, an experimental hub in Ridgewood, Queens that hosts workshops, lectures, and discussions. It serves as an organizing space for various autonomous projects. The Woodbine collective means to develop the skills, practices, and tools for building autonomy. They also serve a mean communal dinner every Sunday.

For Frank, Woodbine represents both the material and the ideal. "It is a local aggregating point, a space for ideas to take shape, while on a larger level it exists for the goal of building a revolutionary life." He says the way to build that life is to build communally, to find the means for collectivities to grow, and to shape them in a way that overcomes the limitations of the context we find ourselves in today.

In search of the common good, I asked Dr. Frank how we might address Health dependency, if he could imagine entirely different models than what are offered, and what he suggests we do now to develop generative communal health care.

You're a doctor but you're also a radical organizer and active member of the revolutionary autonomy collective Woodbine. How'd you get into this?

When I was in high school I wanted to be the surgeon for the New York Mets. I had this grand plan to go to a good college, get into a good medical school, go to orthopedic surgeon residency, and drive BMWs by the time I was thirty. Yeah, I guess I fell off that track, now I ride a 70s Peugeot bicycle to work.

I work in the ER at Bellevue Hospital, I'll wrap up my residency in July. But, I came to medicine circuitously; I was a chubby kid and I broke my arm a lot. The last time I broke my arm I told myself I'd be a doctor so I could fix it and not go to the ER anymore. It's funny, but it got me on this track.

In college, I learned about structural violence, structural oppression, and got into international politics. I still wanted to be a doctor, but I moved to emergency medicine because it's skill based. I wanted to have something to offer a large movement. Most practices are somewhat theoretical and highly dependent on hospital infrastructure. ER medicine is dependent upon ER infrastructure, but it also offers more procedural based learning like suturing, splinting, and dealing with trauma.

I remember thinking when the revolution happens in some Latin American country, I'll speak Spanish and I'll go [there] to be the doctor. In ER medicine, we learn a little about everything so I could deliver a baby, suture an arm, and deal with a chest wound. I thought future struggles would include both acute injuries from gunshots or bombs and sub-acute chronic diseases. I wanted to be like the Che of that country or something. It was a good illusion because it allowed me to have radical beliefs without having to do anything.

After that, I worked in California for a bit and then finally went

to medical school in Boston. It was there, while still involved in international health work, that I realized how ridiculous that idea was, how selfish it is to think someone else in some other country is going to start an uprising and I'm going to help. I began questioning myself, like, why am I not trying to foment that here?

Toward the end of medical school, I still had some idealism about changing medicine from within and I did some programs to teach other med students about radical thought and structural violence. I got fed up with that, though. I began to see doctors as a class, that we're too far gone or too brainwashed by that point to change. I realized the institution itself is the problem.

Through Occupy, I came to New York City in search of a community to build the structures for a revolutionary life, who could ask what that would look like here in the US. For two years, I went to every meeting I could – every socialist group, anarchist group, and communist group – and of course I got burnt out. Around the climate march, I was fed up with the movement, or that our end goal was just to march. After all the meetings, it just felt pointless. I question the strategy and it takes up so much energy. Sure, it can help others get into things and it is worth it sometimes, but I don't know how much effort we should put into it. You have to ask, is this doing anything?

After the climate march, I found Woodbine through an event and felt it was the group I could ask these questions with. For me, it provides the material ground seeds of ideas need to grow, to begin building the worlds of the revolution.

What does it mean to you as a doctor to have a radical perspective?

For one thing, I still view being a doctor in the sense of what can it do for others. I mean, the history of doctors is already radical.

Salvadore Allende, Che, and Rudolf Virchow were all doctors who went into medicine with a social context, understanding that the larger social determinants of health is a social issue primarily and a medical issue secondarily. They were all politically active. They were protectors of the belief in a right to health. For me, that will always counter a proto-capitalist narrative. For me, that is what it means to be a radical doctor. It is community organizations with the idea of de-professionalizing health and trying to decrease the reliance on health institutions to put health back into people's hands. I think it can only be done inside communal milieus or communities of service.

During medical school and residency, I tried to start initiatives to ask what radical medical application could look like, but unfortunately, there's been a professionalization of medicine. Doctors tend to carry ideologies or idealisms when they're younger, thinking they're going to change the world through the medical system, but then eventually it goes away and it's just a means to an end.

After Trump was elected though, I noticed at work, where I have a bit of a reputation, that these ideas were being respected more – political revolution or social upheaval is not as crazy as it seemed before because really, what we want is not that crazy. We want a world where people are healthy, where we can support each other, where we can have families, and people are not oppressed or discriminated against. We want clean water.

I think this is new to our generation, but there still must be a betrayal of your class to some extent. Most doctors come from upper middle class or middle class socioeconomic status. There is a strong subculture of petite bourgeois ways of life, that you must remove yourself from and negate to produce autonomous means of medicine.

It appears class distinction is built into your profession. It does go with the stereotypical projection of doctors: scrubs, stethoscopes, and millions of dollars behind them.

That came about in the fifties and sixties with the rise of insurance companies, especially Medicaid and Medicare, and the idea that people should no longer pay out of pocket for services. Insurance companies paid comparatively massive reimbursement rates in regards to out of pocket payments by using collective pooling. Outside payers with large sums of money came with increases in medical technology and higher and higher rates.

Before that, you had a generic local doctor, who carried a black bag to your house. Maybe they were more affluent than others, but they were part of the community. They couldn't easily charge a neighbor for services they couldn't afford. There was more respect for the profession, for the ability to help heal and they, in turn, had more responsibility in the community.

But to become a doctor today your family has to have money, or you take on massive loans. And if your family has wealth, statistically you will be less understanding or empathetic to the poor, or even if you are empathetic, it is unlikely you will betray your class upbringing. And if you take out loans, well, some argue the debt is meant to control you. Doctors tend to owe upwards of 400k when we graduate, which is honestly a crushing amount of debt. It can force you to cater to debt: to work a nice job, have car payments, maybe a house and kids. Debt traps you in a certain way of living.

Now, there's systemic pressure on doctors to worry about their loans first, or their lifestyle first. It's subtle and maybe this is clouded because I'm in residency, but there is a sense that doctors need to get theirs. That, as a doctor, you deserve a certain level of living: happy hours, vacations, apartments.

That could stunt the movement.

I think it is the same with any revolutionary group. If people want revolutionary change, they have to accept their lives will not be

comfortable anymore. Change is chaotic, especially for doctors. Doctors are in a very comfortable position.

Drastic change in this country means war and you may not be on the winning side. You'll lose material comforts and psychological comfort. Right now, I can get a job anywhere in the country and it's an amazing privilege that I have, but to let go of that is still too much for doctors. I have communal support, people who support these ideas, but if I was on my own with a family it would be hard to think about the positives of revolutionary change. That's why more and more people take a pragmatic approach to change, but I don't think we're in a time in which a pragmatic approach is possible.

Does Obamacare or the repeal of Obamacare concern you?

What concerns me is that we don't think of health as a human right. We're forced to think of health insurance coverage as a product to buy and, in the current system, everyone should buy that product, even when it does not guarantee the ability to receive health care. Obviously, there are differences between Trump and Obamacare, like Trump's is more free market-based, but [to go from Obamacare to Trump] isn't as big of a shift as, say, if Canada were to switch to a free market system. That'd be a huge ideological leap.

We talked about this at Woodbine recently, during a Trump lecture series. The Affordable Care Act increased coverage for people, up to forty million people, but there is still at least twenty million people uninsured. It covers preexisting conditions and limited what health insurance companies could reject. A lot more people come to the ER with insurance, which is great, but they come because they don't have access to the other services that they are paying for, like primary care or referral services. The ACA increased access to coverage but it did not increase access to health care, which are separate things often lumped together. Now more people have insurance

coverage, but health infrastructure was not increased. People have a primary care doctor but often coverages say they can only see their primary care once every six months. This begs the question: if they cannot easily access their primary care doctor, do they even have one? It mandated coverage for birth control and maternal health – each beneficial for greater society, but the problem is that it enshrines insurance coverage. It enshrines the idea that people need a third party to get health care.

What about the Republican plan?

The Trump program is just an exacerbation of free-market based policies. It tried to deconstruct certain regulations to further health care as a commodity. The idea is that if given unrestricted access to the market, the best product will come out. This, in theory, makes some sense, if you are buying a car, but in health care, you can't have educated consumers. There's too much difference in the understanding of medical problems. If someone says you must get something otherwise you'll die, it is not a fair situation. Health care shouldn't be on the market at all. Trump's plan is a rough continuation of neoliberal policies that Obama, Clinton, and others carried. Now it appears we're in this situation where we don't want the repeal of ACA but we also don't want to defend it, that's the tricky area people are falling into.

With the idea of health care tied to health coverage, the term doctor immediately connotes higher education and institution. Do you believe health care can be emancipated from the medical industrial complex? Do you see a future in communal medicine?

That is something I think about often and I think it is possible. There's starting to be a failure of the medical system piece by piece. People don't want to have health insurance because they don't see

a lot of the benefits. Even myself, I only have emergency health insurance. A lot of younger people are not going to see a need to pay for something that they're not using. There will be more of an emphasis on preventative, holistic living. I think it is possible, but I think doctors must make a choice.

I worry the Healthcare fight will further individualism, though. There is already hyper-specialization and right now no one can afford to become a community doctor – myself included. I went to emergency care because I could not contemplate the idea of dealing with insurance companies all day. We're somewhat shielded from it, but as health care costs increase and health care education increases, people will more and more go into specialties because that is where they'll make money.

Right now, one of the major obstacles for community based health-care models is fear in medical communities and regulations. For example, if I open an autonomous health clinic, I'm liable to lose my license and never practice again. Due to the legal push to treat patients like customers, with campaigns to increase patient satisfaction, we now treat medical care as a commodity. Initially introduced to protect patients against pseudo-doctors, it has made it impossible go without licensure in a formalized bureaucratic structure, which makes it nearly impossible for health practitioners to practice anything resembling autonomous care.

The regulations compel us to work within the system of medicine. But, still, I believe these are risks doctors must take. We need ways to mitigate risk, but we should still act. We can't wait for the government. We can't wait for healthcare models to change.

Do you have experience with autonomous health care models? I know you've worked with the Zapatistas.

I've been to Chiapas a few times to work with a doctor who trains

health promoters. They have a bare-bones clinic, few medications, lots of outdated stuff and because of their lack of resources they rely on preventative, intuitive models integrating holistic and western models of medicine: herbalists, bone setters, and preventative medicine. The health promoters train the community to recognize and treat basic diseases normally treated in a hospital. Vaccines, blood pressure checks, and glucose checks are basic preventative care.

For the Zapatistas, it is too risky to go to the hospital, for fear of violence. They could be detained by the police and you know, it gets worse from there. It is also terribly expensive, so its almost impossible to go, but sometimes they are forced to, if someone might die without medication. Their idea is to limit that and educate the community to recognize red flags.

The doctor I worked with has been doing this for fifteen years. Eventually, the health promoters will teach the next generation so they're not reliant on outside doctors. If someone is sick, they do have connections to the hospitals, albeit western style hospitals in Mexico, with a lack of resources all around.

The Zapatista model shows us we have to be flexible, we have to be scrappy, and we have to be okay with having no money or resources and building from there.

And you sense we're in a time of societal change in regards to health?

We are in a chronic crisis and as far as health is concerned it is a horrific time. I think we're going to see the dismantling of people's access to health care. This is a crucial time when we should look at models like the Greek solidarity clinics. When there's an economic crisis, there must be pop-up clinics. The same with the Zapatistas creating their own healthcare systems, and Rojava, which had a decimated health care system and they tried to recreate it. The ben-

efits of looking at these models is that because they lack resources they focus on primary care and preventative care. They advocate not just healthy diets and daily exercise, but mental health care. They mean to keep people healthy. In the US, we treat sick people and that is very resource intensive.

Another example is the GynePunks in Barcelona, they essentially do do-it-yourself gynecological exams and create their own speculums for lab testing, because those services are not around. You look at the war on Planned Parenthood, it is not hard to imagine how a woman's ability to get an abortion is being impacted and at some point, our clinics are going to need underground services again. How do we develop that capacity? This is something we must think about.

Do you follow these models at Woodbine?

Woodbine's Health Autonomy track does skill shares to de-professionalize health. To share health knowledge with people, but also create an idea of community care. Our mental health is a detriment right now. Most of us don't have an idea of being in community. Caring for people in the community is foreign to a lot of people. So, we ask: How can we normalize community and also put it in practice? What do we do when a friend has a cut, or how do we help a sick parent? How can we create communities that can take care of elders and kids? But also, what do we do when one of us has a mental break down? What do we do when the police beat our friends up? We can't all become surgeons and we cannot all deliver babies. We can however find and balance the needs of the community and how we can project our proposed resources into the future.

What other community medical roles can we fulfill today?

Let's start with chronic depression and chronic anxiety. There is a chronic feeling of unease that can be treated in a community setting, perhaps it can only be treated in community settings. We need to recognize our limitations, like if someone is having an acute psychotic break, we may not be able to treat them. Sometimes there is a role for medications, but those are last resort versus our first resort.

We can start with the basics of health. We can learn how to cook for ourselves. We can learn what is generally good food. We can learn physical fitness and get away from bad habits. We can deal with basic injuries because most injuries are not that acute. And we can learn to name the more acute things, what we cannot address.

In April, we're having a herbal medicine series, not to make people into herbalists, but to show some basic herbs that you can try. In the ER, a lot of what we see in the public hospitals are chronic issues, back pain for example. Lots of people have back pain, but the majority of back pains are not acute issues, like those caused by muscle strain or poor posture. These can be treated by non-medical modalities like massage or acupuncture. When people with back pain go to a hospital they get funneled into a way of thinking about pain which will inevitably lead to surgery, imaging, MRIs, and things like that. Often, that's not the best way to deal with it.

We had an acupuncture series and we're going to have another. And another basic first aid series. Start with things your grandmother might talk about, holistic home remedies, like putting honey on burns – which actually have a lot of truth to them.

For the record, herbalist/holistic methods work?

Absolutely. There is a lot of evidence for it. Addressing that fact is a good start. That and the fear of the body perpetuated by consumerism, objectification, individualism. Like the hatred of aging, we still fear this thing as the cause of our problems. We need to stop fearing our bodies so we can focus on the materiality of what is going on, otherwise, we'll just get caught up in the bullshit of 4chan, Twitter wars, and all things that are meant to drive you crazy. I think that stuff is meant to wear you out.

What's next for you in regards to autonomous health?

At Woodbine, we are hosting an “Intro to Health Autonomy” in the next few weeks and will be focusing on three areas: physical, mental, and communal. Health autonomy is split up but each relies on the other. To me, communal care addresses the physical needs of the individual, be it through collectives farming food, growing medicinal plants, or just taking care of the physical body. This can also attach to ideas of fighting and resisting, to the idea that what our movements often fight against is the oppression of the physical body like the contamination of water via pipelines or the price of goods. The second is the mental, that our mental health is as real as our physical health. People are anxious, depressed, manic, and suicidal. These each need to be addressed, and historically, we have viewed them from individual means alone. We're trying to change that model to represent mental health as indivisible from the third aspect, which is the communal. We all need to feel part of collectivities, to have groups that support us. We all have a human desire to be part of something more.

JANE

RACHEL WILSON
ALLY SHWED





SOON, HEATHER RECEIVED MORE AND MORE CALLS.



ILLEGAL ABORTION WASN'T DISCUSSED OPENLY, ONLY HEARD ABOUT WHEN A WOMAN TURNED UP DEAD. BUT WITH A GROWING NUMBER OF WOMEN SEEKING HELP, HEATHER REALIZED ABORTION WASN'T A MEDICAL ISSUE — IT WAS A FEMINIST ONE.



THEY CHOSE JANE.



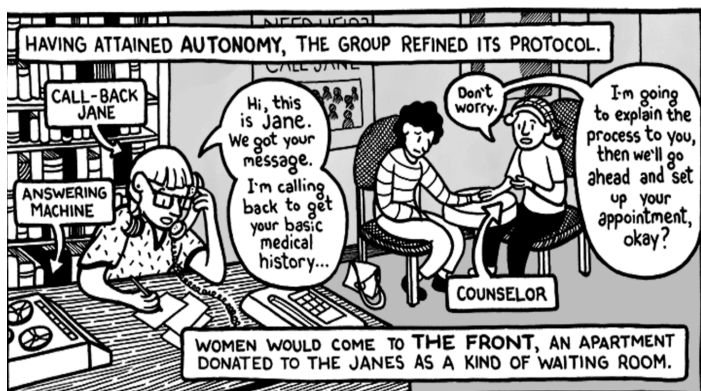
THE JANES WERE UNHAPPY WITH HOW LITTLE CONTROL THEY HAD OVER THE PROCESS. ABORTIONISTS CHARGED BETWEEN

\$500 to \$1000

AND WOULDN'T ALLOW WOMEN TO BE ACCOMPANIED. ALL THE JANES COULD DO WAS CHECK ON THEM AFTER THE PROCEDURE.



THUS, THE GROUP WAS ABLE TO REGULATE THE PROCESS FROM *start to finish*, KNOWING WOMEN WOULD BE **SAFE** IN THEIR HANDS AND SUPPORTED ALL THE WAY THROUGH.



SINCE THEY WORKED IN THE DAYS BEFORE "MEDICAL" ABORTIONS—THOSE INDUCED BY THE MIFEPRISTONE—MISOPROSTOL—ALL JANE ABORTIONS WERE **SURGICAL**.



JANE PROVIDERS WOULD USE THE **DILATION AND CURETTAGE METHOD**; THIS INVOLVED DILATING THE CERVIX, ADMINISTERING LOCAL ANESTHETIC AND THEN **SCRAPING FETAL TISSUE FROM THE UTERINE WALLS**.

THIS METHOD WAS ONLY SUITABLE FOR EARLY TERM PREGNANCIES OF UP TO 12 WEEKS. FOR LONGER TERM CASES, A **MISCARRIAGE** HAD TO BE INDUCED. THIS WAS MORE EMOTIONALLY CHALLENGING, BUT JANE BELIEVED IN A

WOMAN'S ABSOLUTE AUTHORITY OVER HER OWN BODY.

WHEN THE WOMEN OF JANE PICKED UP THEIR INSTRUMENTS AND PERFORMED ABORTIONS, A WOMAN'S RIGHT TO CHOOSE QUITE LITERALLY BECAME PALPABLE *in their hands*.



GIVEN THE RELATIVELY LOW COST OF A JANE ABORTION, THE FRONT BECAME A RARE POINT OF DIVERSITY IN THE OTHERWISE WHITE, MIDDLE-CLASS LANDSCAPE OF WOMEN'S LIBERATION.



ANY WOMAN CAN BECOME PREGNANT WHO DOESN'T REALLY WANT TO BE. THERE WAS JUST AN ENORMOUS RESPECT FOR EVERYONE. —JEANNE GALATZER-LEVY

THERE WERE ONLY A FEW WOMEN OF COLOR IN JANE'S MEMBERSHIP AT ANY ONE TIME, AND LOIS SMITH* WAS ONE. IN AN INTERVIEW WITH LORETTA J. ROSS, SHE REMEMBERS: "WE COULD NEVER DEVELOP A CRITICAL MASS."

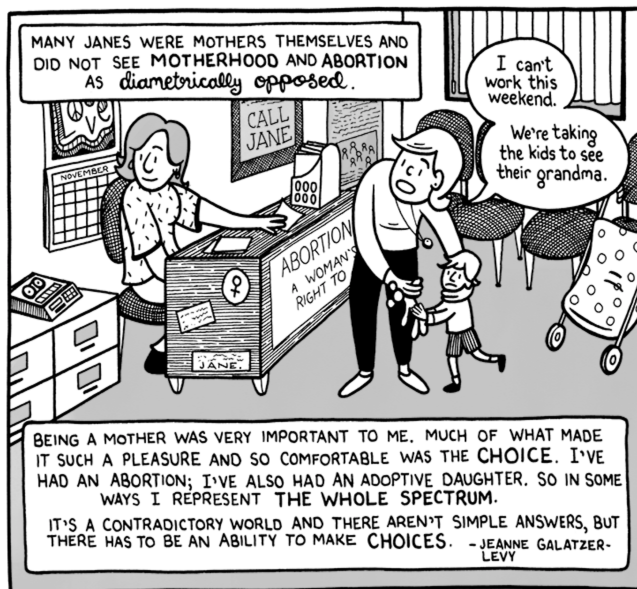


"BUT WE DIDN'T LOOK ON IT AS A BLACK OR WHITE WOMEN'S ISSUE; WOMEN NEEDED TERMINATION OF PREGNANCIES AND THERE WAS A unity CREATED BY WOMEN WHO WERE DESPERATE."

*PSEUDONYM
**SEE BIBLIOGRAPHY



THERE WERE MANY REASONS FOR WOMEN TO SEEK ABORTIONS. JANE NEVER ASKED WHAT THE REASONS WERE — THEY JUST MADE SURE A WOMAN WAS CERTAIN SHE WANTED THE ABORTION AND WASN'T BEING FORCED INTO IT BY HER FAMILY OR PARTNER.



IT'S TEMPTING TO VIEW JANE AS A *legend* OF THE WOMEN'S LIBERATION MOVEMENT, BUT FORMER JANES REFUSE THE IDEA THAT THE GROUP WAS SOME SPECIAL PRODUCT OF HISTORY.

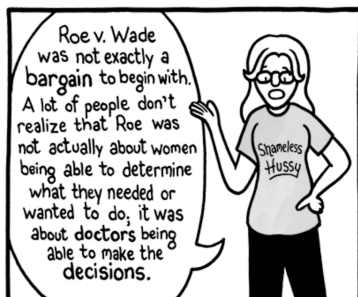


AS JANE CONTINUED THEIR WORK IN CHICAGO, THE PRO-CHOICE MOVEMENT WAS GROWING AROUND THE COUNTRY.

SEVERAL STATES MADE ABORTION LEGAL.

THEN THE LANDMARK **ROE v. WADE** IN 1973 MADE ABORTION LEGAL *nationwide* IN THE FIRST THREE MONTHS OF PREGNANCY.



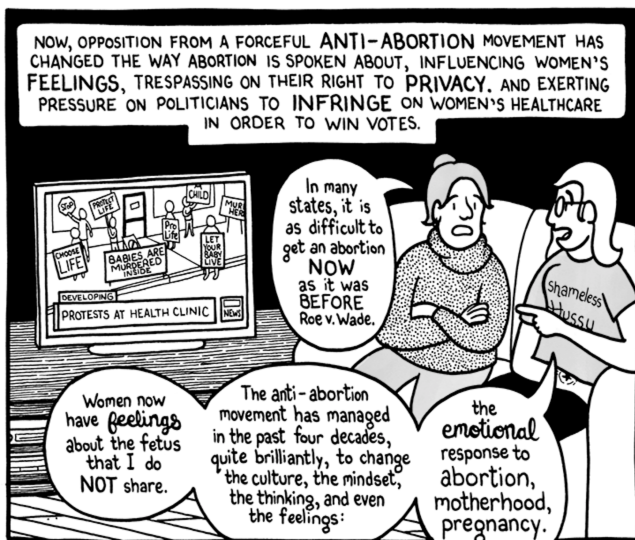


SINCE THE RULING, ATTITUDES TOWARD ABORTION HAVE CHANGED.

JANE WANTED TO demystify THE PROCEDURE.

BUT IN MANY PARTS OF SOCIETY, ABORTION IS STILL CONSIDERED **TABOO** AND WOMEN ARE LEFT **UNSUPPORTED**.

THIS wasn't THE FUTURE OF REPRODUCTIVE CARE THAT THE JANES HAD WORKED SO HARD TO CREATE.



Their radically violent wing is very active and **EXTREMELY DANGEROUS**, so the danger to women who are attempting to do the good work now comes not only from the officials—the cops and the politicians—but also from the serious bad guys.

I'M REALLY VERY *encouraged*, DESPITE EVERYTHING. THERE'S AN ENORMOUS AMOUNT OF *ANGER* AND *PUSHBACK*— THERE'S A LOT OF UPPITY WOMEN OUT THERE! I'M SEEING THEM MOVING US FORWARD. I'M FINDING IT A VERY *exciting* TIME FOR WOMEN.

THE THING ABOUT THE WOMEN IN JANE IS WE WERE PERFECTLY ORDINARY PEOPLE; IT'S A MATTER OF, YOU *PUSH* ORDINARY PEOPLE FAR ENOUGH AND ORDINARY PEOPLE DO

EXTRAORDINARY THINGS.

—JEANNE GALATZER-LEVY



JUDITH ARCANA —

I'M ACTUALLY *hopeful*, IF YOU CAN BELIEVE IT, BECAUSE THE YOUNG ONES ARE *SO SMART*. THEY'RE TOUGH AND THEY REALLY *REALLY* ARE PISSED OFF. THERE AREN'T MILLIONS OF THEM YET, BUT THERE ARE THOUSANDS AND THOUSANDS ALL OVER THE COUNTRY, AND *THEY'RE DOING IT!* AND I JUST THINK:

Let's → **OKAY!** ← get going here!

IN THE BRONX



REVOLUTIONARY HEALTH CARE PROGRAM FOR THE PEOPLE

JANUARY 1970

Mingo El Loco was a brother off the block who helped out the Young Lords Organization every once in a while. He would loan the Organization his car, would help pass out our literature, would recruit for us .. A few weeks ago Mingo was stabbed by another brother. It happens all the time in the street. Our people are always killing each other off instead of fighting the enemy-the pigs, the businessman, the politician.

The ambulance was called. For one hour it didn't come. Meanwhile the pigs arrived, Mingo was dying on the street, but the police did nothing. Finally, the people tried to take him to the hospital in their own car. He died on the way to Metropolitan.

People dying because of ambulances that arrive late, or in emergency rooms of city hospitals while they wait for hours, happens often. 'The people have become used to butcher health care and resigned to the fact that they'll never be decently treated by the health system. But the Young Lords, after Mingo's death, began to investigate health in New York and we have begun a program to organize the people-community and workers-to demand decent health care.

As we talked to dozens of sympathetic doctors, nurses, medical students, maintenance, clerical and laboratory workers in Metropolitan Hospital, we began to understand more and more about health oppression.

We learned that many of the diseases that our people die of could be simply cured or even prevented with correct mass health programs which the hospitals do not have. For instance, thousands of children become sick or die because of lead poisoning, from eating fallen plaster in ghetto buildings. A mass lead-poison detection program could save the lives of thousands of our children. Anemia, tuberculosis, bad nutrition, upper respiratory infections, could be stamped out with mass health programs that go out to the people, into the homes and communities, instead of waiting for a patient to come in to the hospital with the disease already in advanced stages.

We learned that doctors were making 560-70 thousand a year because poor people have to have health care. That their organization, the fascist American Medical Association, for years has been trying to keep the number of medical schools down so that doctors could charge higher fees.

We learned that the drug companies, like Upjohn, Park and Davis, etc, not only push many useless or harmful drugs just for profit, but that they have much influence in Washington and state legislatures over medical bills. Many times officers of these companies sit on the boards of private hospitals and help determine the policy that has been mistreating our people for years.

We learned that there are things called health empires: medical schools and private hospitals that through affiliations (contracts with the city) operate and run city hospitals. In New York, for instance, Columbia controls Harlem Hospital, Albert Einstein controls Lincoln Hospital, Beth Israel controls Gouverneur Hospital, New York Medical College controls East Harlem's Metropolitan. These affiliations end up helping the medical school much more than the municipal hospital. For instance, interns and medical students have much more practice and experience in the city hospital, because in the private hospital, patients are treated by their own doctor and refuse to be treated by students. The poor people who come to the city hospitals are used as guinea pigs, sometimes, for new treatments, methods, new medicines that will then be used on the rich. The priorities for the medical schools are training and research. The needs of the people are for mass, quality free health care. The two are often antagonistic in our society.

We learned that in our communities, control of health must be taken out of the hands of drug companies, avaricious professionals, pig politicians, and racist administrators and put in the hands of the people. That is why we demand:

COMMUNITY WORKER CONTROL

FREE HEALTH CARE

MASS HEALTH SERVICE

The Young Lords have developed a Ten-Point Program of Health that explains what we want, the minimum necessary for our people-for Puerto Rican, black and poor white oppressed peoples. We have joined with revolutionary workers in other parts of the city, with the Health Revolutionary Unity Movement at Gouverneur Hospital on the Lower East Side, with the Lincoln Hospital workers in the South Bronx, with the Black Panther Party Free Health

Clinics in Staten Island and Brooklyn. We are building a city-wide revolutionary health movement that will shake the city to rotten pig core.

The revolutionary health groups have also begun forming an alliance with radical medical students and professionals around a week of activities in February, 1970 – People's Health Week, which will attempt to have teach-ins, demonstrations, and mass health programs, and educate the people about the difference between capitalist medicine and socialist medicine, between medicine that oppresses the people and medicine that serves the people.

By becoming involved in Breakfast Programs, Clothing Programs, Health Programs, the Young Lords are demonstrating to all Latin and other oppressed peoples that we truly do serve and protect. Wherever the people suffer and resist oppression, we are there to aid, shape and lead their struggle.

Long Live Boricua
Long Live Independent Puerto Rico
Free Health Care for Everyone
Hands off Cha Cha

Venceremos.

SOCIALIST MEDICINE

JUNE 1970

Every Saturday, the YOUNG LORDS PARTY goes door to door in El Barrio and the South Bronx, testing for tuberculosis. Even though t.b. has been eliminated among the rich, the middle classes, and white people in general, it is alive and spreading in the Puerto Rican and Black colonies of amerikkka, the “richest” country in the world.

Tuberculosis is known as a disease of oppression, just like lead poisoning, anemia, malnutrition, etc. It comes from being so oppressed by the man that we cannot get jobs that pay enough, houses that shelter us right, or hospitals to care for us; it comes from not being able as a nation, as Borinquenos, to control all these things; it comes from being poor, oppressed, and powerless.

During the last 3 months, in El Barrio, and the last month in the South Bronx, we have given over 800 tests for tuberculosis. One out of every three people tested has had a positive reaction. Why aren't the hospitals doing anything to prevent t.b. in our communities? Because the hospitals do not serve the needs of our people. They exist only to make a profit. Hospitals are only interested in hospitalization (which costs in the hundreds per day), lab tests and medicines. All of which they can charge a lot for. But, as the YOUNG LORDS PARTY has shown, all that is necessary for t.b. testing is a few hours work and dedication.

We live in a country that makes proper health care a luxury only rich people can afford. Heart transplants and brain surgery are done on rich people; the preventive medicine is not done on Puerto Ricans and Blacks because this capitalistic system wants to make the rulers live longer and let the spics and niggers die off as quickly and quietly as possible.

The racism of the health empire must be exposed. It is in every area

of medical service. Puerto Ricans have had “drug problems” for many years, but it wasn’t until a few white kids in the suburbs started getting strung out, that the health empire “discovered” drugs, and a big stink was made in the press. This is like Columbus “discovering” Puerto Rico. The 70,000 Taino Indians had always been there, but just like the drug problem, until the man feels it directly, in his pocket or in his home, it doesn’t exist and he doesn’t give a damn.

Point 5 of the YOUNG LORDS PARTY 13-Point Program and Platform states “We want community control of our institutions and land” and Point 13 says “We want a socialist society.” In a socialist society, the institutions like the hospitals are controlled by the hospital workers and the patients. Also under socialism they extend their services out to the people visiting them in their homes and setting up Free Health Clinics in every block. This type of service which keeps people from getting sick in the first place is called preventive medicine. Although doctors admit it is needed, preventive medicine will never be done in amerikkka, as it is today because it is a capitalist society. Capitalists run hospitals and make money out of Puerto Ricans being sick and if there’s no money, they’re out of business. Socialists are concerned with keeping people healthy, not with making money.

As long as we don’t control institutions like the hospitals we will continue to die of disease like t.b. and receive poor or no health services in general. We must begin to fight together as a people to take over all the institutions that control our lives, by taking the central power that protects the capitalist hospitals, the state Pig administrators who run hospitals and profit from other people’s suffering must be put up against the wall. As long as pigs like these are in our communities, they will continue to use (exploit) us.

The YOUNG LORDS PARTY will continue to serve our people through our Preventive Medicine Programs, and we will at the same time continue to expose the way in which the institutions in our communities exploit us. The YLP will fight until hospitals,

police, schools, etc are run by the people, especially those who work in and are affected by these institutions.

FREE HEALTH CARE FOR ALL!
LIBERATE PUERTO RICO NOW!

Carl Pastor
Ministry of Health
YOUNG LORDS PARTY

TB TRUCK LIBERATED

JULY 1970

Everyday, Puerto Rican people are faced with the same deadly health problem tuberculosis – a disease that affects our lives and a disease that can be prevented. The reason that t.b. isn't being prevented is that preventing diseases like t.b. cuts the profits of the capitalists that run the city hospitals. Therefore, the hospitals don't work on preventing these diseases.

The YOUNG LORDS PARTY has always said that the time will come when the people take over all the institutions and machinery that control and exploit our lives. On June 17, the YOUNG LORDS PARTY put this idea into practice. On this day, we liberated an x-ray truck from the politicians that had been using the truck only for propaganda purposes that serve their own interests and profiteering businessmen that only think about making money.

The truck was seized only after members of the YLP had gone to the Tuberculosis Society several times asking them for the use of the truck. Each time, the request was refused. By refusing us, they made it clear that they aren't concerned with the health of our people. These trucks have been seen in our community only on a very limited part-time basis. We realized that the reason our people didn't use it was because the people running the show prior to the LORDS were outsiders who couldn't relate to our people, our language, and our customs. They never made any real attempt to get the people to use the x-ray facilities.

In the three days that we have had the truck, we have already tested 770 people. According to the technicians, the usual amount of people taken care of in the same amount of time is about 300. So, as far as the YOUNG LORDS PARTY is concerned, this truck rightfully belongs to the people!

The last point of our 13 Point Program and Platform states that “We want a socialist society.” Under a socialist society, medical services are extended outside of the hospital by setting up clinics in all communities and by visiting people’s homes. This type of medical service is called preventive medicine. Although doctors admit it is needed, preventive medicine will never be done in amerikkka as it is today, because in the capitalist society in which we live, capitalists run health services in order to make more money, not to improve health care. The sicker we are, the more money the capitalist makes. ‘The YOUNG LORDS PARTY believes that health care should be a right for all people not a privilege. That is why we put the x-ray facilities in the hands of the people.

The Ramon Emeterio Betances Free X-Ray Truck now belongs to the people. It will be on the streets 7 days a week, 10 hours a day. This truck is here to service the needs of our people.

ALL POWER TO THE PEOPLE!
FREE HEALTH CARE FOR ALL!
LIBERATE PUERTO RICO NOW!

SEIZE THE HOSPITALS!

DECEMBER 1970

For years Lincoln Hospital has been the scene of a continuing fight for better health care. In March, 1969, a group of mental health workers with the help of the Black Panther Party took over the Mental Health Center. In the summer of 1970, the Young Lords Party along with the Health Revolutionary Unity Movement (HRUM) and the Think Lincoln Committee took over the Nurses' Residence of the hospital. In the most recent action on November 11, HRUM and the South Bronx Drug Coalition took over the sixth floor of the Nurses' Residence. This action was taken to: 1) Implement a drug program that would serve the community effectively and be run by the community, 2) Provide an educational program that would teach the true nature of our oppression and the connection between capitalism, dope and genocide, and 3) Demonstrate the need for a drug program at Lincoln since the South Bronx has a total of 40,000 drug addicts and Lincoln has facilities to deal with at the most 40.

At noon on November 11th. about 35 addicts along with workers from the hospital and community people sealed off the sixth floor and began to implement the drug program. Physicals were given by doctors that had volunteered their time. Beds were assigned, and medicine was given out.

In the meantime, negotiations were going on in the office of the hospital administrator, Lacot. Lacot took the typical anti-people position. His response to the valid community demands was "No program," and he ordered the people out of the hospital. At 4:00 p.m. Lacot and about 40 helmeted police in riot gear came to the sixth floor (which is only used as sleeping quarters for doctors on call) and ordered the people off the floor or be arrested. When the police finally managed to get past the barricade, 15 people were arrested. These people were put in jail because their interest was in saving the lives of their people.

We have to understand that this action as well as all others was taken after people saw a problem in the community, asked for help and were refused by the hospital. Not until people take positive actions (which are sometimes called “illegal” by the real criminals) does the administration attempt to do something. It has always been this way. This situation was no different. Not until the community and workers got together and took over the sixth floor and were arrested did puppet Lacot (he is only the mouthpiece for the hospital corporation that really controls Lincoln) attempt to throw a program together. What happened in this program run by the hospital was that addicts weren’t getting medicine, were going around sick, and had to go through a whole irrelevant run-around. Finally the program was closed down because of mismanagement

We must begin to ask questions about all the things that affect the lives of Puerto Rican and Black people. Who can better determine what’s best for ourselves than us? If this is the richest country in the world, why is it that this country is 13th in the world in health care? Why is it that we have to live in housing that is not fit for animals? Why do we have to be subjected to an inferior school system? Why is it that the jails are filled with Puerto Rican and Black people? Is it that we are a criminal people? Or is it the conditions that create the problems?

We must begin to realize that we live in a system that does not concern itself with the lives of the majority of our people (who are poor), but rather only cares about how it can obtain more wealth for a few money-hungry businessmen. This country can only exist by exploiting and killing other people, mostly Third World people, like it’s doing in Vietnam, Puerto Rico and all other colonies inside and outside the united states.

We must begin to create struggle everywhere we go, not only in the hospitals but in all institutions that control the lives of our people. We must make them more responsible to our needs.

ALL POWER TO THE PEOPLE

Could you tell us a bit about the groups you were involved in during 1960s and 70s?

I was in the Black Panther Party (BPP) and the Young Lords Organization (YLO). YLO was the Puerto Rican equivalent to the BPP whose major focus was New York City and between Puerto Rico and New York City. The goal was Puerto Rican freedom and independence, and equality and justice for people of Puerto Rican descent in the U.S. In the 1960s-70s, black people, Puerto Ricans, and people of color couldn't get jobs that made enough money to survive on. Sometimes it was because you didn't speak the language, or you didn't have education, or you didn't have equality in housing or health care. There was simply no justice. Young people saw the Civil Rights Movement's strides in fighting for justice and equality and began to see that in order to gain equality, justice, respect, dignity, you had to fight for it. YLO was a very young group. The average age was somewhere between 16-18 years old. We were young, but committed and courageous. The Think Lincoln Committee (TLC) was a coalition of doctors, nurses, community members, hospital workers from Lincoln, and orgs like YLO and BPP. We all came together around a single issue: quality, free health care is a right. We came together because health care conditions were so horrendous we could not ignore it. Lincoln Hospital was (and still is) in South Bronx. In the South Bronx and Harlem, asthma rates were extremely high because of the environmental situation and housing conditions. Infant mortality rates in South Bronx and Harlem were (and are) higher than many third world countries. You could go to the hospital to the ER on Saturday evening and be left waiting for 72 hours. You could go into surgery and have the wrong kidney taken out, easily. We heard stories of people with surgical instruments left inside their bodies. Mental health treatment meant giving out psychotropic drugs and keep just keep people drugged up. 1/4 of the

people in South Bronx and Harlem were addicted to heroine. 1/4 of the population! There was no program for drug addiction treatment. There were other environmental issues like lead poisoning and sickle cell anemia. It was an uncaring form of health care delivery; it was essentially racist. The service and treatment at Lincoln Hospital would never have been allowed in a rich community. So it just seemed to us that this was a logical thing to work around.

What did the Think Lincoln Committee do?

We set up a table in the ER to (1) take complaints, and (2) be an advocate for people who came to ER. I learned what little Spanish I know by translating for people. 3-4 people at a time would sit at the table. We were never not there. They would throw us out consistently and we would come back with our table. Throw us out, we would come back in! If we couldn't get into the ER, we'd sit at the door! We would write down people's complaints. It didn't take long to prove there was a problem at Lincoln. We would carry huge stacks of complaints, written by hand, into administrative offices and said, "This is the problem you're having!" We worked with some young doctors who would tell us what they just learned. They taught us things like lead poisoning symptoms. We would take that information, study, understand it, break it down, and share with the community. That's how the community work started. We would get nurses, doctors and community members together and we would borrow/liberate/abstract equipment from hospitals, Department of Health offices, and doctor's offices. TLC was known for stealing a tuberculosis truck. The City wasn't using it, so we just took it. We took a doctor with us and we went around testing everyone. Free, preventative care was not being done at that time; we showed that it could be done. We found a lot of people who needed to be taken to the hospital to get treatment and they didn't know it.

How did you move from tabling at Lincoln Hospital and "liberat-

ing” the TB truck to the occupation?

This was actually the second take over. A lot of people don't know that. The first was by workers in the mental health center. I had a job as a community mental health worker, which is how I met the TLC people. My first week, the workers said they were pissed off, not treated well, had no education, and wanted to be respected in the psychological team. The union thought they were just trouble-makers. So workers took over the mental health center, demanding training and upgrading. People don't realize that TLC's occupation was only possible because of what the mental health workers did before. What TLC did was possible because of what workers did before. The struggles before.

So this whole time, TLC was learning about the disparity inherent in how the system functioned. We spent time trying to figure out what we could do to turn this thing around. We thought we could turn it around by taking a bold action. At the same time, this was the occupation years. Everybody who was pissed off occupied the thing they were pissed off at and demanded something. It was obvious to anybody who looked at the conditions in our communities all over the country that something like this would be done. And then there was a critical event: the death of Carmen Rodriguez. She died as a result of a saline abortion at Lincoln Hospital. At that time, the U.S. Government was using Latino and African American women as guinea pigs to do research on birth control methodologies and lots of women were dying as a result. Birth control pills were tested on women in Puerto Rico without their consent. The death of Carmen Rodriguez in the OB GYN department sparked anger among community. So we planned this take over.

So you occupied the hospital. Were there people on the outside supporting you?

Lots of people. People brought food, water; everything we needed came from the community. There were older people who thought we were crazy but they didn't want us to get beat up or starve so they brought food. Even the churches supported us. When the police came to kick us out and beat us up, it was a church who protected us! They took us to the basement to hide. No one knew where we were. Then, we came out in lab coats in small groups with 10 or 15 minutes between each group. I walked out of there right past two police cars and into the church. 100 of us walked out like nothing! The police wanted to beat us up but they had no idea where we were. We just disappeared!

Were mental health center workers involved in TLC and occupation second time?

Absolutely. Without them it wouldn't have been possible. We had nurses, interns, residents, attendants, doctors. It was diverse and intense. We all used to meet together in the mental health center. It was kind of an evolution. And we came together.

IN CHIAPAS



This article is based on information provided by a compa who has been working to train health promoters in two different areas of Chiapas. He stressed that he could only discuss healthcare in two of the five caracoles, the self-governing geographical regions into which Zapatista territory is divided. Each caracol is autonomous; they all start from the same idea – land and freedom – but each area has developed distinctly, with a different programme, and a different way of doing things.

The compa first worked in Los Altos, the highland zone, in the ‘caracol of resistance and rebellion for humanity’. In this area, the people decided to first create a big central health clinic, La Clinica Guadalupeana. This clinic now serves hundreds of communities. Health promoters from these communities continue to come to the central clinic for training in ways to support people’s basic health needs. The next stage was the creation of smaller micro-clinics, (there are now thirteen of these), and finally, simple basic ‘health houses’, or consulting rooms, were set up in the majority of the communities. These are often run by only one health promoter,

who comes from that community.

If a patient can't be treated at the 'health house', they go to the micro-clinic, or if the promoters there cannot deal with the case, the patient is then referred to the main central clinic. The aim is not to rely on the government at all, but some cases still really need treatment at the state hospital, which is often not an option due to the cost, the distance, and for political reasons. Although full autonomy is not achieved yet, the promoters are doing very well, and starting to develop more specialist care particularly in the care of the eyes and the ear, nose and throat, as well as in women's health.

In Clinica Guadalupeana, there is a laboratory where analysis of samples can be done. There is a special women's consulting/maternity/birth room run by women health promoters. There is an operating theatre, a pharmacy, a 24 hour emergency room and a room for treating eye problems. There is a herbolarium for herbal medicines, most of which come from local plants. The Zapatistas here remain desperately short of medicines, equipment and resources, but despite this, they continue to strengthen their health service.

The highlands are the poorest region of Chiapas, there is a greater shortage of food, poorer crops, less land, and difficult cold, often wet, weather. Yet, in this caracol, the health system has been taken on board very well, and the number of health promoters has increased from 45 to over 360 in the last eight years. They continue to go on training courses run either by the communities, or by international groups.

The health promoters are chosen by the communities. They are chosen because of their commitment and desire to learn, and often because they can speak, and perhaps write, in Spanish, although many are not fluent. Many of the training courses are in Spanish, with translators to translate into the appropriate indigenous languages. The health promoters are all volunteers and receive no salary. It is not easy to be a health promoter: they have to give up their daily work helping to provide food for the family, and they usually

have to work in their second language.

The training courses are for one week every month. The promoters have to leave their homes, and support and feed themselves while they do the courses, which shows how deeply they believe in what they are doing. They then take the knowledge they have learned back to the community. After two years of training, most health promoters can identify six or seven of the common illnesses.

Health promoters live and work in the clinic, treating people during the day, and being on call for emergencies at night. The more experienced health promoters pass on their knowledge to other local indigenous people who are training to be health promoters. Being a health promoter involves taking on and promoting a new concept of, and approach to, healthcare and treatment, a mixture of their own indigenous culture with western medicine. "We aim not only to treat illnesses, but to create a better system of health, one which respects Maya culture, an autonomous health system".

The second area where the compa is working is the Selva Norte, the northern jungle zone, in the 'the caracol that speaks for all', situated on the border with Tabasco, where the situation is totally different. The healthcare system here is based on health promoters, and 40 to 60 'health houses', tiny surgeries, trying to support the communities. There are no main clinics.

The reality of the illnesses present is determined by the lack of safe water, the insects, and the weather which varies between hot, wet and cold. The houses are very basic structures offering little protection from the climate, with the result that pneumonia is one of the main killers.

The health promoters are trying to control illnesses and promote good health in an area where there was previously no knowledge of clean water or of hygiene. They are trying to change peoples' habits and develop preventive healthcare, but this is very difficult. There is less knowledge and experience in healthcare here than in the high-

land zone, which is comparatively quite advanced and specialised. The health promoters here are aged between 10 and 76, and many have little knowledge, but it is very good to see them working in a new and different concept of health.

For many years, people have been told that the plant medicines don't work, and they have learned to "want the tablet". This is an example of the damage that can be caused by western culture. The training courses use a mixture of both traditional and western medicine, but in some places the traditional knowledge has been lost, and is having to be re-learned.

In Chiapas, many indigenous people die of curable and preventable diseases. They are desperately poor, and lack clean water and sewerage. They suffer from chronic ill-health, malnutrition and hunger. Many have open fires in their houses and no ventilation. There are therefore a very high percentage of people suffering from parasites, diarrhoea, skin problems, malaria, tuberculosis, and other gastro-intestinal and respiratory conditions. Some of the worst problems are respiratory ones, due to their poor living conditions; the children develop pneumonia, and the women chronic bronchitis. There is a lack of knowledge of and treatment for, women's health, and many women die in childbirth and children die before the age of five.

Many communities still have traditional bonesetters, mountain healers, and midwives. In some places, they are regaining the knowledge of using plants as medicine, and returning more to the old ways.

The emphasis throughout is on preventive medicine, promoting good health, teaching people how to maintain good hygiene and have better nutrition, "looking after each other to keep ourselves well". The best medicine for illness is the community; by having a collective approach to healthcare, working together and organising, they can support and care for each other.

Health is not only related to the individual, but to the whole community. It is based on the relationship between the worlds and on respect for the earth. The souls of the dead are under the ground and all living things are connected. “You can’t talk about health and not talk about the river”.

Zapatista healthcare is completely independent of all government funding and control; they have developed their own autonomous forms of health, democracy and decision-making. In Zapatista clinics and health houses people are treated with respect, love and responsibility. Because the health promoters are local, people can be talked to in their own language, by someone who understands their needs and culture. In the government hospitals, indigenous people are discriminated against, misunderstood, ignored. Many non-Zapatistas now come to the Zapatista centres for treatment, knowing they will not be turned away.

This means that, in a country where most people, particularly indigenous people, cannot afford medical treatment, which may not be available to them anyway for political reasons, Zapatista healthcare is open to everyone. Non-Zapatistas only pay for the basic cost of medicines or any materials needed; the treatment is free. Healthcare is for all, without distinction. The paramilitaries who have attacked the community with firearms still get treated; the *compa* watched a promoter treating the man who had just shot and killed the promoter’s brother, without hesitation or rancour. “We are all brothers and sisters.”

IN ROJAVA



The following is an interview between three Europeans who have spent time living in Rojava and working in different parts of the healthcare systems and Heval Azad, a member of the health committee in the Cizire canton of Rojava. The interview was conducted with an interpreter. Heval Azad began by introducing the health committee and its aims:

I will start by telling you about the autonomous system. Since the beginning of the revolution we have been trying to establish where the issue of health is situated within a system of democratic modernity. In thinking about how to build up this system in Rojava, we have first been undertaking research of other systems around the world, including health systems. We are criticising those other systems and on the basis of our research and critiques we are developing our own system. The problem is that before the revolution there was a deep connection between health and the power of the state. So we are building up a new system with a new basis – trying to remove this connection. Health is one of the key areas which is

represented by specific structures and institutions in the new system. So the main aims for health in Rojava are:

To solve the problem of relations between health and power/the party.

To critique and rebuild the relationship between society and doctors.

To return ownership of health to society.

What was the healthcare system like before the revolution?

The system in Syria was a state system, and because of this it was based on money. Even if health services are free at the point of care, the doctors still work for money, and a percentage of this money also goes to the state.

In Rojava we are just at the beginning of the revolution so we cannot solve or change everything overnight. This is partly because we aren't strong enough to do that, and partly because we don't have enough doctors, and those we have are all dependent on the old system. So we are talking with the Doctors' Union to try to resolve this. For example there was an operation that cost 100,000 Syrian pounds, and we are negotiating for it to be half the price. These negotiations will go on until we are able to educate our own doctors. Today we are opening a civilian hospital in Darbasiye and in this hospital people will only need to pay for operations, and the prices are cheaper than in hospitals still relying on the old system. But our goal is to provide healthcare without money. This is a long term project. It is not a project of a year, it is a project of four or five years, and right now there is also a war going on – but we will go ahead step by step as we are able to.

At the moment, what are the healthcare structures? Where do people go when they get sick?

There are a lot of private hospitals. We have set up public hospitals in Serekanye, Derik, and Amuda, and a small service in Hasake. We are slowly building them up.

In Darbasiye which has the biggest civilian hospital there are some clinics in the local neighbourhoods, and we want to increase this system, make more and bigger clinics, according to what is possible.

What about other services outside of hospitals, physiotherapy, etc?

Our goal is to do everything without money. Right now we don't have enough doctors, possibilities, strength, so we're going slowly. Now we are opening our universities and our goal is for doctors and other health workers to work without money. Our longer term goal is to take out health from business, so that health does not depend on business.

How is women's health organised? What about specific women's health issues like birth control?

Women are autonomous, so they organise themselves autonomously from the commune to the canton level. The women have their own meetings and they organise by themselves, but at higher levels men and women need to come to agreements on such an important issue as health.

In terms of birth control, it is up to the people to decide whether they want to use it and how many children they want to have.

Some states set rules about how many children women should have, but in Rojava the self-organisation does not consider it has any right to comment or set rules on this.

So the point is to give people education so that they can have the knowledge and decide for themselves. In this education people are made to think about for example, the consequences of having many children if you do not have any money, and what the future might be like for your children. People are thus given the chance to decide for themselves how many children they want to have.

Can you tell us more about the health committee, and its role in the self-organised system?

The first point of reference is the health assembly. Though we also consider the word 'health' itself to be a problem. This is because of the meanings it is associated with – you could imagine that the health assembly is a place where there are doctors and we talk about sicknesses. This is a problem because this way of understanding health reflects the system of the state.

In fact this is not the focus of the health assembly in Rojava. The assembly for health is a place where we discuss problems from commune to neighbourhood to city levels. The people who are involved in the assembly do not need to be doctors and they do not need to be connected to sickness or injuries, the assembly is a place where people are organised.

Twelve different associations and institutions are part of the health assembly at city level: the municipality, the Foundation of Free Women, the Union of Youth, the Doctors' Union, the Vet's Union, the Union of Pharmacists, the Union of the Health Workers, the Union of Dentists, the union of all the different unions, the Kurdish Red Crescent, the Houses of the Injured, and the Union of Journalists. If we consider health in a more traditional way then some of

these organisations would not usually be considered relevant. Only the doctors who work to make people feel better when they get sick would be included. But we are aiming to solve the problems of society so that we can prevent sickness from occurring. For example, the municipality is included, as they are responsible for keeping the streets clean, and the environment has a big impact on people's health. We work with the same unions in each city and we are also starting to have health assemblies at the canton level, and we want to extend this to the level of Rojava.

In the communes things work a bit differently. In each commune there are nine committees, one of which focuses on health. Abdullah Ocalan says that the capitalist system 'reaches right to the hair of the people' so we also have to reach the hair of the people. For example in my commune, if they realise a place is dirty they clean it up, or if there are some people who need health education they get doctors to come and give it. All the committees work in this way, because we want to prevent people from getting ill.

Next we have the level of the neighbourhood. At the beginning of the month each neighbourhood holds their own meeting. Every commune has two presidents and at the beginning of the month they take their report to their neighbourhood meeting. At the neighbourhood level, the reports from each of the communes are combined to make one report. There are two co-presidents who bring their report to the city assembly. Then the assembly of the city itself makes its own record which is taken to the canton level, and then the canton report goes to the level of Rojava. This system of our assemblies becomes a system of self-defence.

There are at least nine committees at each level of the self-organised system. Committees include language, first aid, education, ecology, economy, journalism, youth, and defence. The word health comes from the state. When we say health we don't mean health with doctors and sick people, everything is centred around the nine committees and if we organise around these nine committees the state will disappear.

In Europe some people are trying to re-establish traditional healthcare knowledge that has been lost, or stolen by capitalism. Does anything like this exist in Rojava/Syria?

Of course we want to make a natural system, for example in Ser-ekanye a system started last month for gathering herbs and for starting to get back the knowledge of this natural healthcare system. Our goal is to separate the health system from business, so if there is a possibility to use the knowledge of the system we will use it. The capitalist system hides this information from us; there are people who are 50 years old and don't know how their body works. For this reason it is important to provide people with education so they can learn about their own bodies. Because doctors come out of society, what the doctors know is the knowledge of society. For example in my village people were healing without doctors, we knew how not to get sick and when we got sick we would heal ourselves with herbs. But the things that people used to know, they stole it and now they sell it to the people.

However, there are two sides to this. On one side doctors don't accept these methods, of healing ourselves. On the other side medical techniques for healing people have improved. It is important to put these two things together; the new knowledge of science with the old knowledge.

I want to say something else about the private hospitals. In capitalist systems a lot of money is put into the healthcare system. For example in places where there are a lot of new medical techniques and private hospitals, you can be sure that people will get more sick because they know there are more doctors – they need people to get sick. But they don't put the same resources into preventing people to get sick. If they put the energy into trying to prevent people from getting sick rather than into trying to get sick people better... they look at society as if it is sick and needs to be cured, but it is the system itself that is the illness of society.

IN GREECE



Since the beginning of the Greek financial crisis, both the Right and the Left have advanced a narrow set of narratives, policy possibilities, and even political actors. One movement that has largely remained outside of the discourse has been the solidarity economy movement. A key organization within the solidarity economy movement is Solidarity for All. Solidarity for All is an organization that offers technical support, capacity building, and network-scaling for the various grassroots initiatives around Greece.

In a 2014-2015 report entitled *Building Hope: Against Fear and Devastation*, Solidarity for All draws attention to “the devastating effects of the radical neoliberal experiment on Greek society.” The report also sets out to highlight “another experiment: that of Greek society taking action through self-organization and solidarity, of people standing up and resisting their economic and political ‘sav-
iours.’”

In the report, Solidarity for All cites statistics that are often unseen

in accounts of Greece. For example, the organization notes that “If we include the economically inactive population...56.3% of the population are out of work.” Undoubtedly, this number has increased, as it is drawn from 2014 data. Between 2008 and 2013 the youth unemployment rate increased from 21% to 59%. With the increase in the unemployment rate, there has been dramatic reductions in unemployment benefits, both in terms of the nominal support provided, as well as the relative total of the unemployed who receive any benefit at all. While 58% of the registered unemployed received benefits in 2008, only 14% received (reduced) benefits in 2014. With healthcare tied to employment, at least 2.5 million people have lost “their social security status.”

The report goes on to cite skyrocketing increases in the number of people unable to pay their mortgages, taxes, as well as the total amount of overdue bills. With the foreclosure ban lifted in the midst of crisis, banks have been able to seize and confiscate property and homes. Together all these statistics, and many more, provide a startling image of a country that now sees the majority of its population living under the poverty line. It is for this reason that a UNICEF report has referred to this crisis as a “Great Leap Backward.” The economic cost is clear, but the psychological and social impact is immeasurable.

Nonetheless, as the report emphasizes, there are alternatives, and they are sprouting up throughout Greece. These include solidarity healthcare clinics, food solidarity structures and solidarity kitchens, “without middlemen” networks, immigrant solidarity networks and cooperatives. With the crisis bringing the capitalist mode of production into question, these democratic organizational forms are being sought out and created. As Christos Giovanopoulos – member of Solidarity for All – emphasizes in this interview, these alternative institutions are not simply about fulfilling a need, but about building capacity and ensuring all participants have agency within those same alternative institutions.

Thus, one finds a range of organizational designs and setups even

with one type of alternative institution. As Solidarity for All states, “There is not one model of solidarity clinics, each one is unique, and the same goes for all the solidarity structures. While all solidarity health centers are self-organized, some are linked with local doctors’ associations and trade unions, some with local political groups, or cultural centers.” The solidarity clinics are nationally aligned in the Cooperation of Solidarity Clinics and Pharmacies. With Attica being the main site of alternative institution building, the region possesses the Coordination of Solidarity Clinics and Pharmacies of Attica. As the report itself states, the aim of these clinics is not to substitute for the state, but to fill a need and work in conjunction with existing health workers’ unions.

Food distribution has also taken different forms with solidarity food structures, solidarity kitchens, and “without middlemen” networks. Without middlemen networks connect food producers directly to consumers through mechanisms such as preorder. The result is reduced prices in food, as well as ensuring a higher income for producers. These networks also provide a framework through which socialization of production, distribution, and even consumption, can be steadily built and scaled. One example of this is that each producer of a given bazaar donating two to five percent of their goods, which are then distributed to families that cannot afford to purchase food.

In the case of cooperatives, the state put in place a social cooperative enterprise law. When I visited Greece in August, I was told approximately 700 enterprises are registered under this designation, however, many of these enterprises are not substantively cooperatives, and instead are NGOs. The real number according to the report, as well as a Social and Solidarity Economy volunteer in Solidarity for All, is between 300 and 400 cooperatives. This includes the high-profile workers’ self-managed firm VIOME, a recuperated enterprise that has endured frequent attempts by authorities to liquidate it and sell off its assets.

Also, expanding due to the rapid inflow of migrants and refugees is

immigrant solidarity networks and structures. These have received increased attention in large media outlets, and have been noted for the inclusion of migrants and refugees in the decision-making processes and apparatuses of such organizations.

In this interview with Christos Giovanopoulos, greater context and detail is provided for this turn of events. Giovanopoulos does not claim to speak for Solidarity for All or for the movement as a whole, but rather an actor engaged in the grassroots initiatives. Giovanopoulos provides us with a strategic outlook and philosophy for not simply countering neoliberal discourse and policy, but building an alternative to it.

How did the solidarity movement start in Greece?

The Greek grassroots solidarity movement is the offspring of the Squares' occupation movement of summer 2011. The Squares' Movement had a transformative effect on Greece, as it popularized the idea and practice of self-organization and direct democracy. This was novel for the vast majority of the participants. Many thousands of people came in contact with anti-capitalist grassroots experiences and forms of organizing – alternatives to the neoliberal logic. According to a poll conducted by Kathimerini, the largest rightwing paper, 28% of the Greek population (about 3 million) participated in one way or another in this movement. From this one can imagine the kind of cross-fertilization that occurred in these times of intense political fighting and social innovation.

Popular radicalization from, and political resistance to, the Troika-dictated “state of exception” and the Greek political system, took the concrete form of the grassroots solidarity movement. This started after the Greek parliament accepted the mid-term (2011-2016) bailout program (late June 2011). The popular movement responded by attempting to block its implementation. Strikes and government-building occupations – primarily in the public sector

– occurred, but most importantly, there was a ‘no pay’ campaign against a new household tax. The tax was included in the electricity bills. Refusal to pay meant you risked having your power cut. The last People’s Assembly of Syntagma Square (end of September) called for the ‘no pay’ campaign. The Assembly stated “we won’t leave anyone alone against the crisis.” This became the banner of the solidarity movement. The campaign employed a diversity of tactics, ranging from appeals against the government to the high court, to (illegal) power reconnections. By late October, it spread through the whole of the country, ultimately including many different actors: from left and progressive mayors, unionists and lawyers, to dozens of neighborhood assemblies and committees, which collectively refused to pay.

This movement acted as the bridge between the Squares’ occupation and the appearance of the self-organized solidarity structures. The ‘don’t pay the debt’ demand amalgamated in the tangible act of ‘no pay’ – refusal to pay – the extra household tax. Over the next months, the mass and militant protests of the 28th October 2011 – the national day of OXI (NO) to the fascists in 1940, now acquiring a new meaning – brought down the Papandreou government. On 12th February 2012, it also brought down the technocrat coalition government of Papadimou. In the meantime, a whole network of solidarity structures and alternative economy initiatives had emerged: solidarity clinics, solidarity free-schools, alternative currencies, barter economy groups, self-managed cooperatives, and the ‘without middlemen’ (basic goods) distribution networks.

What is the role and purpose of the solidarity structures? Are they simply a response to austerity? Or something more?

Your question touches on some critical issues. There is an approach, that reads the current crisis predominantly from an economic viewpoint. This overshadows other facets of the crisis by focusing only on the (anti-)austerity discourse. This view, in my opinion,

fails to break with the neoliberal concept (and dominant agenda) of politics, which means the reduction of the latter to mere economic logic. My critique does not imply a 'need to abandon' materialism, class struggle, or, Marxism, as analytical and practical tools. On the contrary, it refuses to reduce them to merely economic demands, or, issues (including the debate over the currency). Such is to refuse the mostly defensive demands that do not necessarily relate with the attempt to create the material conditions for building power(s) that can enable a movement and a people to apply their own policies and produce change. Such anti-austerity discourse usually regards the grassroots solidarity movement as a response to the collapsing 'welfare state', overlooking the different kind of politics and resistance practiced by the solidarity movement. Some view it as an example of an active and compassionate 'civil society' (or, NGO sector) that needs to expand, while others – coming from the 'traditional Modern Left' – consider it a substitute (and thus a threat) to the role the state-run public services should play.

The solidarity movement transcends those positions. First and foremost, the practice of the solidarity structures holds the potential to synthesize active popular participation – as a response to immediate needs of a population threatened by a humanitarian crisis – while it enables the resilience of this society to stand up and carry on resisting. Beyond supporting the suffering, it aims to engage them in the struggle to change both deeply rooted habits of political 'assignment' and the conditions that cause their hardships. Thus, it develops spaces and practices that could form a different paradigm. Specifically, a paradigm for people-managed 'institutions'.

This implies a different role and practice than that of merely supporting an ailing society. Its *modus operandi* – based on assemblies and self-organization – can foster new kinds of social relationships, pushing against the disintegration of the social fabric. Moreover, the practices of the solidarity structures develop a favorable terrain for breaking the split between 'beneficiaries' and 'benefactors'. In that manner the medical practice of a doctor in a solidarity clinic differs from his/her practice in a professional clinic. The political

context within which this movement emerged has entangled needs, desires and emotions with the will to resist and change matters by becoming active and by creating. This is exactly where the dominant unjust system has failed you. Here lies the transformative potential of the grassroots solidarity movement, which is active beyond the confines of being merely support structures. This is where it differs from charities, NGOs, and the ‘civil society’, which are usually in pain to claim their apolitical, or, non-governmental (supposedly independent) role. In reality, they are instrumental of and to the neoliberal social model, where ‘civil society’ – named ‘big society’ (UK), or, ‘participatory society’ (Netherlands) – substitutes for the welfare state model. In contrast, the solidarity movement does not hide its political role and what it stands for, including its aim to produce social and political change, and to create the material conditions that permit a different democratic paradigm to emerge in order to restructure the existing clientelist public (welfare included) system. Thus, its difference from the ‘traditional Modern Left’ political culture is not in its long-term aims, but in that it goes beyond just demanding and voting. It defends social rights in a very tangible way by trying to develop tools and through standing by the people needs. This means forging enduring social relationships in order to show that there is an alternative based on a different set of principles, ideas (e.g. equality, universal rights), and mode of social organization.

This political practice becomes increasingly important in conditions of emergency, devastation, and crisis of social reproduction, which produced by the ‘state of exception’ regime and the neoliberal agenda still active in Greece. Moreover, it alters the concept of politics (and social policies), highlighting the importance of popular participation and/or a different role of the state. For a state not as a substitute of social action through its representational (political or technocratic) structures, but as a legislative insurer of what society can self-manage. From a social point of view, I find this refreshing and emancipatory. It is a process that underlines the importance of building material capabilities. For any kind of political emancipation and (exercise of power for) change to be success-

ful, it must not be limited to an abstract rhetorical social referent. Political emancipation and change must also be oriented towards real popular participation and social autosuggestion. In other words, a notion of politics that enables and implants democratic processes and responsibilities of power in every aspect of social and economic action as a prerequisite for building the social dynamics and infrastructures that can allow one not simply to take power, but to enable the people to have power to exercise their will. Having said that, I must clarify that this struggle does not exclude the need to take power. It highlights, rather, something obvious to all after last summer's tragic reversal of the OXI (NO) plebiscite: that you cannot have political power without having set state-independent bases of social organizing, popular power and alternative economic networks.

Unfortunately, this transformative potential of the grassroots solidarity movement has been dwarfed by fighting the 'big battles' strictly on the representational level (in the literary meaning of the term). In other words, they have been fought as mere symbolic representations of 'Real battles', as simulacra in Baudrillardian terms. The main reason being the Left's (and I do not refer to SYRIZA alone) perception about politics and about where political power lies.

So, if the field that the solidarity movement operates within has been defined, indeed, by the eradication of the welfare state, then constitutive for the movement's formation and practices has been its rooting in the political struggles against the Troika regime. This comes in the form of the fight for democracy and popular sovereignty. A political imperative that has worked as the imaginative glue between heterogeneous attempts that solidified in a loose common front. This enabled the meeting of quotidian politics with the struggle for political power, even if this was expressed through SYRIZA. But, it experimented with collective processes of decentralized, open and participatory forms of bottom-up democratic infrastructures of resistance (today) and power (tomorrow).

In short, I think the solidarity movement has been more than a mere response to austerity.

Have there been past experiments and attempts at building solidarity structures in Greece? For example, what is the legacy of cooperatives in Greece? If so, can you elaborate upon that history briefly? And how is the current movement different from these past experiments?

There have been different moments in Greek history where cooperative and solidarity movements have appeared. This ranges from the history of national independence struggles to the communist movement in Greece. Indicative to this is the reply of Makis, from the recuperated and under worker's management factory of VIOME, to a young German activist in a solidarity meeting in Berlin. Makis was asked if VIOME was inspired by ZANON, in Argentina. Makis replied that the only cooperative example they knew was that of Ampelakia in late 18th century Greece. Ampelakia has been canonized in the Greek national narrative as the form of organization of Greek communities under the Ottoman Empire. This form of organization forged the foundations of the modern Greek nation-state. Then Makis went on to say how they enthusiastically discovered ZANON, feeling their experiences resonated with each other.

I believe, the biggest legacy that exists is still-present memories and practices of a strong community-based culture in Greece. These have been passed-on through generational relay, involving also memories of collective communal production (or, at least re-production) mainly in the countryside. This background has been overlooked by dominant discourses on politics, including those of the radical political movements. Yet, it makes-up one of the most important references for the common people and the development of the current movements, especially among the 'less politicized'.

Regarding previously organized experiences, the most known is by far the farmers' cooperative movement. This appeared in the post-dictatorship times and eventually degenerated, becoming an integral part of PASOK's state apparatus, and therefore a byword for clientelism, corruption, and inefficiency. It is sad that this most recent experience has given cooperativism a bad name.

A positive, but quite marginal experience, was the few short-lived worker cooperatives in the mid-late 1970s, which formed part of the struggles of a radicalized young generation of workers. Yet, by the end of this decade such attempts waned and went unnoticed. To these examples we could also add the EU/state subsidized women's cooperatives, especially in the countryside, as an outlet for local and household products. More social enterprises than self-managed coops.

Such legacy does not imply continuity with the current self-managed cooperatives. The most considerable difference of this new wave is the importance it gives to horizontal processes of decision making, economic self-management and equal pay. This is due to the ideological and political motives of the first cooperatives just before the crisis, as a form of solidarity with the Zapatista movement. They aimed to experiment with a different work-model and solidarity trade as an attempt to create and advance collective modes of economy. The advent of the crisis added the objective of satisfying the need for work and income.

But not all new cooperatives belong to this model, as the idea of co-operatives spreads quickly within the development of the so-called "third sector" (including start ups, social enterprises, etc.). The existing (subject to change) legislation on cooperatives was tailored as a device to outsource services from the public sector, especially from the local authorities towards cooperatives created by former local authority employees. Many have seen this (and thus the cooperatives) as a Trojan horse for the privatization of vital community social services (libraries, nurseries, elderly care, etc). Therefore, the terrain of cooperatives is also a field of contestation, which the

self-managed cooperative movement strives to define. This fight is of crucial importance. It can determine the economic and institutional model of the cooperative movement towards a more socializing form (with transformative economic potential), vis-à-vis the ('social') entrepreneurial one, in a country where 1 in 4 are out of job and over 50% of youth are unemployed.

The cooperatives, though, are only part of the solidarity movement with which compose the ecosystem of solidarity economy. It is not a coincidence that one of the hotbeds of the solidarity movement, in winter 2011-2012, was the huge solidarity wave among the steel-workers of Elliniki Chalivourgia. They occupied their factory in order to roll back the layoffs of dozens of their co-workers. Or, similarly, the solidarity movement for the workers-managed VI-OME factory, which took the active form of distributing the cleaning products of the recuperated factory.

However, as I mentioned earlier, the left and radical movement hesitated at the emergence of grassroots solidarity structures. The unearthing of the communist-led solidarity movement in the mid-war period (with two groups 'Workers Solidarity' and 'Social Solidarity'), but mainly during the anti-NAZI partisan resistance with the 'National Solidarity', played an important role to the victory of the resistance. This legacy has helped legitimize the current solidarity movement. These historical movements, having remained marginalized in the narrative of resistance, now re-emerge under the light of the current experiences, refreshing memories, but also conceptions about multiple modes of popular organization and resistance.

What are the greatest challenges for the solidarity movement in Greece? For instance, what are some of the obstacles to creating more solidarity structures (such as health clinics, cooperatives, etc.)? And what are some of the problems existing solidarity structures currently face?

The further growing of the solidarity and cooperative movement cannot be reduced to a mere logistical matter, but it should be seen on two levels. First, in relation to their immediate needs in order to maintain the ability to meet the growing needs of a society under constant strain, or, to be economically viable in the case of co-ops. Second, in relation to their political potential as hotbeds of a different paradigm of social organization and popular participation. In my opinion the latter is the biggest, and most difficult, challenge and also the most critical aspect for the solidarity movement if it wants to maintain its vitality. Yet, the former is the most pressing one with ongoing policies of exclusion.

Since 2014 the growth-model of the solidarity movement has entered a different phase. This is distinct from the 2012–2013 period, when the solidarity structures mushroomed throughout the country embracing a vast array of everyday life and needs (food, health, agricultural and solidarity economy, education, culture, legal support, housing rights, solidarity to refugees, etc.). Despite the slowing-down of new formed solidarity structures, the constantly growing number of those affected by the memoranda, led more people to the solidarity structures. This resulted in (a) the growing and imminent need for more resources, as the solidarity structures often stretch beyond their capabilities, and (b) the multiplication of the activities of the solidarity structures beyond their initial field. Thus, solidarity clinics develop also food support projects, or, food solidarity structures try to develop cooperative production in order to meet their needs but also to create job places.

In this context the main challenge for the movement is how to deal with the issue of resources, in order to cope with the exponential growth of needs, without sacrificing its political characteristics. If we allow those practices of mutuality and engagement to wane out, the implication will be a restricted practice of mere provision of social services – a function not much different from the NGO, or, volunteering sector. The greatness of this movement has been that it aims to build the ability of the people themselves, through a culture of self-organization, to resist, not simply to survive and get by. Yet,

the latter becomes of primary importance under conditions of violent exclusion, proletarianization, and crisis of social reproduction, as a means to maintain people's physical and moral strength and resisting capabilities. However, if the practices a movement devises do not foster a different mindset, relations and tools, away from a 'benefactors – beneficiaries' model, its scope risks to be reduced to countering the most extreme facets of the humanitarian crisis, instead of contributing structurally to building the potential for its end.

Therefore, despite the pressing and immanent challenge of resources, the most significant challenge is to keep up its role as political energizer and incubator of social transformation. Our ability to respond to this will decide the future character of the solidarity structures as spaces of social self-organization and popular participation. The political atmosphere in Greece after last summer's shocking developments, which have affected the desire of the people to mobilize – as the (political) aims of the previous period (remember the OXI – NO) have evaporated – make this challenge even more crucial for the solidarity movement.

On the positive side the response of the Greek people to the 'refugee crisis' stands as the latest sign of the resilience and the yet available psychological resources of this society to resist, even in times of political frustration and setbacks. Moreover, the solidarity with refugees' actions have prompted in some cases the creation of new permanent solidarity structures that address the needs of both refugees and local communities. One more indication that the people find the strength to mobilize when something motivates them deeply, when they feel they contribute to, and become agents of, something bigger than mere survival.

Regarding the cooperatives' growth, as I said earlier, it is linked to the people's efforts to get out of unemployment and lack of income, while their development stumbles on a hostile and inadequate institutional framework. The main problem is the scarcity of funding and financing options, especially in order to start a cooperative, as

cooperatives are excluded from the state's incentive policies for the creation of new companies (at the benefit of private entrepreneurship). In addition, certain professions (e.g. lawyers, civil engineers) are not eligible to operate under a cooperative scheme. This has led many to create cooperatives with low-level investment in the service sector (cafes, taverns, new-tech support, groceries). There is also the lack of any provision for social use, or socialization, of defunct and abandoned production units, in both private and public sector, e.g., the premises of the old farmers' cooperatives, that now stand idle and dilapidating. For these reasons, we are in the process of founding a cooperative and solidarity economy forum. This is a collective entity which aims to facilitate (a) front desk information and legal support for anyone wants to start a cooperative, (b) development of tools and training according to the needs and aims – financial, or, political – of the self-managed cooperatives, and (c) to stir, intervene and promote a friendly image for the concept of workers' self-management and changes in its legal framework.

What is the relationship of various solidarity structures to the broader left-wing in Greece? Are there any specific state policies that could greatly aid or clear the way for the strengthening of the Greek solidarity movement?

There may be actions the state could take, not for the solidarity movement but, for those hit by the memoranda, alas those are destined to remain gestures rather than 'great aid'. Indicative is the example of the government's 'parallel program'. It was to be discussed just before Christmas, but the government withdrew in less than 24 hours after it announced it, under the creditor's pressure and in order the 1 billion euros instalment of the bailout to be released. The program, which included provisions for health care of the uninsured by the public health care units, returned and adopted last week in the parliament, but reduced. Thus it demonstrates that there is a very low margin for maneuver under the regime of creditors' supervision. In the framework of the third memoranda,

everything must be approved, or tolerated, by the ombudsmen of the Quartet (former Troika). As long as the government's priority, as itself has declared, is the implementation of the structural changes dictated by the bailout agreements, this will determine what in reality can do and what not.

In the cooperative economy, for example, new legislation is on track, indeed. Yet, it is one thing to see it in comparison to the existing problematic one, and it's another in relation to the economic readjustment policies. The latter – privatizations, markets 'liberalization' etc. – in reality drastically diminishes the productive capability and economic stature of the country, undermining its ability for political and democratic sovereignty. In that respect, while the cooperative and social economy can be a tool for promoting a mode of socialized production, the overarching economic conditions move drastically to the opposite direction undermining such potential. It is not a coincidence that, from the government's (and EU's) point of view, the cooperative economy is considered as one of the means to counter the huge and long-term unemployment. It is way to enhance alternative forms of social entrepreneurship, instead of being a model for building a different economic paradigm outside the confines of the dominant international division of labor.

By the same token, one can better understand the government's projects regarding the humanitarian crisis. Financial shortage and bailout commitments allow the allocation only of a certain amount of funds for 'solidarity tokens'. It is attempted, indeed, a rationalization in the use of the existing funds in order to reduce the exploitation of human need by various speculators. However, these programs are disproportional to the needs and numbers of those who slip into poverty due to the ongoing re-adjustment and austerity policies (with more pensions' cuts on the way). In this framework I do not think the state can do much.

After all, the role of the solidarity structures cannot be reduced to that of satisfying the social needs produced by the bailout agreements, regardless who administers them. A fundamental principle

of the solidarity movement is that it does not want to substitute for the welfare state. Its role is, rather, to create those conditions and paradigms that enable the structural undermining of the bailouts and thus become a force of change outside the neoliberal constraints. In other words, its aim should be not to save the world, but to change it. On that political horizon, it can build synergies with various actors, including the state. Yet, when the state decides otherwise, prioritizing the implementation of the bailout and re-adjustment policies, any cooperation, even if it addresses emergent social needs, becomes part of a different agenda. For example, if the solidarity clinics are considered by the government as means to reduce its burden to provide universal health care, this provides a framework that may turn them into replacement for what the government cannot deliver. So it's down to the solidarity movement to decide what kind of relations can have with such policies and institutions. In any case the state cannot replace the function of the solidarity structures as places of social self-organization. Thus, even if universal healthcare is reinstated, the distinct role of the solidarity clinics as a different paradigm of self-managed basic health care centers and generators of people-centered health policies, will come even more to the forefront.

Regarding the relationship with the broader left, I want to repeat that the solidarity movement started and still can be a transversal movement and event, among and beyond the different left factions. Its relationship with the Left (and the antagonistic movement) is a complicated and troubled affair, and not a linear and peaceful one, as many have presented. The fortunate conjunction of the political left with a people's grassroots movement, and of quotidian politics with the struggle for political power is a moment that does not occur often. It's a socio-political mix that reveals our potential. It also tests various limits and dominant perceptions of the political left, more specifically its capability to cooperate with and accommodate the desires and forms of action of "oi polloi" (the many). The discrepancy (and mingling) between the discourse of the 'politicos' and the common people has been a prevalent trait of these years.

The backbone of this movement consisted by the social left and by many who received their political baptism in the anti-memoranda struggles. Its meeting with the political left was inevitable as long as there existed the common aim to rollback the causes of social devastation. As the stakes of the political conflict rose, and the cracks of the political system grew, this popular discontent met with the alternative SYRIZA represented at the time. This was (and is) a process and a relationship under constant negotiation. One that fosters hybrid forms, as it deals with (creative at times) tensions between old habits and established (dare I say, dated) concepts of politics with an emergent political culture constitutive of new agencies. I am not referring just to the parties and social movements relation, but between what I call “specialists of resistance” (political groups, trade unions, social movements) and the emerging political subjectivities and vocabulary of a popular majority. At the same time, the issue of liaising with institutions – local or central authorities held by the radical left (not only SYRIZA) – has been a critical test for the solidarity movement. The grassroots’ movement and the struggle against those in, or for, power (expressed through SYRIZA, but also in the distinct form of the OXI referendum) followed parallel, cross-cutting and (considerable at times) overlapping routes. But it is a mistake to conflate the two, or, to consider them as two separated autonomous realms.

In a double act, the solidarity movement grounds the struggle for political power in the everyday fights and needs of the people while it highlights the centrality of the struggle to remove those in power, in order to open up possibilities for an alternative. This experience suggests a different viewpoint that transcends the distinction (by fusing) “social movements” vs “political representation”. It draws a different line: between those who understood politics as ideological critique and those who understand it as the effort to create the material conditions in order “to make possible the impossible”, as Marta Harnecker argues.

The potential of this movement, as a multiplier of possibilities and capabilities, has been undervalued, if not ignored. The political left

saw it as just another “social movement”, due to its perceptions of change and (through) political power. This movement has laid out a different question, or rather task, than the “take or not take power” (in order to change the world). By building self-organized social structures, it delineates processes to “create power,” which also enable the power to change when one acquires state power. If there is a reason to argue for the transformative potential of this movement, it is exactly due to its capacity as a network of (infra-)structures and as generator of policies designed on the basis of its practices through the deepening of democratic processes and popular participation.

Thus, we speak about a potential public sphere from (those) below, able to produce both alternative policies and the power to exercise (or fight for) it. This is not an ‘optimist projection’ but statement of its strategic potential. Had this movement been considered in its full potential, it could have acted as a counterweight to the creditors’ blackmails. It could have been a means to solidify the political will and perspective of the people. It could have also produced its material backing, had the SYRIZA, as opposition and government, taken it seriously since 2012. Even in the case of being forced into a deal, this movement could have provided SYRIZA with a wider margin to negotiate and move. It could, and still can, foster the potential for a real and pragmatic alternative plan. An alternative plan that extends beyond the impasse of the dilemma of signing onto the purported realism of TINA (“there is no alternative”) and a creditors’ enforced GRexit.

CREATING THE IRREVERSIBLE

AN EXCERPT FROM FIRST REVOLUTIONARY MEASURES

After the break-up of the state apparatus, the main task will be to divide up the affairs of the collective at the most appropriate level. For those pertaining to the local area — housing, food, schools, transport, enterprises, etc. — the new ideas will emerge in the neighbourhoods and reconstituted communes. It would be absurd to handle such matters in the same way everywhere. In France, for example, what is common to problems of schooling in Lozere and Seine-Saint-Denis, or Mayenne and the Marseilles conurbation? Bureaucratic centralism, with its succession of contradictory ministerial directives, has caused havoc here, and it will be necessary to carry out modest ad hoc improvements, through trial and error and collective interventions.

But some fields will have to be addressed at the higher level of the province (the ‘region’, a bureaucratic entity, will have disappeared) or the country as a whole. The dismantling of the nuclear industry and its repercussions for the general supply of energy; the fate of the major highways and air, river and rail transport; the orientation to be given to the motor industries and others; the ways in which the national information media should be given back to the people: these are a few examples of questions that cannot be answered locally.

It is often easy to draw the dividing line between what can be resolved here and now and what pertains to a higher level. With regard to public health, for instance, the siting of dispensaries, emergency services and specialist hospital facilities, or non-authoritarian ways of feeding practitioners into ‘medical deserts’ and addressing any shortage of nurses, anaesthetists and midwives, are clearly local

issues. They were impossible to solve under democratic capitalism, because it was said that the necessary funds were not available. But everything will change as soon as health has ceased to be a major focus of profit-making and the running of things is entrusted to those who have chosen to work there. This is not a naive fantasy. After the Cuban revolution, medicine in that country became the best in Latin America and infant mortality fell to the level of the industrial countries — all without any noteworthy injection of cash.

Let us go further. If the hospital is no longer considered an enterprise, if it is returned to its original purpose as a tool for the community, really major changes are perfectly conceivable. It will be possible to get rid of various parasitic jobs in specialized budgeting, the checking of standards, and the monitoring of profitability. Medical and nursing personnel will be relieved of the administrative tasks that have weighed on them for the past twenty years. Management will be in the hands of a small team of doctors and nurses that is renewed once a year — a part of the hospital staff previously confined to subaltern roles, but which knows better than anyone what needs to be done to provide the best care. The hospital will fight against the division of labour, by involving all the staff in non-noble tasks such as cleaning, sterilization and the wheeling around of patients, and by making it easier for individuals to develop their careers and to move from caring to medical jobs. This cultural revolution will take place with the support of the local population, which will be pleasantly surprised to find itself welcomed through the doors and not shunted into despairing queues. One might even hope that the hospital will one day cease to be the fortified place where the populace is medicalized, that it will spread around it the delicate art of identifying pain and treating one's own and other people's ailments: the caring mission it has monopolized for so long.

But today, wherever democratic capitalism holds sway, public health is being eaten away by a kind of cancer that cannot be treated locally: that is, the pharmaceutical and medical imaging industries, two of the most prosperous and aggressive on the internation-

al scene. Together, they combine to dig the famous 'social security hole', which serves as an argument to justify the deterioration of medicine for the poor.

To expropriate, nationalize or transform into workers' cooperatives the branches of the great German, Swiss or American drug companies is a necessary but insufficient minimum. Their whole output needs to be monitored, in order to eliminate the thousands of useless drugs that mendacious publicity, foisted on GPs by travelling salesmen in medical guise, causes us to swallow throughout the year. It is a specialized task to sift through this vast display and select what is worth keeping, to determine and divide up the main lines of research; moreover, it will be necessary to choose carefully the men and women for the job, bearing in mind the errant ways of the 'drug agencies', which are all contaminated by their incestuous contacts with the pharmaceutical industry.

The difficulty is perhaps even greater when it comes to medical imaging, since a number of magical beliefs have to be confronted and dispelled. By placing their spectacular images in medical journals and the general press, the international corporations that produce ultrasound, MRI (magnetic resonance imaging) and other types of scanner have managed to spread the idea that cross sections of the human body, if sufficiently precise and targeted, will necessarily show the origins of what is wrong. This myth has two consequences. On the one hand, it allows thousands of hugely expensive devices to be sold around the world, which then have to be kept going to make them pay; hence the large component of (mostly pointless) imaging in the 'social security hole'. (In France, radiologists — the name for those who have bought such devices and employ low-paid, low-status 'operators' to handle them — are at the top of the medical income scale.) On the other hand, the magic of imagery distracts from good medicine, most of which is practised with words, eyes, hands and a few simple tools. Without rejecting progress, we might underline what should be evident enough: that it is both effective and cost-free to register what the patient complains of, to examine the troubled knee, to palpate the spleen, to listen to

the lungs, and so on. But these actions take more time and demand more attention than the ordering of a scan — which is what the patient asks for, so powerful is the imagers' marketing. It is necessary to spread a whole new conception of medicine, among both doctors and patients, since the apparatuses will remain in place for many years once the industrial lobbies have been made powerless to do harm.

These tendencies in public health will doubtless reappear elsewhere, in food and agriculture as well as scientific research. To create the irreversible, it is at local level that new ideas will see the light of day and unexpected solutions will be invented. The main task at higher levels will be to erase the after-effects of the old world.

