To the memory of Antonis Pavlis
Creative disability classification systems
The case of Greece, 1990-2015
Abstract


Disability classification systems belong to the core of states’ social/disability policies through which persons with disabilities are classified as eligible or ineligible for having access to disability allowances. The study of disability classification systems has stimulated the interest of several scholars from the broader area of disability studies. Either by conducting comparative studies between different states and describing the similarities and differences of these systems around the world or by conducting studies focusing on the politics and semantics in the development of disability classification systems in specific states, all studies have shown a pluralism in the systems for assessing and certifying disability. In Greece, the development of disability classification systems for social welfare reasons emerged as a controversy that lasted for almost twenty years. One factor that strengthened the controversy was the outbreak of the economic crisis late in 2009 followed by the announcement by the governmental authorities of the enactment of a new system for assessing and certifying disability as part of the austerity-driven policies that the Greek state would enact for facing the consequences of the economic crisis. Drawing on an interdisciplinary approach, the overall aim of this study is to describe and analyze the enactment of disability classification systems in the context of Greek social policy from 1990 to 2015. For the collection of empirical material, a qualitative research method was employed, consisting of interviews, written material, and newspaper articles. The main findings of this thesis are: I) the involvement of the political parties in the development of the systems for certifying and assessing disability; II) the involvement of the disability movement in policymaking; III) the “creative” use of statistics by governmental authorities for the enactment of disability/social policies; IV) how the concept of “disability fraud” has been constructed as a “threat” to the society; and V) the vulnerability of disability classification systems in times of austerity.

Keywords: classification system, statistics, medicalization, disability movement, disability fraud, corporatism, economic crisis, STS, disability theory.

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To read these lines, it means that this journey, called PhD, comes to its destination. But, as the title of one of my favorite songs says, *an end has a start*, and this start goes back early in 2013 when I was informed that my application for this PhD position was shortlisted and two days after I would have a skype interview. Mixed feelings. Happy, anxiety, satisfaction, hope, described these moments and lasted until to be informed that I was finally accepted as a doctoral student at the Swedish Institute for Disability Research at Örebro University. Hard to believe that this journey comes to its end. Time flies. Obviously, I would not be able to complete this project without the help of many persons who were involved, somehow, in this project.

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‘paradigm’ is the reason that I am in this position this moment.

Örebro, July 2017
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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EC</td>
<td>European Commission</td>
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<tr>
<td>ECB</td>
<td>European Central Bank</td>
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<tr>
<td>EPPPA</td>
<td>Single Table for the Disability Percentage Determination</td>
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<tr>
<td>ESAEA</td>
<td>Greek National Confederation of Persons with Disabilities</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>GSEE</td>
<td>General Confederation of Greek Workers</td>
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<tr>
<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IKA</td>
<td>Social Insurance Institute</td>
</tr>
<tr>
<td>IKPA</td>
<td>Institute of Social Protection and Solidarity</td>
</tr>
<tr>
<td>KEPA</td>
<td>Centre for Certifying Invalidity</td>
</tr>
<tr>
<td>KEVA</td>
<td>Regulation for the disability degree assessment</td>
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<tr>
<td>ND</td>
<td>New Democracy</td>
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<tr>
<td>OAEE</td>
<td>Professionals’ and Craftsmen’s Insurance Fund</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OGA</td>
<td>Agricultural Insurance Organization</td>
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<td>PASOK</td>
<td>Panhellenic Socialist Movement</td>
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1. Introduction: Background, research aim, theoretical framework and previous studies

1.1 Background, research aim, and research questions

Background
After the start of the economic crisis late in 2009, the Greek minister of labor and social security and the minister of finance announced the upcoming pension scheme reform as part of the austerity-driven policies that the Greek governmental authorities would enact for deep structural reforms in the operation of the state. The pension scheme reform entailed, among other things, stricter measures in the social security system, cuts in health care budget, changes to the eligibility criteria for someone to be awarded a pension, and changes to the system for assessing and certifying disability. Though the draft law was ready before May 2010, the pension system reform was postponed until July 2010. The reason for this delay concerns the inclusion of the country under the financial support mechanism of the European Commission (EC), the International Monetary Fund (IMF), and the European Central Bank (ECB). Because of the enactment of the First Economic Adjustment Program, every change to the operational structure of the state need to be discussed and approved by the troika, that is, the EU, the IMF, and the ECB.

In the last twenty-five years, however, the development of a system for assessing and certifying disability has been a continuous debate in Greek society. The system that was announced in 2009, for example, aimed to replace the system that was developed and implemented early in the 1990s. Nevertheless, from 1995 to 2008, two more incomplete attempts took place. The first attempt, called “disability card,” started in 1995 and continued until 2003; the second attempt, called “functionality card,” which was to adapt the International Classification of Functioning, Disability and Health (ICF) that had been developed by the World Health Organization (WHO), began in 2004 and lasted until 2008. But why did the development of a disability classification system emerge as a controversy, and what was the role of the political landscape?

In parallel with the controversy for the development of a system for assessing and certifying disability, another controversy that emerged concerns the issue of alleged “disability fraud” and its association with persons with
disabilities’ access to the welfare state. One of the most important points in the Greek politicians’ rhetoric was that, among the disability beneficiaries in Greece, there was a significant percentage who were not persons with disabilities, in fact, but still received benefits from the state. More recently in 2011, for instance, the deputy minister of labor and social security, when presenting the system for assessing and certifying disability that had been developed in times of austerity, underlined how the system implementation would put an end to fake disability pensions (*Eleftherotypia*, September 6, 2011). But how was the enactment of the disability classification system debate intertwined with the alleged “fake disabled?”

The development of a system for assessing and certifying disability that began after the outbreak of the economic crisis aimed to replace the system(s) that already existed since the early 1990s for assessing disability. I chose the year 1990 as the starting point of this project because in that year the first initial steps for the development and implementation of a more structured system for assessing and certifying disability in Greece were taken. I chose 2015 as the endpoint in order to explore not only the development of the disability classification system that began during the economic crisis but also the first reactions to the system after its components for assessing and certifying disability were implemented.

While this study focuses on examining the controversy over the development of the disability classification systems in Greece during the past twenty-five years, thus adding one more piece to the already existing studies about the development of systems for assessing disability worldwide, the Greek case offers an opportunity to further contribute to the study of disability classification systems by also examining the vulnerability of disability classification systems under extreme events, such as an economic crisis. After the financial crisis of 2007–2008, a new round of discussions began regarding the measures that national economies ought to enact for facing the challenges of the financial crisis. Several scholars have already started to examine the consequences of the financial crisis on persons with disabilities in terms of access to the welfare state (e.g., Taylor-Goody & Stoker, 2011; Yerkes & van der Veen, 2011; Briant et al., 2013; Goodley et al., 2014; Tyler, 2014). The study of the Greek case, however, will show the vulnerability of the systems for assessing and certifying disability to the austerity-driven policies that were imposed by the lenders to the governmental authorities.
Research Aim
The purpose of this project is to describe and analyze the enactment of disability classification systems in the context of Greek social policy from 1990 to 2015. Rather than taking the disability classification systems for granted, this study aims to open the black box of the disability classification systems by examining the political and social choices that are embedded in them: from the problematization stage and the negotiations between the key actors—such as governmental authorities, the disability movement, policy makers, and physicians—to what happened in the processes of their enactments to the vulnerability of disability classification systems to extreme events such as an economic crisis, I will present and analyze the practices through which a disability classification system is enacted.

Research Questions

- What was the relation between the political system in Greece and the development of disability classification systems?

- Which social groups were involved in the enactment of disability classification systems, and in what ways?

- How did governmental bodies use statistics to guide the reforms of the systems for awarding disability benefits?

- What was the relation between the economic crisis in Greece and the disability classification system?

- How have persons with disabilities been labeled in relation to the disability classification systems?
**Structure of the thesis**

This book consists of eight chapters plus a shorter chapter called *Parergon* at the end of the thesis. As seen, Chapter 1 offers an introduction to the topic by presenting the topic of this project, the purpose, and the research questions. Also, the following sections of Chapter 1 first discuss the theoretical framework that this project relies upon for answering the research questions, and then offer a literature review regarding previous studies in the field. Chapter 2 focuses on the methodological choices for the data collection and analysis for this project.

Chapters 3 through 7 are the empirical chapters of this thesis. Thus, in Chapter 3, I describe and analyze the first attempt at the development of a more structured system for certifying and assessing disability, through a period that the Greek state and especially the social security system were in crisis. I will also discuss in Chapter 3 how the concept of “disability fraud” began to be constructed. Chapter 4 examines the “disability card” classification system, an attempt which, although incomplete, included the strong involvement of the Greek disability movement from different subject positions. Similarly, Chapter 5 explores the adoption and adjustment of the ICF classification scheme in the Greek context. The ICF attempt was also incomplete, but, as we will see, a different procedure was followed for its adaptation.

Chapters 6 and 7 discuss the development of the disability classification system that emerged after the outbreak of the economic crisis late in 2009. Specifically, Chapter 6 focuses on the development stage of the new system by examining how the austerity-driven policies, which were imposed after the outbreak of the economic crisis, influenced the enactment of the disability classification system. Chapter 7 focuses on the period after the completion of the development process by shedding light on the

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1 At the end of the thesis, there is an extra chapter, called *Parergon*. The idea of this chapter comes from Neni Panourgia’s (2009) book “Dangerous Citizens: The Greek left and the terror of the state.” Panourgia (2009) describes *Parergon* thus: “[it is] not simply notes...[but] notations to the text that make the text show its complexities, as they bring into the main narrative the realities of multiple positions, make interventions that show that there is no stability in this history, that the story itself constantly shifts ground” (p. xxv). In this project, the history of the establishment of the Greek disability movement was not part of the main content of this thesis. But there are events in this history that will be helpful material for the reader to further understand the reconstruction of the disability classification systems; or, as Panourgia puts it, “*parergon*...contain[s] text that is both explanatory and indispensable” (ibid., p. xxvi).
reactions of the society against to the system components, before the system transformed into a black box. Chapter 8 is the conclusion of this thesis, where I summarise the most important findings of this study. Lastly, at the end of the thesis, there is one more chapter, called Parergon, which contains a short presentation of the history of the establishment of the Greek disability movement.

1.2 Theoretical framework

This section presents the theoretical framework this study relies upon for the analysis of the empirical material. Inspired by Bowker and Star (1999), the point of departure for this study is to examine disability classification systems prior to their transformation into more transparent technologies or infrastructures. That is, the study seeks to shed light on what has happened in the background with regard to disability classification systems by studying the “political, ethical, and social choices [which] have without doubt been folded into their development” (Star & Bowker, 2010, p. 233). Having said that, this study approaches the development of disability classification systems as a problem that concerns and involves more than one scientific field.

To that end, this project adopts an interdisciplinary approach for the reconstruction of the disability classification systems by building a theoretical framework with theories, concepts, and methodologies at the intersection of four scientific fields. Specifically, I employed theories and concepts from the scientific fields of science and technology studies (STS) (classification schemes, power of numbers), disability studies (the conceptual model of disabilities, disability statistics, disability movements), sociology (new social movements), and political science (corporatism, clientelism, neoliberalism). In what follows, I will present and discuss the theories and concepts that I employed for the study.

As for the order of the theoretical framework discussion, it was inspired by the content of the empirical material. As will be discussed later in this thesis, in each discussion of the development of a new disability classification system, the point of departure was the reference to the rate of disability beneficiaries. Thus, I will start to build my theoretical framework by discussing the power of numbers in politics and how it is related to disability. Then I will continue with a presentation of the theoretical understandings of and approaches to the development of classification systems as they have emerged in the field of science and technology studies. Following Altman’s (2001) argument regarding the close relationship between
disability classification scheme and disability models, the third element in my theoretical framework concerns the different conceptual models of disability. Historically, the mobilization of people with disabilities and the formation of the disability movement have contributed to new understandings of disability, and people with disabilities have come to be involved in policy-making. Last, the fourth element of the theoretical framework concerns local political ideologies, in terms of governing, and their role in the enactment of social and disability policies.

1.2.1 The politics of numbers: Disability statistics and policy-making
It is well known that numbers and statistics constitute powerful instruments for the governing of modern societies (Alonso & Starr, 1983; Porter, 1993, 1995; Rose, 1999; Fioramonti, 2104; Best, 2001). Fioramonti (2014, p. 2) describes numbers as “driving forces behind our social, economic, and political decisions.” Theodore Porter (1993, p. 90) calls statistics a “policy science” for showing the bond between statistics and politics. Also, etymologically, the roots of the term statistics are related to the concepts of state and status, which shows how statistics is the science of the state (Fujiura & Rutkowski-Kmita, 2001, p. 70).

The first use of statistics as an instrument of the state goes back to the seventeenth century in England. “Political arithmetics,” as the discipline was called in that period, was used for gathering demographic data (Best, 2014). As Best states, by analyzing the rates of births, deaths, and so on, the analysts could examine if the state was healthy (ibid.). In France in the eighteenth century, similarly, the monarch or the governmental authorities, by relying on statistics, gathered information about how healthy their kingdom or their state was (Porter, 1993).

Gradually, statistics lost its role of merely informing administrative and governmental bodies, and it became a political instrument, an instrument that had the power to enact objects: “every statistical estimate has the potential to become a new thing” (ibid., p. 93). For instance, birth rates, fertility rates, and death rates, to name but a few, had the potential to be new things. Statistical rates, instead of representing just a figure, gave the administrators who were responsible for collecting the data the opportunity to compare and extract information from the statistics. Thus, the numbers, or the statistical rates, offered “legitimacy for administrative actions” (ibid., p. 96). In other words, statistics was transformed into a mechanism to control the population; or as Porter points out, statistics enact new
things and in the case of the population, “people are made governable” (Porter, 1993, p. 96).

Numbers or statistics have the power to enact or “create objects,” and at the same time, they have the power to “control subjects” (ibid., p. 97). For instance, Nicholas Rose (1999), in his account of how numbers rule or govern modern societies, identifies four ways to describe the relationship between numbers and politics: i) “Numbers determine who holds power, and whose claim to power is justified”; ii) “Numbers operate as diagnostic instruments within political reason”; iii) “Numbers make modern modes of government both possible and judgeable”; and finally, iv) “Numbers are crucial techniques for modern government. They have become indispensable to the complex technologies through which government is exercised” (1999, pp. 197–198).

The use of statistics had an essential role in the enactment of disability policies. According to disability-studies scholars Abberley (1992, 1995), Bowe (1993), Fujiura and Rutkowski-Kmitta (2001), Hahn (1993), Kirchner (1993), and Zola (1993), policy makers, take disability measurements and disability statistics into consideration when designing and enacting disability policies. Using tables and figures, policy makers can extract the information they need for the reforms of social policy. For instance, Abberley (1992) refers to the Office of Population, Censuses and Surveys (OPCS), or Official Statistics, and its survey regarding people with disabilities in Great Britain. Abberley, particularly, discusses the role of disability statistics or measurements in regard to the welfare allowances people with disabilities receive, since the government’s decision concerning such was linked to the results of that survey. Through this example, Abberley stresses the power of disability statistics to both inform policy makers as well as enact reforms.

Echoing Foucault (2003), national governments use statistics as a means to count and control the population. In the case of disability, what is counted is i) the number of citizens who have a disability, ii) how disability is distributed within the population, and iii) the major disability causes (Fujiura & Rutkowski-Kmitta, 2001). Kirchner defines disability statistics as:

numbers that estimate not only the prevalence of people with disabilities in the general population, but also numbers that describe their social situation, such as parenting status and employment.

(1993, p. 3)
In other words, disability statistics constitute an essential apparatus for the state and particularly for policy makers to be informed about the health status, work capacity, and so on, of their citizens and, then, to guide or set the necessary reforms or policy decisions that are necessary. Abberley, considering the views of Oliver (1983), Hindess (1973), and Irvine et al. (1979), challenges the objectivity of statistics by claiming that “all statistics are constructed by particular people in particular social and historical contexts for particular purposes, and can only be understood as such” (1992, p. 143).

Following Abberley’s argument, disability statistics are not neutral; rather, political choices are embedded in their shaping. Sociologist Zola (1993) also participates in the discussion about the counting of disability, arguing that disability is not something fixed but that, on the contrary, it is linked with continuous changes. To Zola (1993, p. 30), disability is something that can be measured, but “its conception, measurement, and counting differs validly with the purposes for which such numbers are needed.”

Based on the above discussion, disability statistics constitutes an important instrument for policy makers and the state. Inspired by the former argument, in this project I am interested in examining the role of disability statistics and measurements in the development of disability classification systems in the Greek context. Specifically, I am interested in exploring the role of disability statistics in the revision of disability classification systems as well as how the representatives of the governmental bodies have used disability statistics in their rhetoric to stress the need for a new disability classification system.

1.2.2 Classifications schemes and politics of change

This project aims to shed light on how classifications systems, and specifically disability classification systems, came into being by exploring what happened before classification systems were transformed into a given infrastructure. Corker and Shakespeare (2002, p. 8) argue that, although the notion of impairment existed for an extended period, as well as issues related to this, it was only after the development of medical and scientific classification systems that disability classifications were brought into being. In the same vein, Strand (2011, p. 273), who studies the development of the DSM-III classification scheme in the field of psychiatry, claims that the DSM-III developed as a classification scheme of mental illness because of “conflicts among psychiatrists, psychoanalysts, and clinical psychologists.” Following Corker and Shakespeare (2002) as well as Strand (2011),
classification schemes have “the potential to enact new things” (cf. Porter, 1993, p. 93), such as disability and mental illness. But the questions that arise here are What are classification systems and why are they such powerful technologies to enact things?

Geoffrey Bowker and Susan Leigh Star (2001), both scholars from the field of science and technology studies who have examined how classification schemes and standards are shaping modern societies, argue that a good citizen for the modern state is the citizen who can be counted, or classified. For them, classification systems are “key sites of work, power, and technology” (Bowker & Star, 2000, p. 147). Bowker and Star (1999) pose three questions regarding the role of classification and standards: (i) What work do classifications and standards do? (ii) Who does that work? and (iii) What happens to the cases that do not fit? (p. 9). And I would add (iv) Who creates the classifications and standards? These four questions could be a point of departure in the study and analysis of the disability classification systems, but at the same time, they could also be a point of problematization or of challenge, since the procedure of designing disability classification systems is not transparent and neither is it clear who is responsible for or who participates in their development. Bowker and Star define classification schemes as “spatial, temporal or spatiotemporal segmentation of the world” (2000, p. 149). A classification system is developed and exists in a specific environment and at a given moment. They also claim that classification and categorization are two different concepts with different meanings: “Classification arises from systems of activity...[that] are situated historically and temporally. Categories...come from action, and in turn from relationships” (ibid., p.149).

Another point that Bowker and Star stress concerns the consequences after the development of these systems. To them, a classification system is a technology, which is constituted by/of complex informatics systems. This technology, however, has consequences for people who use or will use it. In the case of disability classification systems, for example, people with disabilities are classified as able or disabled to participate in the labor market. Furthermore, depending on the specific cultural context in which this classification is enacted, the labeling of a person with disabilities as able or disabled has consequences in terms of their identity.

Matt Drabek (2014), who has studied the relationship between the labeling and classification of specific social groups or individuals based on their activities, argues that the classification process might have consequences for the members of social groups; specifically, he talks about their
marginalization (ibid.). For instance, in the case of the disability classification system, the human body is enacted as a body that fits, partially fits, or does not fit with the needs and standards of modern society. In line with Drabek, the labeling of persons with disabilities as a social group that does not meet the standards of society might have negative consequences for people with disabilities by marginalizing them.

Iris Marion Young (1989) also talks about marginalization as one of the five faces of oppression. To Young, for connecting her approach with the discussion regarding social policy and classification schemes, marginalization creates a kind of dependency between the marginalized groups and the state, with the former to be totally dependent on the rules that the latter impose on them, or in other words, marginalization works for state authorities—either the government bodies or administrative authorities—as a means or a technique to exercise power over these social groups labeled as marginalized.

Bowker and Star propose four themes for understanding classification and standardization as well as their politics. These four themes are i) ubiquity, ii) texturing classification and standardization, iii) the indeterminacy of the Past, and iv) practical politics (Bowker & Star, 1999). Ubiquity and texturing classification and standardization themes refer to the space of classifications, while the indeterminacy of the Past and the practical politics themes refer to the time of classifications. By applying these themes together, each of them will add a piece to the puzzle of how classification systems have developed historically.

More analytically, ubiquity means that the classification and standardization schemes are an integral part of our daily lives, from the simple things to the more complex, from shelving books in a bookcase by subject, for example, to classifying them according to subject in terms of specific diseases or disorders based on the International Classification of Diseases (ICD). Bowker and Star note that the use of these schemes helps with the coordination of heterogeneous technologies. The establishment of disability classification systems, for example, is associated with states’ social policy, since states use these systems both as a means to control their citizens by calculating the citizens’ abilities to work and as a criterion for offering benefits and allowances to those same citizens.

Also, classification and standardization schemes are material and symbolic. They are material because “they are built into and embedded in every feature of the built environment” (Bowker & Star, 1999, p. 39). Classification schemes are the outcome of a combination of physical enti-
ties and conventional arrangements (ibid.) Physical entities refers to the actors who participate in a classification scheme’s enactment, the relevant legislation taken under consideration, paper forms, and so on. Conventional arrangements refers to the symbolic nature of classification. They are not material, as are the physical entities; rather, they are more abstract. For instance, in the case of disability classification systems, a health committee established to carry out disability assessments could be viewed as a physical entity of the system, whereas the choice to have disability claimants assessed by medical experts (revealing the dominant role of the medical understanding of disability) could be viewed as a conventional arrangement created by the systems developers.

The third theme refers to the indeterminacy of the Past. Every time we speak of or evaluate something, we do so based on knowledge we have from the social world in which we currently live. By recalling an event that happened in the past, we evaluate based on our current knowledge. Bowker and Star (1999) claim that when we evaluate a classification scheme from the past, we do so by using the knowledge and information from our current social world.

The fourth theme concerns practical politics. This theme aims to uncover the practical politics of classifying and standardizing. Bowker and Star point out that what we perceive as universal or as a standard is the outcome of negotiations, conflicts, and organizational process (ibid., p. 44). Negotiations are an important step in the development of classification schemes. But where these negotiations take place and who the participants are in these negotiations are issues under investigation. Moreover, who is visible and who is invisible or who is included and who is excluded during the development of classification schemes are also issues for inquiry and analysis (Star, 1991). However, after the implementation of these systems, the practical politics of these decisions are forgotten (Bowker & Star, 1999).

In my attempt to analyze how disability classification systems have been developed in Greece from 1990 to 2015, the themes of indeterminacy of the Past, material and texture, and practical politics will be my theoretical/methodological tools for exploring and reconstructing how disability classification systems have been enacted. More specifically, through the practical politics theme, I want to investigate how these systems were brought into being, who the participants were in the negotiations regarding the development of the systems, and where those negotiations took place. Since there were four attempts in the case that I examine (i.e., four attempts in Greece) to develop a disability classification, I will examine, by
applying the *indeterminacy of the Past* theme, how the developers or relevant actors evaluated the system that was supposed to be reformed. For example, which elements of the classification systems in the period under study were insufficient for further use?

Bowker and Star, in their second theme, *material and texture*, talk about the material and symbolic nature of the classification schemes and standards, and they claim that classification schemes are the outcome of a combination of *physical entities* and *conventional arrangements*. I find it challenging to apply this theme in my study, especially regarding the “conventional arrangements.” Usually, finding the *physical entities* that participated in these procedures seems easier than finding the *conventional arrangements*. Through this theme, I am looking both for the conventional arrangements that were considered during the development of these systems and for what was perceived as a “conventional arrangement” in the case of disability classification systems.

### 1.2.3 Conceptualizing disability and the role of the disability movement

In the late 19th century, the conceptualization of disability in Western societies was affected by industrialization and the dominance of medical knowledge. On the one hand, after industrialization, people with impairments belonged to a social group that did not have the capacities to participate in the new factory-work system, and, consequently, they were excluded from productivity as invalids (Barnes, 1998). On the other hand, it was a period during which medical knowledge was dominant, and medical experts were represented as the only authority that had the power to participate in discussions and practices regarding the human body and its condition(s). Both industrialization and the dominance of medical knowledge affected the way disability was perceived during that period and later in the 20th century as well. Echoing Oliver (1996) and Galis (2011), disability, within the context of the medical model, was understood as a “personal tragedy,” and it was linked to the physiology of the individual body and to the sociocultural beliefs of individuals.

In the context of the medical model, disability was the result of the abnormal body, which caused limitations to the functions of the individual body (Barnes & Mercer, 2010). Medical experts, who were inspired by the disease model, understood disability as a condition that needed treatment (Llewellyn & Hogan, 2000). By applying methods, such as diagnosis and treatment, medical experts aimed to cure the abnormal body in a similar
way as for disease. Until the middle of the 20th century, the medical model was the main model for the conceptualization of disability.

1.2.3.1 The mobilization of persons with disabilities and the emergence of the social model of disability

Already from the time of WWI and WWII, persons with disabilities, as a reaction to their social exclusion and oppression because of the medical understanding to disability, started to politicize and form disability organizations looking for ways to demand their rights and/or to be heard (see, e.g., Barral, 2007; Kouroumblis, 2001). According to Oliver (1996), the main argument was that disability is not a condition, like a disease that can be treated or cured by medical experts; rather, disability is a social state that is not treatable or curable. To Oliver (1996), the individual model has two characteristics: first, it locates disability in the individual body, and second, the problem of disability derives from the limitations of the functions and/or psychological losses of the individual body.

Even though the politicization and mobilization by persons with disabilities has its roots in the 19th century, it was between the 1960s and 1970s when there was a strong wave of mobilization by persons with disabilities, especially in Britain, to form disability organizations (Oliver, 1996). During that period of mobilization, persons with disabilities who had a hybrid identity—they were both persons with disabilities and activists or scholars—proposed a new socio-political model for the conceptualization of disability. Following the social-model scholars’ argument, disability is not located in individuals’ bodies, as medical-model scholars argue, but within society. To Oliver (1996), “[it] is not individual limitations...which are the cause of the problem but society’s failure to provide appropriate services and adequately ensure the needs of disabled people” (p. 2). Therefore, disability has nothing to do with the body, but it is society that puts up barriers for people with disabilities. Under the social model, disability and impairment are two different concepts, a position that has been introduced by the Union of the Physically Impaired against Segregation (UPIAS).

More specifically, in 1976, the UPIAS published a set of principles that defined disability as a phenomenon that is socially constructed and not a result of impairment (Thomas, 2004). According to the UPIAS (1976), disability is “the disadvantage or restriction of activity caused by contemporary organization which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities,” and impairment is “lacking part of or all of a limb, or
having a defective limb, organism or mechanism of the body” (p. 14). In the social model, disability refers to the exclusion that people with impairments face with regard to their participation in social activities, such as employment, education, civil rights, and so forth (Thomas, 2004). As for impairment, the social model does not deny its existence, but it argues that impairment is not a condition that is closely connected to disability (Barnes & Mercer, 2010).

The social model of disability introduces two key elements regarding the conceptualization of disability: first, there is a political strategy embedded in it, since its aim is to remove the barriers placed by society for people with disabilities; second, it offers people with disabilities a voice to claim their position in society (Shakespeare & Watson, 2002). Within the context of the social model, people with disabilities are not treated as patients—abnormal or invalid—who need cures or treatments to be normal; instead, they are liberated (ibid.).

The shift in the conceptualization of disability that occurred through stressing the political strategy embedded in it, as well as the need for removing the barriers erected by society for persons with disabilities, gave a boost to persons with disabilities to demand their position in society (Shakespeare & Watson, 2002). Persons with disabilities realized that if they wanted their voices to be heard, it would be essential for them to form a movement “in order to speak with one voice on behalf of the disability community” (Barnartt et al., 2001, p. 436). Oliver (1990) argues for the need to establish organizations of persons with disabilities, instead of organizations for persons with disabilities. The difference between the two is that disability organizations of persons with disabilities are established and run by persons with disabilities themselves, whereas disability organizations for persons with disabilities are established by other actors, such as parents, scientists, and so on. For Branfield (1999) and Oliver (1997), the disability movement should only consist of disability organizations of persons with disabilities.

Considering that the formation of many disability organizations is linked to the specific disability categories of the organizations’ respective members, people with disabilities realized that, in order to be heard, there was a need to form umbrella organizations. The purpose of the umbrella organizations was twofold: to represent the disability movement in negotiations with governmental authorities and to influence those authorities during the processes of development and implementation of policies relevant to disability. Thus, one of the characteristics of the disability movement is that it has acted as a pressure group or advocacy group (see: Barnartt et al., 2001; Becker, 1983;
According to political scientist George Mavrogordatos (2001, p. 21), a pressure or advocacy group has three characteristics: it is “i) an organized group ii) for the defense of its interest iii) by applying pressure to those in power [my translation].”

1.2.3.2 Critiques to social model of disability and the emphasis on the disability experience

Although the social approach to disability has contributed to the enhancement of the self-esteem of persons with disabilities, the social model did not manage to fulfill Oliver’s (1990) ambition to develop a social theory for disability by putting the emphasis on the experience that people with disabilities face in their daily lives. That is, though the social model offered a new understanding of disability by changing the discussion about disability into one about society rather than bodily impairment, it still failed to consider the lived experience of disability, or “how disability is experienced in everyday life and through different subject positions” (Gal lis, 2011, p. 828).

Voices from inside the field of disability studies criticize the social model’s lack of reference to the disability experience as well as the absence of the disabled body (Pinder, 1997; Corker & Shakespeare, 2001; Shakespeare & Watson, 2002). The main argument against the social model of disability concerns the distinction between disability and impairment, and of the social model leaves out discussions regarding both the experience of pain that people with disabilities face in their daily lives and the limitations people with disabilities experience because of their impairments (French, 1993; Thomas, 1999).

Disability studies scholars Corker and Shakespeare (2001) argue that the social model, by turning its attention to the built environment or society as the main cause of disability, downplays the importance of examining disability as a personal experience, since there is no relation between the impaired body and disability under the social model. Nonetheless, a person with disabilities is a person with impairment(s), and such impairment(s) should also be considered; it is not something that can be ignored (Shakespeare & Watson, 2002). To put it differently, various types of impairments cause different experiences, difficulties, or needs for people with disabilities and for their interactions with society.

What emerges here is a gap regarding the understanding of disability as an experience. While the medical model approaches disability by focusing on the
individuals’ bodies, the social model approaches disability by locating the issue of disability in the society by cutting any bond with the individuals’ bodies. The World Health Organization (WHO), through the development of the *International Classification of Functioning, Disability and Health* (ICF), proposes the adoption of a biopsychosocial approach for the understanding of disability; this is a “synthesis” of the medical and social model (Barnes & Mercer, 2010). According to the biopsychosocial model, disability is approached as a “complex relationship between an individual’s health condition and personal factors, and the external factors that represent the circumstances in which the individual lives” (WHO, 2001, p. 17).

In addition, considering the critique against the social approach to disability and the lack of reference to disability experience, scholars such as Diedrich (2005), Moser (2006), and Galis (2011) argue that the study of disability experience should not be limited to personal experiences that are related to the impairment; instead, they propose that the study of disability experience should be extended to the material context, or from personal issues to policy-making issues. For instance, Moser (2006) poses the question of how people become or are made disabled, and Galis (2011) asks, “Who has the authority to determine what disability is and how it is represented?” (p. 829). According to Diedrich, the focus should be on specific experiences of disability and how the disability came into being in various environments, such as institutions, practices, and specific cultures (Diedrich, 2005).

1.2.3.3 The disability movement as a new social movement
As already stated, the roots of the formation of the disability movement go back to the 1970s and the 1980s. This was a period during which there was also wider mobilization by various oppressed and marginalized social groups to demand their rights. The peace movement, the feminist movement, the student movement, the civil-rights movement, and so on—both in North America and in Europe—are some examples of the movements that emerged during that period (Scotch, 1998; Laraña et al., 1994). The mobilization of the aforementioned movements gave a boost to persons with disabilities as well, including in their attempts to be organized in a more collective organization. According to Scotch (1988), the common element between persons with disabilities and the movements by the students, feminists, minority groups, and so on, was that all these social groups were “seeking greater participation in social institutions, and more autonomy and control in their lives” (p. 164).
Social scientists such as Habermas (1981), Touraine (1985), Melluci (1994), and Laraña et al. (1994) argue that the movements that emerged both in Europe and North America after the 1960s did not share the same point of departure with the social movements that already existed, such as the labor movement. They talk about a new wave of social movements that they call new social movements, to stress the difference between the old and the new social movements.

According to D’Anieri et al. (1990), the social movements that emerged in postindustrial societies should be understood as a reaction to the extensive control of the state. As they point out, the economic growth of the 1950s and the 1960s and the state’s resulting prosperity led to the formation of the welfare state as a means to cover citizens’ needs (ibid.). The state’s role, however, was not limited to the economic control of society, as was the case during the “industrial phase of capitalism” (ibid., p. 446). Instead, the state’s control extended over citizens by introducing institutions, such as bureaucracy (see also: Graeber, 2015) and control over services and social relations (D’Anieri et al., 1990; Melluci, 1994). In other words, the emergence of the new social movements was a reaction against state control. Also, for the members of the new social movements, their mobilization aimed to “regain control over their personal and collective sense of identity” (D’Anieri et al., 1990, p. 446).

The emphasis on civil rights, inclusion, and participation in society as well as on the defense of participants’ identities makes the new social movements different from the traditional social movements. As Touraine (1985) states, the movements that emerged after the 1960s did not solely focus on the economic issues, as the labor movement had done; rather, the members of the new social movements protested for their rights and for their inclusion and equality in society. To Habermas (1981, p. 33), the difference between the old and the new social movements is that the old social movements were concerned with “economic, social, domestic, and military security” issues, while the new social movements were concerned with “the quality of life, equality, individual self-realization, participation, and, human rights” issues. As for the participants’ characteristics, the members of the new social movements belonged to specific social groups defined by gender, race, age, and so on (Johnston et al., 1994). According to Johnston et al., a unique characteristic of the new social movements is the emphasis on the identity of the members who participated in the movement, which was relevant to “cultural and symbolic issues” instead of economic issues (ibid., p. 7).
The emergence of the new social movements and the emphasis on identity politics motivated persons with disabilities to demand their rights. Inspired by the feminist slogan, “the personal is political,” persons with disabilities understood disability in the same way as “women [did] their gender” (Scotch, 1998). Apart from the political meaning embedded in the above slogan, also encrypted is the reference to the personal experiences of persons with disabilities because of their impairments and/or because of their personal, subjective experience (Morris, 1992, p. 164; see also: Branfield, 1999). Within this context, Diedrich (2005) claims that the examination of multiple experiences of disability as well as the practices through which disability is created will offer a new understanding of disability. Considering the multiple types of disabilities—from inherent to acquired, from temporal to progressive, and from visible to invisible, etc.—turning to the disability experience will shed light on “the complicated and changing relationships between selves, bodies, and worlds that we all live all the time” (ibid., p. 654). In the same vein, Galis (2011, p. 833), drawing on Foucault (2003) and his concept of the insurrection of subjugated knowledges, argues for the involvement of persons with disabilities in the production of scientific knowledge and in policy-making through an “anti-scientific” contribution, which stems from such persons’ personal experiences and knowledge.

According to Oliver (1997), the disability movement should be viewed and examined under the frame of the new social movements. Specifically, since the purpose of the formation of the disability movement, is both to “promote a change” in how disability is conceptualized and to “improve the quality of life and full...inclusion into the society” for persons with disabilities, the disability movement should be involved “in the formal political system and through the promotion of other kinds of political activity” (ibid., p. 246).

It is worth adding here, however, that there is no common line inside the field of disability studies if the disability movement should be viewed and analyzed as a new social movement. Tom Shakespeare (1993), for example, does not agree that the analytical framework of the new social movements could explain the role of the disability movement. To Shakespeare, one of the motives for the formation of the disability movement—as well as for the feminist and racial equality movements—concerned resource allocation, and the disability movement should be understood as a liberation struggle against the established perceptions about disability and persons with disabilities (ibid.).
In the same vein, Angharad Beckett (2006), who has studied the establishment of the British disability movement and has examined if it can be analyzed under the framework of the new social movements, expresses his doubts whether the analysis of the disability movement under the analytical frame of either the new or the old social movement is enough to understand the whole spectrum of the disability movement. For Beckett, the study of the disability movement should be focused more on the relation between citizenship and social movement as well as on the type of engagement by persons with disabilities in the movement (ibid.).

The emergence of the new social movements and the demand for more participation and inclusion in society have motivated persons with disabilities and, specifically, their disability organizations to be involved in debates or issues that concern them. Vololona Rabeharisoa (2006), for example, studies the involvement of the Association Française contre les Myopathies (AFM), or the French Muscular Dystrophy Organization, in the debate between the patients with muscular dystrophy (MD) and society. Specifically, Rabeharisoa’s study shows how the involvement of the AFM managed to raise public awareness regarding both the rare disease of MD and, more importantly, the existence of MD patients (ibid.). Before the involvement of the AFM, French society was unaware of the existence of MD patients in France. The mobilization of the AFM and its involvement in many sectors within French society shows how a disability organization—by using inside knowledge and experience of what MD is—managed to both inform the society about muscular dystrophy and bring about change concerning how the society should approach the disease (ibid.). Thus, to connect this example with what was discussed above, the mobilization and the involvement of the AFM brought a change in French society by making the society aware of both the disease and the existence of MD patients.

On the one hand, there is a discussion about the formation of the disability movement and its aim to promote change concerning issues relevant to disability, but on the other hand, how might a social movement, or the disability movement, be assessed in terms of its success or lack of success? What are the elements that should be looked at when evaluating a social movement? Oliver (1997), following Marx and McAdam (1994) and their argument that every social movement should be evaluated or judged on four criteria, talks about the evaluation of the disability movement by applying four such criteria. In line with Marx and McAdam (1994), these criteria are “whether any new political or economic changes have resulted from their activities, whether any specific legislation has resulted, what
changes in public opinion and behavior have been produced and whether any new organizations or institutions have been created” (as cited in Oliver, 1997, p. 248).

Here, I will discuss how the above discussions concerning the conceptualization of disability and the establishment of the disability movement will be used in my analysis of the reconstruction of the disability classification system. In the prior section, regarding the theoretical discussion about classification systems, Bowker and Star (1999) claim that the development of classification schemes has a symbolic role as well. Taking the aforementioned argument as the point of departure, the use of the conceptual models for the understanding of disability will be a valuable tool for analyzing how the systems developers and, consequently, the governmental authorities have approached disability issues and how the understanding of disability is enacted in the designing of the systems’ material components.

Based on the discussion regarding the disability experience and how disability is experienced in different material contexts, I am also interested in exploring how disability is experienced in the following: in policy-making—for example, in negotiations between the governmental authorities and social groups; in the enactment of specific legislation—for example, during the enactment of specific laws and ministerial decisions; and in the disabled body—for example, in the translation of a bodily condition to a numerical figure.

As for the disability movement as a new social movement discussion and the demand by persons with disabilities for more participation in society, I find it a challenge to examine the involvement of the disability movement in the enactment of the systems for assessing and classifying disability in the Greek political context. Since the development and implementation of the systems for awarding disability allowances belongs to the core of the state’s disability/social policy, studying the disability movement’s degree of involvement will reveal its role and power in policy-making. For example, I am interested in examining the following: i) whether the disability movement was involved in the debates surrounding the enactment of a system for assessing and certifying disability; ii) whether the degree of involvement has been the same through the years; iii) whether any change has taken place in the society because of the involvement of the disability movement in the enactment of the aforementioned system(s); and, iv) whether the Greek disability movement and its actions can be explained using the analytical frame of the new social movements.
Based on Oliver’s discussion regarding the evaluation of the disability movement and the criteria which should be judged, I am interested in examining whether the involvement of the disability movement has brought any political and economic changes and whether any specific legislations has been enacted because of the activities or initiatives of the disability movement. As for the remaining two criteria—that is, whether any changes have been produced in public opinion and behavior and whether any new organizations or institutions have been created—I am not sure that I can judge these two criteria given the specific context that I am studying.

1.2.4 The political economic theories of corporatism and clientelism and their role in the designing of disability/social policies

Disability policy scholar Robert Drake (1999) argues that the designing of disability/social policies depends on how governments conceptualize or define disability. He states:

Governments formulate and implement policies, in part, to give concrete expressions to their ideologies, values, and beliefs, and each administration creates and promotes policies that resonate with its own particular understanding of “disability.” ...The way in which a government conceives of disability has a profound effect on the eventual shape that a country’s laws and institutions will take, as well as on the quality of life that disabled people can enjoy.

(Drake, 1999, p. 35)

Based on the above quote, the study of the enactment of disability/social policies is a rich source of information regarding how various states around the world enact specific legislation for the support of their populations of persons with disabilities. But does the enactment of disability/social policies reflect only the ideologies regarding the understanding of disability by the governmental authorities, or does it also reflect how a state’s political system affects the enactment of disability/social policies?

Considering that the development and implementation of the system for awarding disability allowances belongs to the core of the welfare state, then obviously, features of the political ideologies that have driven the operation of the political system have also influenced the political debates for the enactment of the above systems. Thus, at this point I would like to add two political-economic theories, which describe the operation of the Greek political landscape since Greece’s transition to democracy in 1974.
According to the political scientists Mouzelis (1986), Tsoukalas (1986), Mavrogordatos (1988, 1997), Venieris (1994), Sotiropoulos (1995, 2001), Trantidis (2013, 2014, 2015), and Lavdas (2006), the Greek political system has been influenced by the political economic theories of corporatism and clientelism. More specifically, corporatism is a political economic theory that refers to “interest mediation” between the state or the government and unions and employers (Mavrogordatos, 1988). Political scientist Philippe Schmitter (1979) defines corporatism as a:

system of interest representation in which the constituent units are organized into a limited number of singular, compulsory, noncompetitive, hierarchically ordered and functionally differentiated categories, recognized or licensed (if not created) by the state and granted a deliberate representational monopoly within their respective categories in exchange for observing certain controls of their selection of leaders and articulation of demands and supports.

(PP. 93–94)

To Schmitter, there are two types of corporatism: state corporatism and societal corporatism. The difference between these styles is that state corporatism is created and imposed by the state in order to control unions, employers, or interested groups (Mavrogordatos, 1988), whereas the roots of societal corporatism are in the society, or, according to Kalaitzidis (2010, p. 66), the state “does create multiple networks with them [interest groups] and works to implement policy by excluding the competition.”

The second political economic theory is clientelism, which refers to the asymmetric relationship between actors from the political context and citizens/members of other social groups. The actors from the political context are described as patrons, while citizens or the members of other social groups are described as clients. Tsoukalas (1986), for example, underlining the close connection between corporatism and clientelism, talks about “clientelistic corporatism” by stressing the asymmetrical relationship between the state and the social groups. By that is meant that the state does not develop the same relationship with all social groups; instead, there is a particular selective support of specific social groups that come from “middle or upper-class society” and not from “working class employees” (Nikolentzos & Mays, 2008, p. 165).
1.2.5. Summary

In the above sections, I discussed the theoretical framework that this project relies upon. Here, I will summarize the key concepts that I will use for the reconstruction of the disability classification system. As stated, I locate the study and analysis of disability classification systems at the intersection of four scientific fields: science and technology studies, disability studies, sociology, and political science. By choosing concepts and approaches from these four scientific fields, the purpose is to examine the development of the disability classification system before it transformed into a black box.

Following the empirical material, the enactment of disability classification systems are closely linked with the role of disability statistics. Governmental bodies, by relying upon the power of numbers, use numbers as “driving forces” to argue for and convince the public of the need to reform the systems for assessing and certifying disability. Then I focus on disability classification systems, not treating such systems as “given infrastructures” but attempting to shed light on what took place in the background, before disability classification systems transformed into a transparent technology (Star & Bowker, 2010). To that end, the employment of the theoretical/methodological themes of indeterminacy of the Past, material and texture, and practical politics, as proposed by Bowker and Star (1999), will contribute to exploring the “practical, ethical, and social choices” in the process of the development of disability classification systems (Star & Bowker, 2010, p. 233). Issues such as negotiations, controversies, inclusion and exclusion, labeling, and marginalization are essential aspects in the examination of the enactment of a disability classification system.

Drawing on Bowker and Star’s (1999) claim that classification systems have a symbolic nature and Altman’s (2001) allegation that disability classification schemes are the translation of a disability model into an empirical tool, the opening of the disability classification system black box will reveal how disability is conceptualized/understood by system developers. Considering that the development of a disability classification system belongs to the core of social/disability policy, the employment of the conceptual models of disability will bring to the surface the governmental authorities’ ideologies about disability.

The discussion leads to governmental authorities and their ideologies, and consequently, to issues regarding policy-making. Therefore, by introducing the political economic theories of corporatism, clientelism, and neoliberalism that have driven the operation of the Greek political system, I will examine how governmental authorities’ ideologies have been reflect-
ed in the enactment of the aforementioned systems. Last, staying in the process of policy-making, governmental authorities have a say in the policy-making, but what about the disability movement? By drawing on the analytical framework concerning new social movements, the purpose here is to examine the involvement of the disability movement in the process of the enactment of the systems for assessing disability.

1.3. Previous Studies

In this part of the introduction, the discussion concerns previous studies about the development and implementation of disability classification systems based on the research of several scholars in the field of disability. The previous-studies section consists of five subsections, as it is divided based on the content of the literature reviewed. Considering the topic of this thesis, in this literature review I focused on articles related to classification schemes developed within the context of a state’s disability/social policy for the compensation of persons with disabilities. After reading the previous studies, I categorized them based on their content into five categories, as follows: first, the classification schemes that have been adopted and adapted for the compensation of disability claimants; second, the different disability assessments procedures around the world; third, the consequences of neoliberalism in the development and implementation of the systems for awarding disability benefits and the transition from the welfare state to the workfare state; fourth, the consequences of the financial crisis of 2007–2008 and the award of disability allowances; and fifth, the involvement or lack of involvement of the disability movement or disability organizations in the policy-making.

As for the logic behind the structure of the section on previous studies, I will start with a more general critical description of the disability classification systems that have been implemented as part of states’ disability/social policy agendas. I will then focus on how those systems have been implemented on the local level, either by presenting the findings of the comparative studies or by presenting the politics and semantics concerning the adaptation of the above systems on the local level. In other words, the second section opens the discussion to issues related to policy-making, and this is the link with the third section. The third section discusses the development of the systems for assessing and classifying disability by emphasizing policy-making issues, with the prevalence of neoliberalism at the center of that discussion, since through the 1990s there was a shift in the assessment of disability by moving from compensation-oriented systems to em-
loyment-oriented systems. For instance, in this section we will see how the use of the *Barema classification scheme*, which will be discussed in the first section, is questioned because of its insufficiency. We will also see how, in parallel, the ICF classification system, which introduces the concept of functionality, is recommended as the system that should be adopted in terms of disability assessment because of its stressing the role of disability claimants’ remaining abilities to continue working.

In the same vein, the fourth section talks about the consequences of the financial crisis of 2007–2008 for the reforms of states’ social/disability policy. The last section is linked with the previous sections regarding the policymaking issues relevant to the disability classification systems, but in this section, inspired by the theoretical framework of this project, the emphasis is on the disability movement and its involvement in the policy-making for the development of the systems for awarding disability allowances. In other words, the structure of the previous-studies discussion starts with a more general discussion regarding the disability classification systems that have mainly been used for the assessment of disability claimants, aimed at showing how changes to a state’s political economic situation also affects the choice of the systems for assessing disability.

More analytically, the first subsection, *Disability and classification schemes*, offers a short description of the four most used classification schemes for awarding disability benefits to persons with disabilities, as noted in the material from previous studies. The second subsection, *Assessing disability: The plurality of the disability assessment procedure*, talks about the plurality of ways to classify and assess disability in various states as well as about the variation in disability classification among states that have adopted the same disability classification scheme. The transition from the welfare state to the workfare state is discussed in third subsection, *From the “welfare state” to the “workfare state”: Assessing disability in neoliberal times*. This section, presenting international examples, emphasizes the consequences of neoliberalism on the enactment of (or reforms to) systems for awarding disability allowances. The outbreak of the financial crisis of 2007–2008 and its consequences for persons with disability and their access to the welfare state is the topic of the fourth section, *The financial crisis of 2007–2008 and its consequences for the award of disability benefits*. Lastly, the fifth section, *The disability movement and its involvement in policy-making*, focuses on the role of the disability movement in policy-making as it has been illustrated and discussed.
by scholars in the area of disability in relation to the reforms to systems for assessing and classifying disability.

1.3.1 Disability and classification schemes

In the area of disability, there are several classification schemes that have been developed and used for the definition, evaluation, and conceptualization of disability. For example, there are classification schemes for research on disability (e.g., WHO, 1980, 2001; Good, 2011), education (e.g., McLoughlin & Lewis, 1994; Florian & McLaughlin, 2008; Powell, 2010), athletics (e.g., Tweedy, 2002, 2003; Howe & Jones, 2005, 2006), rehabilitation (Hart et al., 2014), and compensation (e.g., Abrams, 2015; Admon-Rick, 2013, 2014; Council of Europe, 2002; Mladenov, 2011; Stone, 1984; OECD, 2003, 2009; ILO, 2002), to name but a few. However, based on reports of the Organization for Economic Co-operation and Development (OECD), the Council of Europe, the International Labor Office (ILO), and the WHO, the main classification systems that have been adopted and adapted for the compensation of disability benefits claimants are the Barema classification scheme (or disability percentage table); activities of daily living (ADL); instrumental activities of daily living (IADL); and the two classification schemes developed by the WHO, the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and the ICF. In what follows, I briefly describe the above classification schemes by including critiques that they have received.

1.3.1.1 Barema Classification Scheme

The Barema classification scheme (known as disability percentage table) is one of the oldest classification schemes that was introduced as part of states’ social policy for the assessment of disability claimants. According to Fratello and Scorretti (2002), while citizens’ compensation for injuries or impairment goes back to medieval Europe, it was in the 18th century that Francois Bareme, a French mathematician, translated a medieval German law into mathematical tables to calculate such compensation (Marin et al., 2003). The main philosophy of the Barema classification scheme is the translation of bodily loss or impairment into a disability percentage, which is then translated to a compensation amount (Marin et al., 2003; Fratello & Scorretti, 2002). First implemented for disability assessment and compensation of WWI and WWII disabled veterans, the Barema classification scheme was further adopted and developed by more
European states for the assessment of disability claimants (Fratello & Scorretti, 2002; Admon-Rick, 2014).

Despite its early origins, The Barema classification scheme is still in use for granting benefits and allowances to disability claimants in many states (see, e.g., Council of Europe, 2002; Admon-Rick, 2014). However, as Fratello and Scorretti (2002) point out, there is no explanation about how specific bodily injuries, disorders, or impairments are translated into specific percentages. As they further state, the translation of bodily injury or impairment depends on both social and medical factors (ibid.). For instance, studying the report by the Council of Europe (2002), particularly the section that treats of the Barema classification scheme and how it has been implemented by different countries around Europe, one can note differences between the disability percentages for the same disorder or impairment among different countries (pp. 71–133).

In a similar context, Admon-Rick (2014), through a critical account, studies the operation of the disability percentage table classification system introduced in the 1960s in the Israeli welfare state. Admon-Rick describes the translation of the bodily condition to disability percentage as a procedure of encoding, stressing how this translation transforms the heterogeneous characteristics of disability into a numerical figure in order to “eliminate” the differences, thus making disability an easier issue to be governed by the governmental authorities (ibid.).

1.3.1.2 Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) classification schemes

ADL and IADL are two classification schemes that have also been used for disability assessment. In contrast to the Barema classification scheme, with its emphasis on the impairment or disorder that leads to disability, ADL and IADL place the emphasis on the assessment of the abilities of persons with disabilities to complete various tasks in their daily lives (Katz, 1983). Asking claimants whether they are able to get dressed, to have a bath, to feed themselves, and so on, the purpose of the ADL is to assess the abilities or functionalities of the claimant/respondent (Institute of Medicine, 1992). Similarly, the IADL assesses whether the claimant is able to cook, go shopping, do laundry, and so on; in other words, the assessment concerns more difficult tasks than the tasks in the ADL (ibid.).

On the one hand, the ADL and IADL classification schemes do not focus directly on individuals’ impairments but emphasize their remaining abilities to perform specific daily tasks. But on the other hand, though the emphasis
is on claimants’ abilities, these classification schemes are still individual oriented (Marks, 1997) and do not take into consideration, for example, the interaction with the society or accessibility aspects. The content of the ADL and IADL questionnaires thus contain questions about the ability of the individual to perform specific, daily routine tasks. But, again, assessments based on the ADL and IADL are around the individual and his/her personal performance; no other socio-material aspects are examined.

Although the ADL and IADL do not examine and classify applicants in relation to their impairments but in relation to their abilities, scholars around the area of disability stress the vulnerability of these questionnaires. Shildrick and Price (1996), for instance, studying the use of the ADL classification scheme in the UK, challenge the performance of these questionnaires, stating that the claimant might pretend to be more disabled than he or she is in order to be eligible for (higher) disability allowances. Also, based on the above comment by Shildrick and Price, the outcome of an applicant’s answers does not provide a clear picture of his/her needs, and therefore these schemes might not be used and for research purposes (Institute of Medicine, 1992).

From a different point of view, Zola (1993) discusses the structure of the ADL and IADL self-assessment classification schemes by questioning the wording of the questions included in these schemes: Questions such as “Do you have difficulty in doing...?” (a specific activity) embed “negative elements,” according to Zola (p. 28) because they take for granted that the disability claimant has a kind of difficulty. A similar argument is offered by Abberley (1992).

1.3.1.3 The International Classification of Impairments, Disabilities, and Handicaps (ICIDH)

Early in the 1980s the WHO developed the ICIDH as a tool for the definition of disability. The developers’ expectation was that the use of the ICIDH together with the International Classification of Diseases (ICD) would offer a better understanding of health care in that one could, by using both together, describe the existing diseases, the causes of death, as well as the consequences of diseases to people (Gray & Hendershot, 2000). The ICIDH developers also expected that the ICIDH would be used in various fields for purposes ranging from research and epidemiology to welfare and health (Bickenbach et al., 1999).

According to the ICIDH, disablement should not be defined as something single—the limitation of the individual body because of a disease—but as “a
sequence of levels of health experience” (Bickenbach et al., 1999, p. 1175) or as an outcome of different factors that operate in parallel. The ICIDH thus introduces three concepts to define disablement: impairment, disability, and handicap (WHO, 1980). Specifically, impairment concerns any loss or abnormality of psychological, physiological, or anatomical structure or function; disability reflects upon the consequences of impairment in everyday life, such as any restriction or lack of ability to perform an activity; and handicap refers to the disadvantages that individuals experience as a result of their impairments (WHO, 1980; Bickenbach et al., 1999; Gray & Henderson, 2000). What is notable from the above triple categorization is the close association between impairment and disability; in other words, here, disability is the result of impairment and its consequences to everyday life (Llewellyn & Hogan, 2000).

Although the ICIDH was translated into other languages and adopted by several states around the world (Bickenbach et al., 1999), the three definitions it put forth—that is, impairment, disability, and handicap—had been criticized by disability scholars and activists, especially the British. The point of conflict between disability activists and the ICIDH concerns the linear connection between impairment, disability, and handicap. For the disability movement, it is the environment, both social and built, that places barriers to persons with disabilities; that is, disability is a social construction (Fougeyrollas & Beauregard, 2001). For disability scholars and activists, disability is linked to the exclusion people with impairments face regarding their participation in social activities such as employment, education, and civil rights (Thomas, 2004).

Bickenbach et al. (1999), in their critique of the social model, question the claim about the social construction of disability. To Bickenbach et al., the argument regarding the social construction of disability fails to “provide a workable model for research” and “to provide advocates with the hard data they need to convince legislators to pass new laws and change old ones” (1999, p. 1178).

1.3.1.4 The International Classification of Functioning, Disability, and Health (ICF)
Since the 2000s, several states around the world, following recommendations by institutions such as the United Nations (UN) and the OECD, began to revise or replace their existing systems for assessing and certifying disability by following or being inspired by the ICF (see, e.g., Schuntermann, 2005; Leonardi et al., 2005; Okawa & Ueda, 2008; Leonardi et
Starting early in the 1990s, the WHO considered the criticisms that the ICIDH received from representatives of the disability movement and announced the revision of the ICIDH. In contrast to the way the ICIDH was developed, the WHO invited representatives of the disability movement to be involved in the process of developing the ICF.

As mentioned, one of the main arguments against the ICIDH was the linearity between the three concepts for the categorization of disablement that the ICIDH introduced, especially the close association between impairment and disability. For members of the disability movement, a disability has nothing to do with the impairment; rather, barriers from the social and built environment are responsible for disability (Fougeyrollas & Beauregard, 2001). The ICIDH-2, as initially named, attempted to bridge the gap between the ICIDH and the disability movement by introducing the concept of the environment (Hurst, 2003). As Fougeyrollas and Beauregard (2001) point out, the concept of environment refers not only to the built environment but also to the “social, political, economic, institutional, and cultural dimensions” (p. 172).

The development of the ICF follows a biopsychosocial approach to disability to “provide a coherent view of different perspectives of health from a biological, individual and social perspective” (WHO, 2001, p. 20). In other words, disability is approached through “a synthesis of the medical and social approaches to disablement” (Bickenbach et al., 1999, p. 1183). The ICF introduced two umbrella concepts— functionality and disability—for replacing the three concepts introduced by the ICIDH that were criticized by the disability movement (Fougeyrollas & Beauregard, 2001). According to Bickenbach, “the ICF conceptualizes...functioning and disability from the perspective of health” (Bickenbach, 2012a, p. 56). The emphasis on “health and functioning” instead of disability offered a shift in the conceptualization of disability, since it revised the old view that disability emerges where the health ends (WHO, 2002).

The aim of the ICF is thus to set aside what causes the impairment and to focus on a person’s functioning in society (WHO, 2002). In the ICF, human functioning can be divided into three levels: “the body or body part, the whole person, and the whole person in a social context” (WHO, 2001, p. 10). Bickenbach explains that functioning refers to “all Body Functions and Structures, Activities and Participation,” while disability concerns “Impairments, Activity Limitation, and Participation Restrictions” (Bickenbach, 2012a, p. 56). Also, through the ICF, disability
concerns not only a specific social group: rather, all human beings may experience a kind of disability in their lives (ibid., p. 56). Introducing the “ruler of health and disability,” the ICF developers’ claim that every human being could be classified in one point of this line (ibid., p. 56).

Despite the attempt to bridge the gap with the disability movement and to combine the medical and social approaches to disability, disability scholars criticize the ICF on the grounds that, although it adopts a biopsychosocial approach to disability, the individual’s body and functioning remains the starting point of this classification (Barnes, 2003). As Barnes (2003) claims, the concept of participation refers to the individual rather than to his/her inclusion in a social and political context.

In the same vein, Albert (2005, p. 136) expresses his doubts that, despite the intentions of the ICF to include a social understanding of disability, the operation of the ICF will, in practice, approach disability through a “health centered” lens. Similarly, Hurst argues that if the ICF is used as it is designed to be used, then it would be a “useful tool” both for disability assessment and for statistical purposes; however, she expresses her doubts because the operators of the system, who come from the medical society, might not consider the environmental perspectives during the disability assessment (Hurst, 2000, 2005). For Pfeiffer (2000, p. 1081) both the ICIDH and the ICIDH-2 (ICF) are “threat[s] to the community of persons with disabilities.” He further claims that the operation of the ICF adopts “the principles of eugenics,” in the sense that the medical professionals who are the operators of the system would have the authority to decide regarding the quality of life of persons with disabilities (2000, p. 1081).

Imrie (2004), in his critique of the ICF, states that the latter lacks a well-developed theoretical framework for explaining the concepts of impairment and disability. Imrie challenges the adoption of the biopsychosocial approach to disability, which is, according to the ICF developers, the conceptual basis of the ICF. For instance, in line with the WHO, the biopsychosocial approach to disability “provide[s] a coherent view of different perspectives of health from a biological, individual and social perspective” (WHO, 2001, p. 20); however, for Imrie (2004), there is a lack of explanation as to how the combination of biological, individual, and social elements will provide the operators with a “coherent view” of health (p. 297).

Considering the adoption and implementation of the ICF as an instrument for the design of social/disability policies, Symeonidou (2012) challenges the introduction of the “ruler of health and disability,” stating that it could also be a point of conflict. As she claims, if the ICF
were used for the design of social policies, then the number of persons with disabilities eligible for disability allowances would be increased—an event that would have consequences for policy on disability allowances (2012). In other words, an increase in the number of citizens eligible for disability allowances might have an inversely proportional effect on disability allowances by decreasing the monetary amount of the allowances in order to give disability allowances to all persons with disabilities (Symeonidou, 2012).

In another critique of the implementation of the ICF, J. Felson Duchan (2004) wonders, “Where is the person in the ICF?” Duchan focuses on the implementation of the ICF and specifically on the disability assessment procedure, claiming that persons with disabilities may be transformed into “codable” subjects instead of being treated as human beings who have personal experiences (ibid., p. 64). As she further states, the ICF introduces a “scientific, objectifying system for dealing with a patient’s functioning or disability” without giving room to persons with disabilities to have a say during their assessment (ibid., p. 64).

1.3.2 Assessing disability: The plurality of the disability assessment procedure

The prior section discussed the most often used disability classification schemes that have been adopted and adjusted by states as part of their disability/social policy agendas in the context of the welfare state. The presentation of the abovementioned schemes was accompanied by critiques of them, in regard to their operationalization, by scholars from the wider area of disability research. In this section, the emphasis is on presenting the systems for assessing and certifying disability as they have already been studied and described by scholars in the wider context of disability research.

The study of the systems for disability protection constitute a popular topic among scholars that study the enactment of disability/social policies in the context of the welfare state (see, e.g., Stone, 1984; Biskup & Kotrusová, 2002; Zeitzer, 2002; Fultz, 2002; Marin et al., 2003; de Boer et al., 2004; Bartlett & Xhumari, 2007; Winnance et al., 2007; Mladenov, 2011; Admon-Rick, 2013). However, the study of the system of assessing and certifying disability is not only limited to individual researchers; institutions such as the Council of Europe (2002), the ILO (Fultz & Ruck, 2002), the OECD (2003, 2009), the World Bank, and the WHO have also been interested in examining the development and implementation of such systems or proceeding with recommendations and advice for reforms to
existing systems for assessing disability. Hence, if we want to categorize these studies, then we can classify them into two categories: either comparative studies of different countries around the world conducted by institutions such as the OECD, the ILO, or the Council of Europe, to name but a few, or studies that aim to describe and/or investigate the politics and semantics in the development of the systems for awarding disability allowances to disability claimants in a local context. What emerges from both the comparative studies and the single studies in local contexts is that there is not a unique or standard system that has been implemented and there is no a standard disability assessment procedure. Rather, each country has developed its own system.

For example, in 2002, the Council of Europe conducted a comparative study among 21 European countries to examine similarities and differences in how disability is assessed in Europe. One of the findings of this study shows that the Barema classification scheme has been implemented by most of the European countries which participated in the survey. But even though all the countries have implemented the Barema classification scheme, there was differentiation regarding its content. That is, for the same impairment, different disability percentages are attributed from country to country. To give an example, for the amputation of one foot, a person will be evaluated with 50% disability in Belgium, 100% in England, 20% (forefoot) to 40% in France, 30% (partial loss) in Germany, 35% (right foot) in Iceland, and 70% (both feet) in Italy (Council of Europe, 2002, p. 132). Also, according to this study, there is a heterogeneity regarding the purposes for which the Barema classification scheme has been implemented, as it been implemented for workers’ compensation, disabled veterans’ compensation, people with disabilities in general, and so on (ibid.).

Brian Marin (2003, p. 7) questions the operation of the Barema classification scheme, describing it as a “pseudo-scientific way” to assess disability. Specifically, he focuses on the disability percentages attributed to some impairments being different from state to state, and he points out that sometimes there have even been differences between tables used in the same country but for different purposes (ibid.). For Marin, the discrepancy between the disability percentages for the same impairment is the weak point

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2 The countries that participate in this study were the following: Austria, Belgium, Cyprus, Denmark, France, Germany, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, the Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom (Council of Europe, 2002).
of this scheme because it either represents “long-standing stigmatization or prejudices” of the country in which has been adapted or it leaves room for “social administrations” and “lawmakers” to intervene and change the disability percentage based on the current needs of the specific system for awarding disability (ibid., pp. 9–10). The Barema classification scheme, because of its nature, is vulnerable to being changed based on the national or sectoral trends that exist in a specific context or state.

The procedure for disability assessment also differs from state to state, and sometimes there are more than one procedure in the same state (OECD, 2003). According to the OECD (2003) report, Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People, the medical assessment of disability is the dominant method for assessing disability in several states. However, one of the differences that is observed concerns the physician who certifies or awards the disability certificate. In some states the claimant’s physician provides the claimant with a health certificate to submit to the medical committees for assessing disability, but the importance of this document differs from state to state (ibid.). For example, the members of the assessment committee in Germany or in Sweden would perhaps use it because the evaluation is based on the examination of claimant’s file instead of his/her medical assessment; in Austria, the members of the health committees will ignore it; in Australia and Switzerland, this certificate could be an essential document because the claimant’s physician participates, at some point, in the disability assessment procedure (ibid.). In other countries, the members of the disability health committees might not be physicians but officers from the relevant social insurance institute (ibid.).

In addition to the comparative studies that describe and compare the different systems for awarding disability, there are studies that examine specific systems in an attempt to shed light on the politics and semantics that are embedded in those systems. For instance, Mladenov (2011) studies the system for assessing disability in Bulgaria. His study shows how the local political context affects the development of disability policies and, specifically, the enactment of systems for certifying and assessing disability. Thus, in the case of Bulgaria, the disability assessment procedure is linked with the state’s political background: that is, the state’s “social past”—specifically the method for assessing disability—has been influenced by the “Soviet approach of defectology” (ibid., p. 479).
1.3.3 From the “welfare state” to the “workfare state”: Assessing disability in neoliberal times

Since the 1990s, several states around the world have faced a “battle against the numbers,” to borrow a phrase used by van Oorschot and Boos (2000). The beginning of the 1990s marked a time when there were discussions to the effect that the existing disability allowances policy did not work. There are several studies that talk about the increasing number of disability benefits claimants and simultaneous cuts to expenditures by the welfare state, with governments around the world searching for new methods for the compensation of disability (e.g. van Oorschot & Boos, 2000; Ydreborg et al., 2007). For instance, as van Oorschot and Boos (2000) point out, the Netherlands reformed the system for providing disability benefits through enforcing stricter eligibility criteria since the 1980s, but at the beginning of the 1990s, that reform proved insufficient, so new measures needed to be implemented. A similar example comes from Sweden, where the number of disability benefits claimants increased late in the 1990s, causing the Swedish governmental authorities to adopt and implement tighter definitions “of what constitutes loss of work capacity, based on medical criteria” (Ydreborg et al., 2007, p. 2).

What gradually emerged in the 1990s was the “failure” of the reforms regarding the compensation of persons with disabilities, since, despite the reforms, the number of disability beneficiaries continued to increase (van Oorschot & Boos, 2000). Marin (2003) questions whether the systems for compensating persons with disabilities truly provided opportunities to all persons with disabilities applying for disability benefits, saying that there were several citizens who, though they really needed the disability benefits, did not meet that criteria for receiving them. So there was a time for a radical shift—or a “paradigm shift,” as Marin describes it (ibid.)—for the implementation of a new system for disability policy protection by putting the emphasis on the “employment” and “inclusion” of disability beneficiaries in the labor market. According to Marin (ibid.), what was needed was an “employment-oriented equal opportunity model” (p. 32), which would help disability beneficiaries reintegrate into the labor market and lead to their inclusion in society. In this “paradigm shift,” impairment was no longer at the center for awarding disability benefits; rather, the emphasis became the (remaining) abilities and functions of person with disabilities (Marin, 2003; Østerås et al., 2007; OECD, 2003; Parker Harris et al., 2014).

Soldatic and Meekosha (2012), underlining the shift from compensation policies to employment-oriented policies aimed at the reintegration of per-
sons with disabilities into the labor market, talk about the “workfare state” in describing the participation of former disability claimants in disability workfare programs. The United Kingdom, Canada, and Australia, to name but a few, have reformed their systems for awarding disability benefits into the workfare context (see, e.g., McKeever, 2000; Millar, 2003; Chouinard & Crooks, 2008; Piggott & Grover, 2009; Soldatic, 2011; Lantz & Martson, 2012; Soldatic & Pini, 2012; Grover & Soldatic, 2013). For example, van Oorschot and Boos (2000) describe how the Netherlands decided to change its disability policy regarding disability pensions at the beginning of the 1990s by implementing an employment-oriented perspective for handling the increased number of disability allowances claimants in that country. And Parker Harris et al. (2014) discuss the employment-oriented policy as it was implemented in Australia. In the same context, the OECD reports Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People (2003) and Sickness, Disability and Work: Breaking the Barriers—A Synthesis of Findings across OECD Countries (2009) offer an overview of how the new employment-oriented disability policies operate in OECD countries.

The shift from compensation policies to employment-oriented policies also entails a shift in the assessment of disability. As stated, the assessment of the impairment is no longer at the center of disability assessment; rather, the emphasis has been transferred to the abilities and functions of persons with disabilities. The introduction of the ICF by the WHO and the biopsychosocial approach to disability also contribute to assessing abilities and functions instead of impairments. For instance, the medical assessment of disability has gradually been replaced by self-report instruments. In Norway, in the early 2000s, experts designed a “self-report” instrument using the ICF as the basis for assessing the abilities and functions of persons with disabilities (Østerås, et al., 2007). This instrument, called the Norwegian Function Assessment Scale (NFAS), was designed to be used for rehabilitation purposes, for readjustments of the working environment, and for access to disability benefits and services (Østerås et al., 2007).

Additionally, the introduction of the ICF and the new conceptualization of disability through a biopsychosocial perspective, together with the international trends regarding the reforms of systems for awarding disability allowances (see, e.g., OECD, 2003, 2009), have inspired several states around the world to proceed with the adoption and adaptation of the ICF, either as a tool for the reconceptualization of disability or as a classification scheme for the assessment and certification of disability. In a recent study,
Pinilla-Roncacio (2015) examines the development of disability policies and social protections in five countries of Latin America. According to her findings, the proposals by the WHO and the World Bank have influenced the enactment of legislation for the conceptualization of disability by adopting the biopsychosocial approach to disability (ibid.). However, as she states, the biopsychosocial approach to disability was not adopted for the design of social protections: for the assessment and certification of disability, the medical approach to disability has been implemented (ibid.).

Scholars from different disciplines around disability have studied either the influence, adaptation, and/or implementation of the ICF into local social policy settings or some first responses regarding the changes and challenges that the operation of the ICF has brought. To give an example, Australia, Germany, Japan, Italy, Taiwan, and Cyprus are some of the countries that have proceeded with the adaptation of the ICF for assessing and certifying disability (see Australian Institute of Health and Welfare, 2003; Schuntermann, 2005; Leonardi et al., 2005; Okawa & Ueda, 2008; Leonardi, et al., 2009; Teng et al., 2013; Chiu et al., 2013; Chen & Chu, 2015; Symeonidou, 2014).

Symeonidou (2014) and Teng et al. (2013) study the revision of the system for assessing disability based on the adaptation of the ICF in Cyprus and in Taiwan, respectively. They discuss the decisions that the Cypriot and Taiwanese states made regarding disability assessment, which involved putting the emphasis on activities, participation, and environmental aspects and setting aside the assessment of the bodily impairments of persons with disabilities. Symeonidou (2014) challenges the use of the ICF as a means to develop social policy, arguing that the classification of impairments and the assessment of functioning are issues that concern medical professionals, in contrast to the view that disability/social policy ought to be designed by putting the subject (person with disabilities) at the center rather than his/her impairment(s).

Similarly, Teng et al. (2013) identify five challenges that the Taiwanese society faced after the adaptation of the ICF: (i) an increase in the number of medical and paramedical professionals responsible for assessing persons with disabilities, (ii) an increase in the budget for implementing the disability assessment procedure, (iii) an increase in the running costs of the hospitals to operate the disability assessment procedure based on the ICF, (iv) the central planning needed from the government to form a body of professionals educated to assess based on the ICF, and (v) the consequences of the new method for disability assessment to persons with disabilities.
and their families—for example, changes to their existing classifications because of the system revision, reductions to the disability allowances they were already receiving, and increased time required for the disability assessment (p. 696).

1.3.4 The financial crisis of 2007–2008 and its consequences for the award of disability benefits

Though the disability policy reforms go back to the 1990s, the global financial crisis of 2007–2008 was a crucial moment for reopening the discussion for radical reforms to disability policy developments worldwide and, specifically, for radical cutting of expenditures for disability allowances (OECD, 2009; Taylor-Goody & Stoker, 2011; Yerkes & van derVeen, 2011; Briant et al., 2013; Goodley et al., 2014). In 2009, a year after the outbreak of the financial crisis, the OECD published the report *Sickness, Disability and Work: Breaking the Barriers—A Synthesis of Findings across OECD Countries*. The report illustrates the challenges that emerged after the financial crisis and asks OECD member states to take measures or reform their disability policies.

In the same context, Williams-Findlay (2011) and Briant et al. (2013) study how the global financial crisis of 2007–2008 affected the British welfare state, with particular focus on the structural reforms to the disability allowances system as announced by the UK coalition government; Yerkes and van der Veen (2011) study the consequences of the financial crisis to the Dutch welfare system. Briant et al. (2013), through a study that examines how the British newspapers covered the UK coalition government announcement for the reform of the disability pension policy, focus on the rhetoric that the UK coalition government adopted for stressing the need for cuts to disability benefits, including its characterization of persons with disabilities as “folk devils” who cheat the state and receive disability allowances without meeting the relevant criteria (p. 874).

Disability statistics regarding the disability beneficiaries and the association of disability with “disability fraud” constitute two of the main arguments, or instruments, that representatives of the government used to argue for the need of reform to the disability protection policy (Briant et al., 2013; Tyler, 2014). Also, considering the consequences of the financial crisis—the radical cuts to disability allowances and the characterization of persons with disabilities as fraudsters (e.g., Tyler, 2014)—Williams-Findlay (2011) argues that people with disabilities need to form a move-
ment, or mobilize, to defend their rights against the austerity-driven policies toward persons with disabilities.

1.3.5 The disability movement and its involvement in policy-making

Williams-Findlay’s (2011) argument for the need for persons with disabilities to mobilization to defend their vested rights offers a good entry point to present the involvement, or lack of involvement, of the disability movement or disability organizations in policy-making and, particularly, in the development and implementation of the systems for providing disability allowances. Scholars in the area of disability studies have studied the involvement of disability movements, either as disability organizations or as collectives, in policy-making and have noted some variation in such involvement from state to state.

Zeitcher (2002), for example, discusses the reforms to disability pension policies and systems for assessing disability carried out in the Netherlands in the early 1990s. She notes that representatives of the disability organizations were not involved in the debates on the reform of the disability pension system (ibid.). For the government, the social dialogue concerned only the state and other social partners but not persons with disabilities (ibid.). Zeitcher (2002) also notes that, although there were several disability organizations with considerable representation in the Dutch society, for the enactment of policies on issues relevant to disability pensions, disability organizations were perceived as organizations belonging to the “periphery” and not as equal social partners (p. 252). According to Zeitcher (2002), the exclusion of persons with disabilities from debates on the reform of disability pension policies lies in the relationship between the Dutch government and the disability organizations. Although the latter had received funding from the state, the state did not recognize them as equal social partners for participation in the social dialogue. A similar example is presented by Parker Harris et al. (2014) in their study of the involvement of disability advocacy groups in the development of disability policy in Australia.

In another example, Lundävl et al. (2015) study the debate on the introduction of the ICF in Sweden. They find that the representatives of the disability organizations were not involved in the procedure for the introduction of the ICF in Sweden and were not aware of the new classification scheme or of the changes the implementation of the ICF might bring to their lives. For instance, some of the representatives of the disability organizations expressed their fears about the consequences of the new classification scheme for their access to welfare allowances.
On the other hand, Symeonidou (2014) talks about the role of the disability movement in the adaptation of the ICF in Cyprus. As she notes, the disability movement, either by campaigning against the implementation of the ICF or by participating in the meetings and negotiations with the system developers, was involved in the debate on the introduction of the ICF into Cypriot society and on the reform of the social policy. An essential element that emerged from Symeonidou’s study is the plurality of views among disability activists, disability organizations, and the disability movement, with each of the above groups expressing different arguments for and against the ICF.

In a similar vein, Cate Thill (2015) studies the reform of the National Disability Insurance Scheme in Australia, focusing on the involvement of representatives of persons with disabilities in the debate on the partial reform of the system providing disability allowances (ibid.). Specifically, the Productivity Commission Inquiry, which was responsible for the reform, listened to the voices of persons with disabilities regarding their personal experiences as those were enacted because of the implementation of the existing system and used what was said as “evidence for why change is required” (ibid., p. 21). Thill focuses on the personal experiences of persons with disabilities, claiming that it is a kind of “expertise” that can be used as an instrument for the design of disability policies (ibid.). According to Thill, testimonies from persons with disabilities can contribute to both the development and the implementation phases of the new system for awarding disability allowances. Finally, she notes that because of the wide area over which disability extends, there is a need for persons with disabilities to be involved as a collective in policy-making in order to represent all the voices of persons with disabilities.

Good (2011) and Mladenov (2009), who also study the involvement of persons with disabilities in policy-making, offer a different perspective regarding such involvement. For instance, Good (2011) refers to Ireland’s strong disability movement, which has had the power to influence the Irish state and set new demands regarding disability (ibid.). Specifically, the Irish disability movement, through the establishment of the Commission on the Status of People with Disabilities, has been involved in developing a social approach to disability in the Irish state, and this has also been reflected in policy design (ibid.).

Mladenov (2009), on the other side, discusses the participation of persons with disabilities in policy-making in Bulgaria. In Bulgaria, persons with disabilities were represented in the debates with the state on disability
issues by the National Council on Integration of People with Disabilities, while disability organizations had a rather passive role in policy-making. However, as Mladenov (2009) notes, the Council was not an institution that represented persons with disabilities; it was an institution whose purpose was to “sustain the state bureaucratic machine and not challenge its constitution or operation” (p. 35). The Good (2011) and Mladenov (2009) studies provide contrasting examples of the involvement of persons with disabilities in policy-making: In Ireland, a strong disability movement had the power to influence the development of policy-making, whereas in Bulgaria, disability organizations emerged as partners in debate with the state but were passive actors, in terms of influence, in policy-making.

1.3.6 Summary
In this part of the introductory chapter, we saw how the issue of disability classification systems, as part of the welfare state, has problematized the wider area of disability science. Starting with a more general discussion regarding the classification schemes that have been adopted by governmental authorities, a flexibility, in terms of adaptation, has been noticed. That is, though some states adopt the same types of disability classification schemes for enacting their social/disability policies, one finds, upon comparing the classification schemes, that there is variation between them. For instance, in the case of the Barema classification scheme and its use of percentages for the translation of bodily loss, disorder, or injury into disability, it is discussed above that there is no a common codification behind the translation of a bodily loss, disorder, or injury into a numerical figure because the disability percentages differ from state to state.

As indicated, the development of systems for certifying and assessing disability is an integral part of states’ social/disability policy agendas. International trends regarding the conceptualization of disability, recommendations by international institutes such as the OECD, and political and economic ideologies for governing constitute essential elements for development of disability classification systems as well as for the design and establishment of disability entitlements.

Since the 1990s, the economic theory of neoliberalism has been a benchmark to the reforms of the systems for awarding disability allowances. Besides, disability statistics and the alleged “fake disabled” have been used as rhetorical tools by politicians and policy makers to argue for the need to revise the system for awarding disability allowances. Particularly, considering the austerity-driven policies recommended by international
institutes to their member states in order to meet the challenges that emerged because of the 2007–2008 financial crisis, a new era has begun regarding access to the welfare state and the award of disability allowances to persons with disabilities.

While disability studies scholars have problematized the consequences of the radical cuts to disability allowances to persons with disabilities, there is a gap in the literature regarding what happens in the development of systems for assessing and certifying disability in times of economic crisis (or austerity)—something that this study aims to contribute to the field. Specifically, after the start of the economic crisis in Greece late in 2009, a new system for assessing and certifying disability developed as part of the radical structural reforms that were demanded upon the inclusion of the country under the financial support mechanism by the European Commission (EC), the International Monetary Fund (IMF) and the European Central Bank (ECB).
2. Method

Chapter 2 talks about the choices regarding the methods for the data collection and data analysis as well as issues that came up during the fieldwork. Chapter 2 thus consists of three sections. The first section starts with a short presentation of how I identified material from previous studies, and then it describes the methods that I implemented for the collection of the empirical material of this project. The second section, which I call Field Issues, focuses on the difficulties that came up during data collection. As will be discussed, one of the main challenges I faced during the fieldwork was the political instability in Greece because of the economic crisis. Recalling the experiences from the period of data collection, I found this section both an important part of the completion of this project as well as an essential discussion regarding the vulnerability of a social researcher who conducts research in areas that are closely connected with the political context of a specific society, especially during a period of crisis. Last, the third section refers to the choices for the data analysis. The discussion begins with some initial, yet crucial, decisions regarding the handling of the empirical material, and it continues with the presentation of the method that I employed for the analysis of the empirical material—that is, situational analysis (SA).

2.1 Data collection

For collecting the material from previous studies, I used the databases Web of Science\(^3\) and Scopus\(^4\). In both databases, I did a keyword search using the following keywords: “disability classification systems,” “disability assessment,” “disability pension(s),” “disability allowance(s),” “disability benefit(s)” “disability,” and “welfare,” as well as combinations of them. Also, apart from these databases, I found material of relevant previous studies in a nonsystematic way. By that I mean that I searched for previous studies ma-

\(^3\) Web of Science is a research platform that contains material from books and articles to proceedings and patents, and it is maintained by Thomson Reuters. For more information regarding Web of Science, see: [http://thomsonreuters.com/](http://thomsonreuters.com/), retrieved November 30, 2015.

\(^4\) Scopus is one of the largest databases that contains peer-reviewed literature, and it is owned by Elsevier. For more information regarding Scopus, see: [https://www.elsevier.com/solutions/scopus](https://www.elsevier.com/solutions/scopus), retrieved November 30, 2015.
terial either through the study of some of the secondary sources and references that authors had mentioned or through the search for reports from the European Union (EU), the OECD, and the ILO.

For the collection of the empirical material of this project, I conducted a qualitative research study. Specifically, I chose three methods: (i) interviews, in-depth and semi-structured, (ii) written material, such as state legislation, archives, and so on, and (iii) newspaper articles. By employing these three methods, the aim was to cross-check both the reliability of the data and the credibility of the findings (Patton, 2015). The fieldwork took place in Athens, Greece, from 2014 to 2016. Though the disability assessment procedure is the same in every region of Greece, in a personal communication that I had with one of my informants from the Ministry of Health, he suggested that it would be better for my research to also speak with some actors from regions of Greece other than Athens. Keeping that in mind, I conducted two interviews in Kalamata, Greece. The choice of Kalamata was based in two factors: first, Kalamata is a middle-sized city in Greece, and second, it is my hometown, so it was easier to have access to the Directorate of Welfare at Kalamata Municipality, which is responsible for disability allowances and services to its citizens.

During the first days in Athens, I was interested, on the one hand, in examining the development of disability classification systems, with my big concern being how to identify relevant informants for my project. On the other hand, since my time was limited, I needed to act methodically, starting by framing my project. For structuring this frame, the portal www.disabled.gr provided me with information regarding the “big picture” of this project, and it familiarized me with the field’s terminology. The aim of the portal www.disabled.gr was to inform persons with disabilities in Greece regarding issues such as their fundamental rights and social participation. The portal had been online since 1997; however, at the beginning of 2016, the portal stopped working.

In parallel, I started searching for all relevant disability organizations in Greece, relevant ministries, and organizations that participated in one way or another in the development and implementation of disability classification systems. Also, I designed a timeline where I depicted the breaking points of my project as well as relevant information regarding the disability issues in Greece. After completing these initial steps, it was time to

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5 Appendix I, is an example of the timeline that I designed and used during the data collection as well as during the analysis and writing of this thesis.
collect the relevant written material and to meet with the relevant and/or key actors to discuss their experiences and knowledge.

### 2.1.1 Interviews

Interviews was the first method that I employed for data collection. Kvale (2007, p. 11) describes interviews as a powerful method to examine and understand “the experiences and lived meanings of the subjects’ everyday world.” To Kvale, an “interview seeks to obtain descriptions of the interviewees’ lived world with respect to interpretation of the meaning of the described phenomena” (ibid., p. 11).

But how to identify the relevant informants? As stated previously, one of my big concerns was how to identify informants relevant to my project. Since my knowledge of the subject was limited, I did not know how to gain access to the field, so I started by contacting two informants with the help of my personal network. When I contacted them, they said they were willing to contribute to my research and to describe or offer the big picture of the subject under study. At the same time, I was looking to identify key actors relevant to my research topic, from politicians, policy makers, and institutions, to representatives of disability organizations and medical societies. Working in this field, I identified a variety of actors who had participated in the development of disability classification systems, and I categorized them into three categories: (i) actors from the state and the public sector, (ii) actors from the disability movement, and (iii) actors from the medical society.

Having identified them, I started getting in contact with them either by sending an email, when the email address was easy to find, or by calling them or sending a formal cover letter by post; however, I did not receive the responses that I expected. My relatives and friends also suggested some informants who would be able to discuss their personal experiences with me. So I ended up creating a small group of relevant participants for my research project. Those participants then proposed some more actors who had relevant experiences and knowledge. To be more specific, they did not just propose the names of these actors but they also gave me the actors’ contact details. In other words, I adopted the technique of snowball sampling with a view to enlarging the number of relevant informants for the project (Bryman, 2012).

For instance, the Social Insurance Institute (IKA) has had a central role in the operation of disability classification systems. Consequently, a discussion with a representative from this institution was necessary. Hence,
one of my priorities was to get in contact with the IKA. I sent them an email in which I described in detail my research project and the purpose of my email communication to them. No one replied. The last option was to send a formal letter by post, together with a cover letter signed by the director of my institute. In May 2015, when I was in Athens because I had not received any response from the IKA, I asked one of my informants to suggest how I might get in contact with the Directorate of Disability and Occupational Medicine of IKA. My informant was willing to help, and after his personal communication with the Head of the Directorate, he gave me her contact details for calling and booking an appointment with her. I called her, and we met after a few days.

In total, I conducted 18 interviews with representatives from the following organizations as well as with individuals:

- National Confederation of Persons with Disabilities (ESAEA)
- National Federation of the Blind
- Piraeus Association of Physically Challenged
- Ministry of Health
- Ministry of Labor and Social Solidarity
- Ministry of Culture, Education, and Religious Affairs
- Social Insurance Institute (IKA)
- Institute of Social Protection and Solidarity, IKPA (In 2010, IKPA was merged with the National Centre for Social Security-EKKA)
- University of Ioannina
- Directorate of Welfare at Kalamata municipality
- Special Physicians’ Body of Health Committees within IKA
- Panhellenic Medical Association
- Hellenic Medical Society of Disability, Social Insurance and Welfare (ELIEAKAP)

When I started conducting my first interviews, my aim was to hear and learn the experiences of persons with disabilities with the systems for awarding disability allowances as well as the key actors’ experiences in the development of the disability classification systems (see Creswell, 2006).

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6 For a detailed interview list see Appendix II.
Thus, I was trying to identify informants who would be willing to share with me their personal experiences (ibid.).

The help of my relatives and friends was valuable at this point. However, for the selection of the informants, I took into consideration specific criteria. First, I wanted my informants to have knowledge and/or personal experience with the systems that this study examines. Second, regarding the selection of persons with disabilities, I wanted my informants to have personal experience with both systems for awarding disability allowances, that is, with the system in use from 1993 to 2011 and with the current system, which was introduced in the fall of 2011. Second, I was interested to hear and learn how persons with different types of disabilities—e.g., people who are blind, paraplegic, and so on, not focusing solely on a specific disability category—have experienced the disability assessment procedure. Third, and most important, my priority was that the persons with disabilities who agreed to contribute to my research should not feel uncomfortable during the discussion but should feel free to share their experiences with me.

In contrast to many other methods of data collection, in interviews the researcher meets his/her informants/participants and develops a kind of relationship with them. For the researcher, the data collection is based neither on the collection of completed questionnaires from research participants who do not meet in person nor on the collection of documents. Instead, there is a direct communication between the researcher and the informants. Also, the content of the interview is sensitive material in the sense that informants share with the researcher their own accounts or knowledge of the social problem under study. Because of this relationship between the researcher and the informants, as well as the sensitivity of the interviews’ contents, the researcher has the responsibility to protect his/her informants. Hence, I adopted the principle of confidentiality between myself and the informants as a mean to protect the latter (Kvale, 1996; Fink, 2000).

2.1.2 Written Material

The second method for the data collection was the written material. By written material I refer to official material from the Greek state, such as laws, presidential decrees, ministerial decisions, and so on; material from relevant organizations, such as the Social Insurance Institute (IKA), the Ministry of Health, and the Ministry of Labor, Social Security and Welfare; written material of the National Confederation of Persons with Disabilities (ESAEA), such as press releases, letters, and articles from their...
magazine Disability Issues (Θέματα Αναπηρίας); material from the Greek Ombudsman; and so forth.

Though the written material is used as a mean to cross-check the reliability of data (Patton, 2015), it also constitutes a rich source of information. Atkinson and Coffey (2004) describe the written material/documents as social facts, which “are used and exchanged as part of social interaction” (p. 59). Specifically, they say:

Documents are “social facts,” in that they are produced, shared and used in socially organized ways. They are not, however, transparent representations of organizational routines, decision-making processes or professional diagnoses. They construct particular kinds of representations using their own conventions.

(ibid., p. 59)

For instance, the disability percentage table, a table that is responsible for the translation of a bodily condition to a percentage or a figure, is a document that is enacted through a ministerial decision. Certainly, the negotiations between the medical society, the state, and the disability movement are an essential part of its development; however, through this document, disability percentages are enacted. To put it differently, “documents, such as” the disability percentage table, “are like machine tools, tools for producing things” (cf. Prior, 2004, p. 82).

Finding the relevant written material had its own challenges. At an early stage of the fieldwork, one of my informants, Vasilis Dimitriadis, who is paraplegic, a retired employee of Hellenic Railways Organization (OSE), and chairman of the Piraeus Association of the Physically Challenged, prepared me for the difficulties that I was going to face. Specifically, he mentioned his experience, since he had just completed his doctorate, and he shared with me the problems that he faced trying to find relevant material for his research (V. Dimitriadis, interview, January 21, 2014). Also, he suggested using his thesis because there I could find the relevant legislation for disability issues in Greece. Moreover, some of my informants guided me where to go and ask for material, or they provided me with the relevant legislation or various circulars. Because project covers more recent issues, it was easy to find written material online—especially regarding events that occurred since the middle of the 2000s. So the use of the available online sources was a big help, and it easy to retrieve them continuously.

In what follows, I will describe one of my fieldwork experiences that illustrates Dimitriadis’s point regarding the difficulties that I would face
during the data collection. In winter 2014, when I was in Athens, I was trying to find material regarding Greece’s attempt to adopt and to adjust the ICF, developed by the WHO, to the Greek social security system. The Institute of Social Protection and Solidarity (IKPA) was responsible for developing something suitable to the Greek context. Because of the economic crisis and demand for austerity in the public sector, many institutes like the IKPA were either abolished or merged with other Institutes (Government Gazette, 2010b). The IKPA was abolished, and its responsibilities as well as its archives were transferred to the National Centre for Social Solidarity (EKKA) (ibid.). I visited the responsible department at the EKKA, called the Open Welfare Information Center, to ask if I could find material relevant to my project. Both the employees that I talked to informed me that the EKKA lacked such material, with the exception of two books containing the translation of the ICF into the Greek language. Though my initial plan had been to collect written material concerning the ICF project, the abolition of the IKPA and the lack of access to its archives constituted a barrier. To overcome the barrier that emerged, I conducted interviews with the key-actors, including the coordinator and the scientific coordinator of the ICF attempt.

2.1.3 Newspapers
During the past few decades, news media and newspapers in particular have had important roles both in informing the public and in participating in political, scientific, and social debates (see, e.g., Granham, 1994; Livingstone & Lunt, 1994; Mondak, 1995; Verstraeten, 2000; Titchkosky, 2007; Briant et al., 2013). Also, the way that newspapers cover the above debates affects public opinion—specifically, the way the public interprets these issues. For instance, Imogen Tyler (2013) refers to a study conducted in 2011 by the Strathclyde Centre for Disability Research and the Glasgow University Media Unit regarding the role of the news media in covering disability issues as well as its effects on public opinion (see, e.g., Briant et al., 2011).

Considering the importance of the newspaper coverage of the political and social debates as well as its impact on the public, I chose as the third source for data collection material from the following Greek newspapers: Eleftherotypia (Ελευθεροτυπία), Eleftheros Typos (Ελεύθερος Τύπος), I Avgi (Η Αυγή), I Kathimerini (Η Καθημερινή), Rizospastis (Ριζοσπάστης), Ta Nea (Τα Νέα), and To Vima (Το Βήμα). The above newspapers were chosen for two reasons: first, together they are representative of the politi-
cal spectrum, and second, they have the largest circulations in Greece. Specifically, *Eleftherotypia* was a center-left daily newspaper published in Athens from 1975 to 2014, and it had one of the highest circulations in Greece; *Eleftheros Typos* is a liberal-conservative daily newspaper, published in Athens since 1983, with good circulation, especially in the 1980s and 1990s; *I Avgi* is a Greek left daily newspaper, published in Athens since 1952; *I Kathimerini* is a center-right daily newspaper, published in Athens since 1902, with one of the highest circulations in Greece; *Rizospastis* is a daily newspaper, published in Athens since 1916 and the official newspaper of the Communist Party of Greece; *Ta Nea* is a center-left daily newspaper, published in Athens since 1931, with high circulation around the country; and *To Vima* is a center-left daily newspaper, published in Athens since 1922, though only on Sundays since 2011\(^7\).

The lack of digital archives of the above newspapers, with *To Vima* and *Ta Nea* the exceptions,\(^8\) was a significant barrier during the data collection. Given that this project covers a twenty-five-year period and the digital editions of the above newspapers are available only from the beginning of the 2000s until today (2017), and because the number of newspaper articles is enormous, it was necessary to find alternatives to be able to browse all that newspaper material. The solution is based on the use of the historical digital archive of the Lambrakis Foundation. Doing a keyword search using keywords such as *disability assessment*, *disability pension*, *disability*, *people with disabilities*, *social security system*, *disability benefits*, *disability fraud*, *disability card*, *functionality card*, *ICF*, *KEPA*, *pension system*, *KEVA*, *special physicians body of health committees of IKA*,


\(^8\) *Eleftherotypia* used to have a digital archive covering the period from 2001 to 2009, but because of the economic crisis and changes in the ownership and administration of the newspaper, the archive has been out of order since 2013 (Personal communication with the responsible department of *Eleftherotypia* newspaper).
welfare, and IKA,9 my aims were to retrieve the relevant material from Ta Nea and To Vima and to find the key dates in order to continue my research in Athens. I then visited the Library of the Hellenic Parliament with a view to continuing my research using their digital archive, which included microfilms and a local digital database. Since the digital database of the Hellenic Parliament Library covers the period until 2005, whereas I needed some specific newspapers such as Eleftheros Typos and I Avgi after 2005, I contacted the non-profit organization Press Archive (Αρχείο Τύπου)10 and asked them if they could provide me the newspapers I was looking for. They responded to my request immediately.

2.2 Field Issues

The data collection took place in a period during which Greece was faced with a severe economic and social crisis, and this affected my fieldwork. In what follows, I will discuss some of these issues, since they were an integral part of my research and because they highlight the researcher’s vulnerability during fieldwork.

2.2.1 From enthusiasm to access denied

To paraphrase Traustadóttir (2001), What if persons with disabilities think that I am the other? This was one of my initial concerns. Traustadóttir defines othering as doing research with groups to which one does not belong. She states, “We can no longer take for granted that Others will accept us and allow us access to their individual lives and communities. Or that they will accept the way we represent them and write about them” (2001, p. 11).

Keeping that in mind, and before starting my fieldwork, I was worried whether and how people with disabilities would participate in my research. My concerns had to do with my identity as a researcher and particularly how people with disabilities would perceive, understand, and translate my role in this kind of communication. Would I be the intruder

9 The Greek keywords that I used are the following: συντάξεις αναπηρίας, αναπηρία, άτομα με αναπηρία, ΑμεΑ, σύστημα κοινωνικών ασφαλίσεων, επιδόματα αναπηρίας, μαϊμού ανάπηροι, κάρτα αναπηρίας, κάρτα λειτουργικότητας, ICF, ΚΕΠΑ, ΚΕΒΑ, Ειδικό σώμα ιατρών επιτροπών ΙΚΑ, Πρόνοια, and ΙΚΑ.

10 Press Archive (Αρχείο Τύπου) is a non-profit organization working for the conservation, preservation, and storage of newspaper and magazine archives. For more information, see http://www.arxeiotypou.gr/, retrieved, November 29, 2015.
into their personal life or the means to be heard through sharing their experiences and knowledge (see Traustadóttir, 2001)? Thus, an essential question concerning the initial communication with persons with disabilities was how to introduce and present myself to them.

Despite the initial concerns, persons with disabilities were willing to participate in my study by discussing and sharing both their personal experiences during the disability assessment and the consequences of their classification as disabled for their everyday lives. Through this study, they felt that they were given a voice to share and present what it means to them to be assessed and classified as disabled. Thus, my initial concerns were unwarranted.

Nevertheless, the central aim of this study is to examine, as well, the politics of disability classification systems. By that I mean that the role of the state has been critical in that disability classification systems came into being as part of the state’s social/disability policies to support its citizens. Therefore, talking to state representatives, such as policy makers and politicians and representatives of medical society, was necessary. Identifying the relevant actors was a difficult task. Discussing with one my informants this issue regarding the difficulties involved in conducting interviews (e.g., with employees at the relevant ministries), my informant explained to me that the problem lies in the lack of a culture of participation in this kind of study. Employees of the various ministries preferred to simply provide the relevant legislation or other types of documents, rather than discussing or sharing their personal experiences and knowledge.

It was also a challenge to approach politicians. The development of the systems for awarding disability allowances is a political issue; consequently, the choices or the strategy for each development and implementation depend on the political leadership of the relevant ministries. Here, I use the plural (ministries) because, through the period under study, I noticed that different ministries were responsible for the development and implementation of disability classification systems. For instance, early in the 1990s the Ministry of Health, Welfare, and Social Security was responsible for developing and implementing a disability classification system, whereas in the middle of 2000s, the Ministry of Health and Social Solidarity had that responsibility. And in the 2010s, the Ministry of Labor and Social Security—or the Ministry of Labor, Social Security, and Welfare, as it was later renamed—was responsible for developing a new disability classification system.
The (continuous) renaming of the ministries after parliamentary elections or after government reorganizations and the transfer of responsibilities or powers from ministry to ministry were also factors that made difficult the identification of the relevant empirical material—both the key/relevant actors and the written material. Throughout in this thesis, I use the ministries’ names as they were called during the specific period under study. Tables 1 and 2 depict the renaming of the ministries of health and labor from 1990 to 2015.

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_Table 1. The renaming of the Ministry of Health from 1990 to 2015_

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_Table 2. The renaming of the Ministry of Labor from 1990 to 2015_

### 2.2.2 Economic crisis and political instability

Since 2010 Greece has faced a severe economic and social crisis, which has had an impact on various aspects of social, economic and political life. One of these consequences concerns the political instability of the country. By political instability, I mean that during this period there were parliamentary elections almost every year, with different political parties succeeding one another in power. For instance, in 2015 there were elections twice, first in January and then in September, as well as a referendum in July. Conducting research on a topic closely linked to the political context of the country, especially in a period of instability, I anticipated that difficulties could occur in terms of access to the field. Below I provide an example of one of the difficulties I faced due to the political instability.

In May and June 2015, I was in Athens to continue my fieldwork. Since I was at the Ministry of Labor and Social Security for another appointment, I thought it would be a good idea to also visit the General Secretariat of Soc-
cial Security. I asked if it would be possible to book an appointment with the general secretary, since he was an experienced and knowledgeable person regarding issues relevant to the operation of the social security system. Although I did not have an appointment with him, the general secretary agreed to meet me for fifteen minutes so I could briefly explain the purpose of my visit and what I wanted to discuss with him. After that short discussion, and because I had to return to Sweden a few days later, the general secretary gave me his contact details so I could book an appointment with him in September, when I would be in Greece again. I left his office satisfied that I could soon have an analytical discussion with him.

In July 2015, because of the severe political and financial instability of the country and the new austerity measures that the SYRIZA government had to pass, the general secretary announced his resignation in reaction to the pension reform that the SYRIZA government had to enact. After hearing and reading this news, I felt disappointed, and I regretted not having stayed longer in June to conduct the interview at that time. A few days later, the minister of labor and social security stated that he did not accept the general secretary’s resignation, so the latter agreed to remain in his position for “some time.” For me, this announcement was a relief. I thought that in the end I would have the opportunity to meet and discuss with him. In August 2015, after searching thoroughly to find out whether he was still the general secretary, I sent an email to his secretary asking to book an appointment with him. However, three days after my email request, I read that the general secretary had resigned from his position again, this time definitively. Though I was in Athens at the beginning of September, I did not manage to find a way to meet or contact him.

Reaching such people is a difficult task, and when one of them is willing to contribute to your research, it feels like a success. Elisabeth Hsu claims:

A politically eventful field cannot leave a fieldworker unaffected; the body politic affects the individual body and thus how the researcher conducts research, even if it results in the escape out of the field and feelings of disappointment over an unaccomplished task.

(2010, p. 168)

From the feeling of success and confidence to disappointment. Though the fieldwork hides positive surprises regarding the research progress, there are also moments that the researcher feels vulnerable. For Ballamningie and Johnson (2011), restricted access to key informants and topics that
challenge the political context constitute factors that can increase the vulnerability of the researcher.

A question that may arise here concerns the consequences of the difficulties that I faced during the fieldwork in the collection of the empirical material and whether they affected my research—an issue that I always had in mind when I was not able to conduct interviews with some of the relevant informants in this study. For this reason, it was necessary to find alternative ways of obtaining the information I was looking for. Thus, my alternative choices were to either find some newspaper articles and/or other kind of written material relevant to the questions I wanted to ask the people I was unable to interview or to ask my informants, specifically those who were familiar with the topic.

2.2.3 Terminology
Because this project covers a twenty-five-year period, it is also important to say something regarding the field’s terminology. Studying the period from 1990 to 2015, I came across concepts that had been updated through the years through the adoption of European or international terms. To keep the text as reader friendly as possible, I used the same terms throughout the text instead of using terms that were in use during the period under study. For example, I use the term persons with disabilities, even though the “official” term for people with disabilities in Greece until the beginning of the 2000s was people with special needs.11 As for the terms disability pensions and disability allowances, the respective terms in the official translations of the Greek into English are invalidity pensions and invalidity allowances.12

Also, I made one more decision concerning the term for referring to the alleged fake disabled. As we will see throughout the text, the reference to

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12 To give an example, if one visits the European Commission website and, specifically, the section that refers to Employment, Social Affairs & Inclusion, one will see that, under the tab that talks about the rights of EU citizens to move and work in other EU member states, in the sub-tab that describes what happens in Greece, the reference to disability pensions and disability allowances is to invalidity pensions and invalidity allowances. Retrieved January 14, 2017 from: http://ec.europa.eu/social/main.jsp?catId=1112&langId=en&intPageId=3975.
disability fraud was a continuous issue that each government had included in their rhetoric for the need for a new disability classification system. In the Greek language, however, the term that is used for calling something fake or a fraud is the word “monkey.” The term *monkey* has also been used to refer to persons with disabilities who have been given disability allowances and pensions without meeting the criteria for receiving them. For instance, the Greek media, when they want to discuss or refer to the issue of disability fraud, repeatedly used the expression *monkey disabled*, a term that enacts/creates negative and racist stereotypes of people with disabilities. Hence, when I wanted to discuss events linked to fraud, I used the terms *fake disabled* and/or *disability fraud*, instead of the Greek term *monkey disabled*.

2.3 Data analysis
Having completed some steps of my data collection, I started to work with the empirical material. In total, I conducted 18 interviews with a variety of informants—from policy makers, politicians, and representatives of medical society to representatives of the disability movement to persons with disabilities—which, in most cases, I recorded. There were four informants who did not agree to my recording our discussion. In those cases, I kept notes. Because of the sensitivity of the content of the interview, it was important to protect my data. After the end of each interview, I transferred the recorded archive to my laptop, where I renamed each file’s name with a code and added a password for further protection (Corti et al., 2000). The next step was to transcribe the interviews, which I did myself after reading the relevant literature (Creswell, 2006; Kvale, 1996) and considering the importance of confidentiality between the researcher and the informants (Kvale, 1996; Ross, 2010; Tilley, 2003; Wellard & McKenna, 2001).

When I finished, I started to read and study the transcripts. As mentioned, my informants belonged to three categories: representatives of ministries and public administration organizations, representatives of disability organizations, and representatives of medical societies. The first step was to sort out the interview transcripts in line with this categorization. Since I study the development of four disability classification systems, my informants shared their knowledge and experiences either of more than one system or of the only system in which they participated. First, I split the content of the interview transcript based on the system that they referred to. Next, I focused on the content of the interview transcripts. Though I had memorized some part of the interviews, I chose to read them carefully two more
times, and then I started coding them. By coding, I mean that I was trying to identify events, concepts, actions, and so on, that were mentioned by my informants during the interviews (Saldaña, 2009; Benaquisto, 2008). First, studying sentence by sentence, I wrote on the right side of the paper one word which was the translation of what the informant said.

Having completed the first round of coding, I employed focused coding (Charmaz, 2006). Since the amount of my data was large enough, focused coding helped me identify those codes that were repeated through the data. Also, another aspect that I took into consideration during this stage of analysis was the theoretical discussion as well as the research aim and research questions of this project. After finishing with focused coding, I categorized the codes into themes based on their content (ibid.).

In parallel, I was working with the written material, both the official documents and the newspaper articles. Because the amount of written material was huge, my priority was to categorize in chronological order. Given that during the fieldwork I tried to collect as much material as possible, in this stage of data analysis I also devoted time to discerning what was relevant and what was irrelevant. Then I followed the same procedure as with interviews; that is, I read the texts and then I started to code them. Because of the nature of this material, however, it was not necessary to adopt the same technique as with interviews; rather, it was enough to use two or three codes in accordance with the content of the article/text. Perhaps the time that I had devoted to interview coding, especially during the focused coding, had made my coding of the written material more efficient. Again, I categorized the codes into themes in accordance with their content. Having completed the coding of the interviews and written documents, I merged the two sources into one.

The coding and categorization of the empirical material constitute an important step for data analysis. But how could the coding and categorization of the empirical material into themes be transformed into a story? To that end, I employed for the data analysis the method of situational analysis (Clarke, 2003, 2005; Clarke et al., 2016). In what follows, I will present the method of situational analysis and the way I used it.

### 2.3.1 Situational analysis

After completing the coding of the data and its categorization into themes, it was time to continue with the data analysis. Given that the aim of my project is to open the black box of the disability classification systems, a mere list of themes and codes did not work properly for me. If at the be-
ginning of my data collection I faced difficulties concerning how to begin (Agar, 1996; Creswell, 2006), at this phase I did not know how to analyze the latter. In other words, I found myself in what Clarke (2005) calls analytic paralysis. Clarke states that a researcher is in analytic paralysis when s/he has collected and digested the data but does not know how to begin with the analysis (ibid.).

Thus, I was looking for a method that could provide me with the flexibility to move and go deeper into the data. For that reason, I chose the method of situational analysis (SA), which has been introduced by Adele Clarke (2005). To Clarke, “situational maps and analysis can be used as analytic exercises simply to get the researcher moving into and then around in the data” (ibid., p. 84). SA introduces the technique of situational maps, where the researcher illustrates the data or codes by mapping them. Employing the situational maps technique, I depicted my codes on a map. Through the situational maps, I could illustrate the big picture of the situation, or the disability classification system, under study. Being a visual person, observing and representing what I was trying to analyze worked better for me in my thinking.

Clarke proposes three types of situational maps: (i) situational maps, (ii) social worlds/arenas maps, and (iii) positional maps. For my analysis, I chose the situational maps, which work “as strategies for articulating the elements in the situation and examining relations among them” (ibid., p. 86). The reason I focused on situational maps lies in the research aim and theoretical framework of this project. Since the goal is to open the black box of disability classification systems, what I was expected to find after coding and digesting the data was a system or a network with various actors, non-human elements, and so on, which were somehow related. By employing situational maps, I was able to illustrate all these elements, and by asking questions about the data, I was examining if and how they related to each other by drawing lines.

But, how did I design the situational maps? The first step in the shaping of a situational map, according to Clarke, is to create an abstract messy situational map, where the researcher adds all the human and non-human elements that participate in the situation, based on the data (ibid.). To Clarke, these elements could be “human and non-human elements (actants), political or economic elements, sociocultural elements, spatial elements, key events, discourses, etc.” (ibid., p. 90). Additionally, in my messy map, I decided to add elements from my theoretical framework. Considering that the purpose of the messy map is to illustrate the situation under study, that
is, the disability classification system, having elements both from my data and from the theory helped me to move around and better examine the relations between them as well as to continue with the analysis.

As stated earlier, when I coded my material I organized it into themes and categories. I created four broad themes, according to the classification systems that I would analyze. These themes are the “KEVA” classification system, as I named it (Chapter 3), the “disability card” classification system (Chapter 4), the “ICF” classification system (Chapter 5), and the “KEPA” classification system (Chapters 6 and 7). Though I used the same messy map for each system, I worked with different copies for each of the above themes.

After adding the codes of my project into the map, I started to think and ask questions about how these elements, human and non-human, could be related. To Clarke (2003), the relations between the elements of the relational map is the key to the data analysis. Hence, as I thought about each question that I wanted to answer, I drew lines between the elements whose connections constituted the answer to that question.

Beginning with more general questions, such as what happens in the general situation under study (e.g., the development of the disability card classification system), and moving to more specific questions about how my elements related to each other (e.g., which social groups participated in the negotiations for the development of the disability classifications systems), the purpose of drawing lines among the elements was to move around my data and think about and go deeper with the analysis of the empirical material. Thus, every time I marked a new relation between the elements of my messy map, I was thinking about what is at stake with the relation, where the relation leads me (e.g., to another element), whether relation gives me something strong for further discussing the relation, and whether there are elements that remained invisible in the specific classification system that I examined, and so on. Also, keeping in mind the research aim and research questions of this project, I was asking, as well, how the relation(s) I had already identified helped me to answer my questions.

In other words, the use of messy maps, or the mapping technique, gave me the flexibility to move around the data. That is, I was able to investigate the role of each element in the situation under study and then to proceed with possible relations between the (both human and non-human) elements in order to examine what emerges from the relation(s), and consequently, to tell the story behind the enactment of the specific disability classification system.
3. The crisis of the social security system and disability: the development of the IKA disability classification system (1990–1993)

At the dawn of the 1990s the conservative party, New Democracy (ND), won the parliamentary elections and succeeded the socialist party, PASOK, in power. As part of its policy agenda, the new ND government was determined to proceed with structural reforms to the operation of the state, with the pension system reform among them. According to the deputy minister of social security, the pension system reform was necessary for preventing a crisis in the social security system (Sioufas, 2013). One of the main arguments in the government representatives’ rhetoric concerned the high rate of disability beneficiaries, which was not in accordance with the European average, thus suggesting the need to develop a tighter system for assessing and certifying disability. Though this system developed in the context of the social security fund of the Social Insurance Institute (IKA), it was gradually adopted by the other social security funds, and it became a point of reference for disability assessment in Greece until the summer of 2011.

Chapter 3 deals with the development of the disability classification system of IKA early in the 1990s. Specifically, it aims to open the black box of that system by examining the reasons there was a need for a new system, how the system was enacted, who participated in the development process, which actors had a dominant role or were excluded in the design process, and the practices through which the disability classification system developed. Since the reference to alleged fake disabled will be continuous throughout this book, Chapter 3 will also seek to shed light on how the concept of disability fraud has been constructed in the political and social context of the country since early in the 1990s.

Chapter 3 consists of four sections. Inspired by Bowker and Star’s (1999, p. 37) suggestion that “new eyes are needed for reading classification systems,” I rely upon the three theoretical/methodological themes proposed by Bowker and Star (1999)—indeterminacy of the Past, material and texture, and practical politics—for the structure of this chapter and the following chapters in order to explore how the disability classification system discussed in each chapter was enacted. Thus, the first section talks about the period of the initial discussions for the development of the new disability
classification system. By exploring which social groups participated in the discussion, the aim is to uncover how different “voices” evaluated the existing system for awarding disability benefits and why, according to those voices, there was a need for a new system. The second section focuses on the negotiations and conflicts between the actors who participated in the process for the development of the new disability classification system. Next, the third section describes and analyzes the system’s material components. Last, the fourth section examines the issue of disability fraud. As we will see throughout this thesis, the notion of disability fraud has been used repeatedly by representatives of the state to inform their rhetoric regarding the need for reform of the system for awarding disability benefits. Based on an event in 1992, this section will show how the notion of disability fraud began to be constructed as an established concept in the political and social scene of the country.

3.1 Social security system in crisis and disability pensions

The purpose of this section is to examine how the issue of the development of the system for assessing and certifying disability emerged in the political scene of Greece as part of the pension scheme reform in the early 1990s. Obviously, the point of interest in this chapter is not the pension scheme reform but the discussion around the need for the revision of the existing system for assessing disability. Bowker and Star (1999), through their proposed theoretical/methodological theme of indeterminacy of the Past, claim that events that happen in a present state help us to revise or evaluate our past knowledge. Following their argument, in this section, by applying the aforementioned theme, I want to examine how the event of the crisis in the social security system was reflected in the evaluation of the existing system for assessing disability, and I want to examine what kind of vocabulary was adopted by the social groups that had a say in the revision of the disability classification system.

In April 1990, the conservative party of ND won the parliamentary elections. According to the representatives of the new government, the social security system in Greece needed to be reformed immediately. Dimitris Sioufas, Deputy Minister of Social Security from 1991 to 1992 and Minister of Health, Welfare, and Social Security from 1992 to 1993, describes the condition of the social security system as “chaotic” (Sioufas, 2013). Specifically, he compares it to a “time-bomb ready to explode” and states further that if the government wanted to prevent the upcoming
bankruptcy of the social security funds, then measures needed to be taken immediately (ibid., p. 47).

The then-current ND government blamed the former PASOK government for the “chaotic” conditions of the social security system (ibid.). As stated by Prime Minister Konstantinos Mitsotakis, the PASOK government, during the 1980s, had enacted several social benefits and allowances for supporting specific social groups, such as persons with disabilities, without taking into consideration whether the social security funds had sufficient financial resources to provide those benefits and allowances (Palaiokrasas, 2013). The administrators of the social security funds assigned specific committees to investigate their current condition. For instance, in 1990, Giorgos Hiotis, the governor of the Social Insurance Institute (IKA), assigned five working teams to investigate the current situation at the IKA and to suggest solutions for its reformation (Ta Nea, March 30, 1990). According to the working teams’ results, among the causes that explained the “bad” financial condition of the IKA were the “privileged policy” by the state and the high number of disability pension beneficiaries, with one in four pensioners receiving disability pensions at the time (ibid.).

During the early discussions regarding the general causes that affected the social security system and what should be done to consolidate the system, reference to the high percentage of disability pensions was continuous. Minister of National Economy Giorgos Souflias and Minister of Health, Welfare, and Social Security, Marietta Giannakou-Koutsikou, argued that the percentage of disability pension beneficiaries was high and that many recipients did not meet the criteria to receive such benefits (Ta Nea, May 4, 1990). To give an example, Sioufas (2013) refers to the percentage of disability pensions during the 1980s, which was increased by 92% both in the social security funds of IKA and in the Agricultural Insurance Organization (OGA), which covered approximately 75% of the population.

Indeed, the emphasis on this high percentage in Sioufas’s illustration seems problematic, and his example was an obvious critique of the former government; but Sioufas fails to mention that it was in the 1980s that the social welfare state emerged in Greece. As discussed in Parergon (pp. 284-285).

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13 The Social Insurance Institute (IKA), founded in 1934, is the largest insurance organization in Greece, offering health insurance and pensions to employees in the private sector and covering the needs of 50% of the population (Stathopoulos, 2005).

14 The Agricultural Insurance Organization (OGA) was founded in 1961 to offer health insurance and pensions to farmers, who make up 25% of the population.
286), it was in the 1980s that the Greek state made room for persons with disabilities to claim their rights and enacted several social measures and benefits, among other things, including for persons with disabilities. For example, Yannis Kyriopoulos, a professor of health economics, in an interview in the newspaper *Ta Nea*, claims that what the state spent on social protection in 1980 was only 13% of GDP, compared to the end of the 1980s, when the social cost was at more than 25% of GDP (*Ta Nea*, May 30, 1990).

Nevertheless, for representatives of the government, the high percentage of disability beneficiaries was both a political and a financial problem because it was one of the reasons for the bad financial situation of the social security funds. One of the government’s arguments regarding the then-current system for disability assessment was that it was “insufficient” and that it was responsible for the high percentage of disability pensioners (*Ta Nea*, July 27, 1990; *Eleftheros Typos*, July 29, 1990).

In parallel, the high number of disability beneficiaries and the insufficiency of the system for assessing and certifying disability were issues that were covered by the daily newspapers. In covering the discussion regarding the pension reform and in presenting the existing system for disability assessment, the newspapers also participated in the debate. In an article that was published in the daily newspaper *To Vima*, for instance, the journalist (Pipili) describes the existing system as “flawed” (*To Vima*, July 22, 1990). Pipili, referring to the percentages of disability pensioners, questions the way that health committees assessed the claimants for disability pensions and allowances (ibid.). Also, in the same article, there is an interview with the head of the Directorate of Health and Disability Pensions at the IKA. He states that the physicians who participated in the health committees were not well trained, that the constitution of the health committees was not concrete, and that external factors—political, social, occupational, and so forth—put pressure on the members of the health committees to provide applicants with higher disability percentages than warranted (ibid.). To give an illustration, he refers to cases that were assessed by three different health committees, where each of the committees attributed a different percentage to each case (ibid.).

Summarizing what was discussed in this section, we saw how the politicians of the conservative government of ND and the representatives of the social security fund of IKA retold the story about the existing disability classification system, with each of them using a different terminology to support their arguments. Specifically, politicians retold the story for the need
to revise the system for assessing disability by using expressions that spread fear in society (e.g., “a time bomb ready to explode) as well as numerical expressions (e.g., “high rate of disability beneficiaries”). The terms that enact a feeling of fear and the numerical terms belong to a neoliberal vocabulary (Steger & Roy, 2010), denoting thus the adoption of a neoliberal-driven agenda to the pension scheme reform, which has also been a benchmark for other countries in the 1990s (see, e.g., van Oorschot & Boos, 2000; Ydreborg et al., 2007). Representatives of the social security fund of IKA retold the story either by referring to the high rate of disability beneficiaries or by labeling the operation of the health committees as vulnerable to external factors, such as political or social factors, to name but a few. Borrowing terms that come from a positivist and political vocabulary, the representatives of the IKA retold the story by questioning the objectivity of the disability classification system and of the health committees in particular because of the vulnerability of the latter to external factors, such as political, social and/or occupational as well as because of the physicians-disability claimants relationship.

3.2 Negotiations, conflicts and exclusions in the social dialogue for the enactment of the disability classification system

In the summer of 1990, the prime minister, after a meeting that he had with Andreas Papandreou, the leader of the opposition PASOK party, and Charilaos Florakis, the leader of the Communist party, stated that they had “reached a basic consensus over welfare reform” (Venieris, 2006, p. 76). This consensus also involved the initiation of social dialogue, which was announced by the prime minister (ibid.). Specifically, government representatives’ “intention” was to reform the pension system after negotiations with relevant social actors (Eleftheros Typos, July 21, 1990). To the prime minister, the negotiations should be conducted between representatives of the government—specifically, of the Ministry of National Economy, the Ministry of Finance, and the Ministry of Health, Welfare and Social Security—and representatives of social groups such as the General Confederation of Greek Workers (GSEE), higher trade unions, employers’ organizations, and the social security funds (Eleftheros Typos, July, 22 1990). As for participation of the representatives of other political parties, it was not considered necessary by the governmental authorities (ibid.).

The minister of national economy, who had the leading role in the pension reform, invited 19 social groups to participate in the negotiations
In his invitation he underlined the points to which attention should be paid. One of those points concerned persons with disabilities, specifically the eligibility criteria that they should meet for receiving benefits and allowances from the state (ibid.).

The representatives of the government wanted to reform the pension scheme as an outcome of negotiations between the state and representatives of various social groups that had an interest in the pension system (see, e.g., *Eleftheros Typos*, July 21, 1990, July 22, 1990). Thus, the minister of national economy, who, according to the source considered, was the one who defined which social groups had an interest in the pension system reform, sent an invitation to those social groups asking them to participate in the negotiations. But what is noticeable after a careful reading of the list of invited social groups (see footnote 15) is that most of the social groups represented employees, employers, and pensioners. Even though the pension reform also aimed to change the disability assessment procedure as well as the criteria to be used for eligibility for receiving disability pension, representatives of the disability movement were not invited. Instead, for the state, GSEE, which is the highest tertiary trade union in Greece, was the social group that was invited to participate in the negotiations and, among other things, speak on behalf of persons with disabilities (*Ta Nea*, August 4, 1990).

But how does the disability movement explain its exclusion from the social dialogue for the reform of the disability classification system? In the words of Yiannis Vardakastanis, chairman of the National Confederation of Persons with Disabilities (ESAEA):

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15 The social groups invited to the social dialogue for the pension scheme reform are as follows: i) General Confederation of Greek Workers (GSEE), ii) Civil Servants' Confederation (ADEDY), iii) Confederation of Democratic Rural Associations of Greece (SYDASE), iv) Hellenic Confederation of Professionals, Craftsmen and Merchants (GSEVEE), v) Trade Union Associations, vi) Hellenic Federation of Enterprises (SEV), vii) Athens Bar Association (DSA), viii) Technical Chamber of Greece, ix) General Confederation of Greek Farmers' Associations (GESASE), x) Panhellenic Medical Association, xi) National Federation of Civil Pensioners, xii) Pensioners Federation of IKA, xiii) Greek Federation of Bank Employee Unions (OTOE), xiv) Panhellenic Federation of Postal Association, xv) DEI General Staff Federation (GENOP-DEI), xvi) Greek Federation of Builders and Associated Professions, xvii) Federation of OTE Employees (OME-OTE), xviii) General Confederation of Professional Motorist in Greece, and, xix) National Federation of Railway Workers (*Eleftheros Typos*, 4 September 1990).
No, we did not participate... The disability movement was not well-enough established. We existed as a Confederation—we established in 1989, and as associations we preexisted—but there was not a culture of consultation between the political system and our associations. Besides, they considered us, somehow, marginal and that our associations were at the periphery.

(Y. Vardakastanis, interview, September 4, 2015)\(^\text{16}\)

Although the pension system reform concerned people with disabilities, and disability organizations had already established since the 1970s,\(^\text{17}\) the conservative government of ND did not offer them a place in the negotiations. The term “periphery” that Vardakastanis used to describe the relationship between the ND government and the disability organizations brings to mind the findings of Zeitcher’s study (2002) regarding the involvement of the disability organizations in the reform of the system for awarding disability pensions in the Netherlands, which took place during almost the same period as in the Greek case, early in the 1990s. As Zeitcher notes, although the Dutch disability organizations had a relationship with the government, in terms of funding support, when there was a social dialogue for the reform of the system for awarding disability pensions, the Dutch state approached disability organizations as belonging to the periphery and not as equal social partners (ibid.). Similar to the Dutch government, the ND government did not consider representatives of the disability movement as a social group that had an interest in the pension reform, and consequently, they were excluded from the social dialogue.

If the representatives of the disability movement were excluded from the negotiations because they belonged to the “periphery,” then the role of the representatives of the Ministry of Health, Welfare, and Social Security was unclear. As reported in the newspapers, the minister of health, welfare, and social security was ignored during the initial announcements for the upcoming reform (\textit{Eleftheros Typos}, July 24, 1990). Usually, the pension reform is under the responsibility of the Ministry of Social Security; in this case, the responsibility was given to the Ministry of Health, Welfare, and Social Security. The Ministry of National Economy, however, had the leading role. As mentioned, the minister of national economy was the one

\(^{16}\) I would like to add here that all the interviews I conducted were in Greek, and the interview quotes throughout the thesis are my own translations.

\(^{17}\) Regarding the history of the establishment of the disability movement in Greece, see the relevant discussion in \textit{Parergon}.
who announced the upcoming reform, invited the social groups to participate in the negotiations, and stressed the points of pension reform to which attention should be paid.

Even though the Ministry of Health, Welfare, and Social Security seemed to participate in the negotiations, much of the initiative belonged to the Ministry of National Economy. To give an example, in an article published in *Eleftheros Typos*, a newspaper friendly to the ND government, there is a reference to the relationship between the two ministers. According to the article, the minister of health, welfare and social security expressed her dissatisfaction with the minister of national economy because the latter had not informed her ahead of time about the announcement (*Eleftheros Typos*, July 24, 1990). Additionally, the Panhellenic Medical Association challenged the role of the Ministry of the National Economy in the pension reform (ibid.).

The debate between the political leaderships of the Ministries of National Economy and Health, Welfare, and Social Security about their roles in the enactment of the system for awarding disability benefits gives us the opportunity to challenge the origins of the system and to ask *Who creates classifications and standards?* Even though the development and implementation of a disability classification system is usually under the responsibility of the ministry that includes the domain of social security or of the Ministry of Health, in the above case we saw that it was the Ministry of National Economy that had the leading role in the development period. Though the political leadership of the Ministry of Health, Welfare, and Social Security was a copartner in the revision of the disability classification system, its role was downgraded by the Ministry of the National Economy.

### 3.3 Shedding light on the material components of the disability classification system

In the former sections the discussion focused on the reasons, according to the voices of different actors who had a say in the implementation of the system, that there was a need for a system for assessing and certifying disability, as well as on uncovering the *practical politics* in the establishment of the new system. Setting aside the negotiations and conflicts in the initial stage of the development of the disability classification system, this section seeks to examine the material components of the system. By applying the theoretical/methodological themes of *material and texture*, and *practical politics* (Bowker & Star, 1999), I will describe and analyze the three materi-
al components of which the disability classification consists. These components are (i) the classification of disability into the three categories of severe disability (80%–100%), ordinary disability (67%–79.99%) and partial disability (50%–66.99%) to replace the former disability categorization scheme (Government Gazette, 1990); (ii) the establishment of the Special Physicians’ Body of Health Committees of IKA\(^\text{18}\) as the main body responsible for the disability assessment (Government Gazette, 1991b); and (iii) the development and implementation of the disability percentage table, or the Regulation for Disability Degree Assessment (KEVA), as it is called (Government Gazette, 1993). In the following subsections, I will present and discuss more analytically the above components.

### 3.3.1 Classifying disability into three categories

The first component of the new disability classification system was made after the enactment of the Law 1902/1990. In September 1990, the minister of national economy announced the upcoming changes to the pension system that would be applied at the beginning of 1991. Among other changes in the pension scheme, the Law 1902/1990 introduces the classification of disability into three new categories to replace the former disability classification. According to the previous system, there were three disability categories based on how severe disability was, specifically,

(i) severe disability (67%–100%),
(ii) ordinary disability (50%–66.7%) and
(iii) partial disability (33.34%–49.9%)  
*(Eleftheros Typos, September 7, 1990).*

Thus, if a person was assessed with 33.34% to 49.9% disability, then they were eligible to receive a temporary allowance, and if they were assessed more than 67% then they were entitled to get a full disability pension (*Eleftherotypia*, September 7, 1990).

Because of the enactment of the Law 1902/1990, the above disability categorization scale was replaced by a more austere classification. Again, disability was classified into three categories based on severity; however, in the new scheme, each category was associated with new and tighter disability percentages. So, the new classification was

\(^{18}\) In Greek, this body of physicians is called Ειδικό Σώμα Γιατρών Υγειονομικών Επιτροπών ΙΚΑ. Since there is no official translation in English, the English translation is mine.
(i) severe disability (80%–100%),
(ii) ordinary disability (67%–79.99%) and
(iii) partial disability (50%–66.99%).

(Government Gazette, 1990)

According to Article 27, if an insured is classified with “severe disability,” then they should receive the full amount of disability pension; if they are classified with “ordinary disability,” then they should be given three-fourths of the disability pension; and if they are classified with “partial disability,” then they should receive half the amount of disability pension (Government Gazette, 1990, p. 1176). As noted, the new triple disability classification scale is tighter than the former scale. For example, under the new scheme, someone would be classified with a severe disability if their total disability percentage was more than 80%, whereas under the former classification it was enough for a claimant to have more than 67% disability percentage to be classified as severely disabled.

Though there is a change to the disability classification scale, according to the data of this study, there is no reference to why those percentages or scales were chosen. For example, why should someone with 79% disability percentage be classified under ordinary disability, while someone with 80% is classified under severe disability? Ioannis Gkiouzelis, a psychiatrist and the chairman of the Hellenic Medical Society of Disability, Social

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19 It is essential to explain why the discussion is oriented mainly toward the IKA. IKA is the biggest social insurance fund in Greece, covering approximately 50% of the population. Also, since the 1980s, IKA’s medical committees for disability assessment have offered their services to other insurance organizations as well, such as OGA, which covers 25% of the population. In other words, IKA has a significant role in disability assessment for the majority of the population in Greece.
Insurance and Welfare (ELIEKAP),\textsuperscript{20} states that there is no a specific explanation of why these percentages were chosen; rather, according to him, it was a convention adopted by the government without explanation (I. Gkiouzelis, interview, February 11, 2016).

While the disability classification referred to percentages, there was not a specific disability percentage table for translating health conditions into disability percentages. For that reason, the Panhellenic Medical Association was responsible for publishing a temporary regulation where a specific medical condition, from a disease to a physical, sensory, or mental impairment, was translated into a scale from 0–100\%, where 0\% means no loss and 100\% total loss (\textit{Government Gazette}, 1990, p. 1176).

Another element that was introduced with the Law 1902/1990 refers to the disability beneficiary’s qualifications to be eligible for receiving a disability pension. Particularly—since at the IKA the insurance depends on number of days the insured has worked rather than the number of years (as it applies to the rest of social security funds)—an insured at the IKA, in order to be eligible for disability pensions and allowances, must have worked 1500 days in total, with 600 of those days during the last five years (ibid., p. 1176).\textsuperscript{21} However, when the draft law was submitted to Parliament by the political leadership of the Ministry of National Economy, representatives of the GSEE reacted negatively (\textit{Ta Nea}, September 7, 1990a, September 7, 1990b).

In accordance with this draft law, an insured at the IKA would be eligible for applying for a disability pension and/or disability allowances if they had worked 1500 days in total, with 900 of those days during the last five years. After a wave of general strikes against this draft law, one of the demands of the social groups that participated in the dialogue concerned

\textsuperscript{20} The Hellenic Medical Society of Disability, Social Insurance, and Welfare (ELIEAKAP) established in 2013 after an initiative by the physicians who belonged to the Special Physicians Body of the Health Committees of IKA (which, it will be discussed more analytically later in this Chapter) and have participated in the health committees for the disability assessment and certification of disability claimants. Among the objectives of the ELIEAKAP are further education of the physicians who participate in the health committees for assessing and certifying disability; participation in the processing and continuous updating of the regulations concerning the disability assessment; and the study of the circumstances (social, economic, occupational, and so on) under which a disorder or impairment leads to disability. For more information regarding ELIEAKAP, see: \url{http://hmsofdisability.blogspot.gr/} [in Greek].

\textsuperscript{21} With the former legislation, an insured should have worked for 300 days to be eligible for disability benefits and/or allowances.
the disability beneficiaries’ qualifications to be eligible for disability pensions. Specifically, the GSEE demanded the reduction of working days from 900 days to 500 days during the last five years (ibid.). The government gave in regarding this parameter, and when the Law 1902/1990 was enacted the working days were reduced to 600 days (*Government Gazette*, 1990, p. 1176).

### 3.3.1.1 The role of disability statistics in the development of the first component of the disability classification system and the alleged disability fraud

As discussed in the first section of this chapter, one of the main arguments used by the politicians to influence public opinion regarding the need for a new and tighter system for awarding disability allowances was the high percentages of disability beneficiaries, implying that the high percentage included disability beneficiaries who had fraudulent, or faked, disabilities. During the negotiations for the enactment of the first component of the disability classification system, the government representatives referred again to the high rates of disability pensioners, but, this time they compared the Greek rate with the European average (*Eleftheros Typos*, September 8, 1990).

More specifically, the governmental authorities compared the rate of disability beneficiaries of IKA, which was 30% of all the IKA pensioners, with the European average, which ranged between 9% and 15% (ibid.). To the governmental authorities, the deviation between the aforementioned rates was a strong indicator that the system for awarding disability pensions was inadequate for further use (ibid.), or as the Minister of National Economy stated, this deviation was “proof” of the insufficiency of the existing system (ibid.). In another newspaper article, government representatives described the existing system for certifying disability as a “factory” which produced “fake disabled” and claimed there were many disability beneficiaries who had deceived the state and particularly the social security funds (*Ta Nea*, September 8, 1990). Thus, in line with the governmental authorities, the development of a tighter disability classification system was necessary for discerning the “real” disability pensioners from the “fake,” as well as to “punish” those who cheated the state (ibid.).

On the one hand, Kirchner (1993) notes that states use disability statistics as a means to retrieve different information regarding the disabled population and to design social/disability policies. In the Greek case, the government indeed used the statistics of the disability pension beneficiaries as a
means to build its rhetoric and to design its social/disability policy. But, on
the other hand, it is worth noting here that the disability statistics that the
politicians relied upon came from the social security funds instead of an
official state institution responsible for offering statistical estimates and
information about persons with disabilities in Greece. As Christos Nastas,
General Secretary of the ESAEA, underlines, until 2015 there was no statis-
tical survey or census about the disabled population in Greece (C. Nastas,
interview, January 14, 2015). Nevertheless, the ND government, by focus-
ing on the statistics of disability pensioners as derived from the social secu-
ring funds, started to design a new social policy aiming to limit the number of
disability pension beneficiaries.22

At this point, it is worth commenting on the vocabulary that the govern-
mental officials used in their rhetoric to argue for the need for the pension
scheme reform, in general, and for the disability classification system, in
particular. Recalling the discussion at the beginning of this chapter, we saw
that the then-current deputy minister of social security described the condi-
tion of the social security funds using the metaphor of a time-bomb “ready
to explode.” Also, the politicians’ argument about the alleged disability
fraud and its presentation as a “threat” to the state, the social security
funds, and the society, as well as the government’s talk of “punishing” those
who cheated the state, are terms which generate the feeling of fear in public
opinion. Echoing Steger and Roy (2010), the choice of the above terms did
not happen at random. Rather, it is linked with a neoliberal vocabulary and,
consequently, with the neoliberal ideology that the ND government adopt-
ed; it aimed to spread fear in the whole society by stressing that there is no
alternative (Harvey, 2005) to the enactment of austerity-driven policies.

The previous paragraph focused on the terminology that politicians used
to stress the need for a tighter disability classification system, labeling disa-
bility pensioners as frauds. But while the pension system concerns all in-
sured, and thus various social groups participate in it, in the government’s
rhetoric regarding the reasons for the critical condition of the social security
funds, there was a reference—a negative reference—only to the social group
of people with disabilities. There was no other reference to any other social
group—only to persons with disabilities. As is well known, the social group
of persons with disabilities belongs to those social groups aptly described as

22 I will leave for now discussion about the use and origins of the disability statis-
tics by the Greek politicians. However, in Chapter 6 I will further discuss and
challenge the use of the disability statistics.
vulnerable and marginalized. Because of their marginalization and no or limited access to the labor market, persons with disabilities are fully dependent on institutions designed to support them, either through interventions that aim to make them “able and useful to the society and the state” (Moser, 2000, p. 207) or through their access to the welfare state and its services. However, as Iris Marion Young argues:

Being a dependent in our society implies being legitimately subject to the often arbitrary and invasive authority of social service providers and other public and private administrators, who enforce rules with which the marginal must comply, and otherwise exercise power over the conditions of their lives.

(1990, p. 54)

Thus, this attack against persons with disabilities denotes the exercise of power on the part of government authorities over persons with disabilities, with the authorities taking advantage of the latter’s dependency on the welfare state’s support.

3.3.1.2 Putting the new disability classification scale into use and the reassessment of disability beneficiaries

In January 1991, the Law 1902/1990 would go into effect. Because of the introduction of the new disability classification, all disability pensioners would have to be re-examined by the health committees, except those who had already been classified as permanently disabled by the former disability classification scheme (Eleftheros Typos, September 8, 1990). In financial terms, the re-examination of disability pensioners resulted in cuts of over 20 billion drachmas (approximately 60 million euros) (Ta Nea, September 8, 1990).

The political leadership at the Ministry of National Economy argued that this first component of the new disability classification scheme would not affect the rights of “real” disabled people and that it would be “valuable” to discern the “real” from the “fake” disabled (Ta Nea, September 8, 1990). But the political leadership at the Ministry of Health, Welfare, and Social Security challenged the new classification scheme because it did have adverse consequences for “real” disability pension beneficiaries (To Vima, May 19, 1991). In the article “Why Souflias’s Regulations ‘Failed’,” Pipili claims that voices from the Ministry of Health, Welfare, and Social Security questioned the introduction of the new classification scheme, since many “real” disability pensioners “were affected” by the new regulation (ibid.).
For the Ministry of Health, Welfare, and Social Security, the system’s reform should be based on the application of the relevant legislation, instead of on decisions such as the new disability categorization (ibid.).

The Ministry of Health, Welfare, and Social Security’s argument raises a question here concerning the consequences of the update and the tighter classification of disability for then-current disability beneficiaries. Despite the assurances of the Ministry of National Economy that the new classification of disability would not affect truly eligible disability beneficiaries, the implementation of the new disability categorization had adverse effects on persons with disabilities. Due to the new classification scheme and the reassessment of disability beneficiaries using stricter eligibility criteria, beneficiaries who had been classified as disabled under the previous system were suddenly reclassified as not disabled and thus ineligible for receiving disability pensions. The reclassification of the existing disability beneficiaries offers an opportunity to ask What happens to the cases that do not fit? (Bowker & Star, 1999), since people who were already classified as disabled were suddenly reclassified as non-disabled, not because of improvement in their health but because of the changes to the disability standards.

Though the purpose of the systems for awarding disability allowances is supposed to be to support claimants who lack, temporarily or permanently, part or all of their ability to work, the continuous reference to the amount of money that the social security funds would save because of the tighter eligibility criteria leaves room to challenge that stated purpose. Recalling the rhetoric of the Ministry of National Economy, which had the leading role in the enactment of the first component of the disability classification system, what is notable is its emphasis on how the social security funds would save money after the enactment of tighter eligibility criteria for disability allowances and its lack of emphasis on persons with disabilities. The only reference to the social group of persons with disabilities or disability beneficiaries was in their being labeled as “frauds” or “cheaters” and as a “threat” to the state.

3.3.2 The establishment of the Special Physicians’ Body of Health Committees of IKA as the gatekeepers to disability allowances

At the beginning of this Chapter, we saw that the administration of the IKA argued that the health committees that had the responsibility for the disability assessment of the insured were not trained well enough to assess the disability of the insured and that they were vulnerable to external factors (To Vima, July 22, 1990). Also, Nastas stresses the vulnerability of
the health committees since politicians as well as the physician–patient relationship had the power to intervene and change the results of the disability assessment (C. Nastas, interview, January 14, 2015). Even though the government wanted to adopt an anatomo-physiological examination for disability assessment (Sioufas, 2013), the operation of existing health committees was questioned (To Vima, July 22, 1990).

The operation of the health committees responsible for disability assessments was a crucial issue for both the politicians and the administrators of the IKA. For example, late in the spring of 1991, the governor of the IKA, in an interview in To Vima, suggested that if the aim was to “save” IKA, then it was important to establish specific health committees exclusively for disability assessment (To Vima, May 5, 1991). He further argued that, for the motivation of physicians to participate in these committees, a sufficient salary was necessary (ibid.). In the same vein, Kostas Zacharakopoulos, a pathologist and representative of the Panhellenic Medical Association and member of the Special Physicians’ Body of Health Committees of IKA since the 1990s, adds one more dimension in order to explain the need for a specific body responsible for the disability assessment procedure. According to him, the establishment of a special body responsible for disability assessment was a means “to break the monopoly” of the existing body of physicians who were responsible for it (K. Zacharakopoulos, interview, January 9, 2015). These two statements by the governor of IKA as well as by a physician of the health committees suggest the insufficient operation and denote the lack of reliability and objectivity of the existing health committees.

Thus, in the fall of 1991, the Law 1976/1991 was enacted and introduced (among other things) the second material component of the system for awarding disability benefits (Government Gazette, 1991b). This component was the Special Physicians’ Body of Health Committees of IKA as the main authority responsible for disability assessment. In line with Arti-

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23 At the daily newspaper To Vima, there was a column under the title Letters where the readers could send their letters to the newspaper. In this column, there was a discussion between two physicians who disputed the scientific objectivity of the medical committees. For example, see: Έλληνες και συντάξεις αναπηρίας [Greeks and disability pensions]. (1990, September 9). To Vima, p. A14; Οι υγειονομικές επιτροπές του ΙΚΑ [The health committees of IKA]. (1990, October 28). To Vima, p.A12; «Ραχάτ» συντάξεις και υγειονομικές επιτροπές [‘Rahat’ pensions and health committees]. (1990, November 14). To Vima, p. A14; Συντάξεων αναπηρίας μέρος δεύτερο [Disability pensions, second part]. (1991, May 12). To Vima, p. A12.
cle 12 paragraph 2, this body was established at the IKA, and the physicians should also be employed at IKA in order to be eligible to participate (ibid., p. 3153). The IKA was responsible for announcing the call with the selection criteria for the staffing of the new health committees only to physicians of the IKA; however, doctors who were dentists, radiologists, and microbiologists were excluded from the call (ibid., p. 3154). Then, after physicians submitted their application, a three-member committee, which comprised one representative from the IKA, one from the Panhellenic Medical Association, and one from the Panhellenic Federation of Physicians of the IKA, was to evaluate the applications and choose the physicians who met the criteria (ibid., p. 3153).

Since these physicians were to work exclusively on disability assessment, in accordance with Article 12, training should also be provided (ibid., p. 3153). But what did the training include? Ioannis Gkiouzelis, who has participated in the health committees of IKA since 2001, describes his training experience as follows:

I belonged to the 2001 generation. Our training lasted five to six full days, if I remember correctly. Then for an extended period, which could be several months, we just observed, as the “fourth” member of the health committees, the disability assessment procedure...My training included the theoretical part, the description of the legislation as well as how to read and how to apply the latter, and the training also included many examples. We have this case, for instance, what we are going to do, and so on. Besides, there was training regarding what everyone was entitled to receive. You might know that an elderly pensioner does not have the right to receive the total invalidity benefit unless they are blind, but their dependent (for example, widow or widower) has the right to receive it. You should learn these [details].

(I. Gkiouzelis, interview, May 26, 2015; my emphases)

Focusing on Gkiouzelis description regarding the training that members of the Special Physicians’ Body of Health Committees of IKA received, what it is notable is that the whole training was on issues of legislation (for example, see the italicized phrases in the above quote). There is no any reference to issues of clinical practice; rather, Gkiouzelis’s description reveals the bureaucratic-oriented role of physicians in the disability assessment. Thus, physicians’ “primary tasks are to obtain relevant information from clients, and to classify clients, for the agency’s purposes” (Stone, 1979, p. 235) where in this case, by
“clients” is meant the disability pension beneficiaries and by “agency” is meant the social security funds. Or, as Stone states, physicians are the “gatekeepers” in the system for awarding disability benefits, since an applicant is deemed eligible or ineligible to receive disability allowances based on the physicians’ assessment and certification.

The aim of this body was to staff the health committees in Athens, Thessaloniki, and Patra, while the committees in the rest of the country, according to Law 1976/1991, should be staffed by two physicians employed at the local hospital of the IKA, with the president of the committee to be a member of the body (Government Gazette, 1991b, p. 3154). Regarding the staffing of the health committees in Athens, Thessaloniki, and Patras, it was not permanent; rather, physicians were selected to serve on the committees through a public drawing held every four months (ibid., p. 3154). Finally, members of the body were responsible, in collaboration with the Panhellenic Medical Association, for developing a disability percentage table to be used by the health committees during the disability assessment procedure (ibid.).

3.3.3 The practical politics in the enactment of the Regulation for Disability Degree Assessment (KEVA)

The third component of the new disability classification system was the Regulation for Disability Degree Assessment (KEVA), which began to be developed after an initiative by the Ministry of Health, Welfare, and Social Security. Specifically, the minister of health, welfare, and social security describes the development of the KEVA as the “most critical” component of the first integrated disability classification system (Sioufas, 2013). According to him:

The disability percentage table constituted a remarkable and a contemporary scientific task, difficult and highly specialized. It was an essential component for the operation of Social Security for at least ten years, in order for the disability assessment to be complete, accurate and scientific, as well as objective, fair and, most of all, to help the views of the members of health committees to converge.

(ibid., p. 40, my translation)

What is notable here is the use of positivistic terms to highlight the characteristics of the disability percentage table. For example, the enactment of the KEVA is associated with terms such as “accurate,” “scientific,” and “objective.” Following Bowker and Star (1999) and their ar-
argument regarding the symbolic role of the classification systems, in my interpretation the use of the above positivistic terms symbolizes how the conservative government of ND approached disability issues by adopting a medical approach to disability. By that I mean that the application of the KEVA has similarities with how a physician uses technologies such as a microscope or a stethoscope, for example, to perform an objective medical examination. Thus, as a physician isolates a specific part of the human body to perform a medical examination, simultaneously putting a distance between him or herself and the patient, so in a similar manner do physicians perform the disability assessment. In the case of the disability assessment, the role of the microscope or stethoscope has been transferred to the “technology” of the KEVA, where specific conditions of health are translated into disability percentages. In other words, disability, for compensation purposes, is approached as a “disease that needs treatment”, and the KEVA symbolizes the medical intervention in this “treatment” (Llewellyn & Hogan, 2000, p. 158).

Although the representatives of the Ministry of Health, Welfare, and Social Security presented the development of this table as something new and innovative, Nikos Karapatsas (2015), an ophthalmologist, current member of the Special Physicians’ Body of Health Committees of IKA, and member of one of the working teams for the preparation of the table, claims that the table was an update of an already existing table. According to Karapatsas:

The first disability percentage table in the history of Greek state was done by Makris, who took the Barema\textsuperscript{24} disability table and adjusted it to the context of the Greek state.

(N. Karapatsas, interview, January 15, 2015)

Moreover, Vardakastanis (interview, September 4, 2015) and Stratis Hatziharalabous (interview, June 14, 2015), who is a sociologist, head of the Department of Health Education and Prevention at the Ministry of Health, and a person with disabilities himself, offer statements similar to Karapatsas’s. Both mention a previous disability percentage table that had been used since the middle of the 1970s for providing disability pensions from the social security funds as well as from the welfare directorate at the Ministry of Health with a view to offering disability services and benefits. Hatziharalabous states

\textsuperscript{24} Regarding the Barema classification scheme see the discussion in Chapter 1, pp. 44-45.
that for the disability assessment of civil servants, health committees had adopted the military disability code by adjusting it to their needs (S. Hatziharalabous, interview, June 14, 2015; see also: Government Gazette, 1979). Vardakastanis refers to the Law 1813/1988, which had to do with regulations regarding the civil and military pensions (Y. Vardakastanis, interview, September 4, 2015; see also: Government Gazette, 1988). But, to the minister of health, welfare, and social security at the time, “it was the first time that a disability percentage table was compiled, the most valuable tool in the hands of the new constituted Body for disability assessment, so as to purge this area” (Sioufas, 2013, p. 40, my translation).

A contradiction emerges here between the minister of health, welfare, and social security’s argument and the points of view of the ESAEA chairman, the physician from the Special Physicians Body of Health Committees of IKA, and the policy maker from the ministry of health. While the minister argued for the innovative character of the KEVA, the aforementioned informants to this project challenge the minister’s argument regarding the origins of the disability percentage table, claiming that the KEVA was just a revised version of an existing disability percentage table.

3.3.3.1 Reconstructing the KEVA
The development of the KEVA was the outcome of a collaboration between physicians who belonged to the Special Physicians’ Body of Health Committees of IKA and representatives of the Panhellenic Medical Association. The physicians were divided into nine working teams based on their specializations. The nine working teams were as follows: 1) neurological disorders; 2) orthopedic disorders; 3) cardiac disorders; 4) pathological disorders; 5) ophthalmological disorders; 6) lung disorders; 7) otorhinolaryngological, dermatological, and endocrinological disorders; 8) surgical and gynecological disorders; and 9) occupational disorders. All the working teams worked together to develop the disability percentage table.

In October 1993, the KEVA was published by the Ministry of Health, Welfare, and Social Security; later, the copyright was transferred to the IKA (N. Karapatsas, interview, January 15, 2015). As for the disability movement, it did not participate in the development of KEVA. Vardakastanis challenges the development procedure:

What we know about the KEVA, which we learned afterwards, is that the KEVA was a collage of the various aspects of medical associations, physicians, and so on. It did not have a single sys-
temic and methodological approach—in other words, no basic structure.

(Y. Vardakastanis, interview, September 4, 2015)

The KEVA consists of eight chapters and two annexes, as follows:

Chapter 1. Internal medicine: Systemic diseases, infectious diseases, metabolic diseases, connective tissue diseases
Chapter 2. Dermatological disorders
Chapter 3. Psychiatric and neurological disorders
Chapter 4. Orthopedic disorders
Chapter 5. Otorhinolaryngological disorders
Chapter 6. Surgical decisions
Chapter 7. Eye disorders
Chapter 8. Occupational disorders
Annex I: Disability percentage table on hand’s amputation and parts of it
Annex II: Regarding the diseases which are an obstacle for granting or renewing driving licenses

(Government Gazette, 1993)

Browsing through the Ministerial Decision, the first thing that the reader will notice—other than its size of approximately 500 pages—is that there is no homogeneous structure. Each chapter has its own structure, and sometimes there are differences between the sections within the same chapter. For example, the structure of chapter 1 of the KEVA, which deals with the different types of diseases (e.g., systemic, infectious, metabolic, and those involving connective tissues), is as follows: First, there is the title of the disease, then an analytical description regarding the pathogenesis of the disease. The next subsection is on the severity of the disease, and it discerns three different levels of severity. For each level, there is one subsection about clinical findings and a second subsection about laboratory findings. Also, for a few diseases in this chapter, there is one more subsection regarding prognosis and socio-medical aspects. At the end is the relevant disability percentage. Following Admon-Rick (2014, p. 112), the translation of the heterogeneous elements such as the disease pathogenesis, the clinical findings, and the laboratory findings to a figure or a disability percentage is a procedure of encoding in order to “eliminate the possibility of discussion and critique.” Below there is an example extracted from the infectious diseases section.
Acquired immune deficiency syndrome (AIDS)

A. Pathogenesis
Caused by the human retrovirus HIV. A specific enzyme acts with reverse transcription upon the RNA and constructs identical copies at the host-cell by polymerizing the DNA. The disease is characterized by the immunosuppression of the immune system because it destroys the receptor cells. The pathophysiological features of the disease are three: immunosuppression, autoimmune events (Lymphocytic interstitial pneumonia, immune thrombocytopenia) and neurological manifestations.

B. Severity levels
1st level
Clinical findings:
1. HIV-positive people without symptoms
2. HIV-positive people with general symptoms such as fever, night sweating, weight loss, recurrent diarrhea, tingling (peripheral neuropathy) and personality changes lasting for weeks.

Laboratory findings:
Anemia, leukopenia (lymphopenia), thrombocytopenia, polyclonal hypergammaglobulinemia and hypercholesterolemia. Initial abnormality of T lymphocytes and then progressive reduction of CD4 lymphocytes are characteristic of an HIV infection.

Prognosis and socio-medical aspects:
Potential intervention regarding the symptoms with poor response.

Disability percentage: 20-25%

2nd level
Clinical findings:
Manifestations of the skin and mucous membranes as leukoplakia, Kaposi's sarcoma, blepharitis, conjunctivitis constitute warnings signs of lesion.

Laboratory findings:
Same as the first level. The prevalence of the antigen P24 increases the likelihood of disease progression. Skin and mucous membranes as leukoplakia, Kaposi's sarcoma, blepharitis, and conjunctivitis, etc.

Prognosis and socio-medical aspects:
Irreversible damage. The use of AZT might inhibit the progression of the disease, provided that the side-effects of the treatment do not prevail.

Disability percentage: 67-80%

3rd level
Clinical findings:
Severe cachexia and manifestations from various systems: respiratory, central nervous (CNS), peripheral nervous (PNS), gastrointestinal, musculoskeletal

Laboratory findings:
The absence of immune defense mechanism and the whole spectrum of degenerative diseases.

Prognosis and socio-medical aspects:
Extremely severe condition with rapid conclusion.

Disability percentage: 100%.

(Government Gazette, 1993, p.1-3, my translation)

Chapter 2 of the KEVA has a different structure than chapter 1. For melanoma, for example, the first section contains a medical description of melanoma. Then the next subsection concerns the severity of melanoma, splitting it into two levels. In each level, there are three subsections regarding (i) the clinical findings, (ii) prognosis and socio-medical aspects, and (iii) the disability percentage. In other words, following this description step by step, there is a translation of the medical condition into a percentage. For some disorders, the duration of the health condition (e.g., from 1 to 2 years) follows, in parenthesis, the disability percentage. In chapter 2, since the content treats of dermatological disorders, the structure of each section is almost the same. Chapter 3 of the KEVA, which addresses psychiatric and neurological disorders—perhaps one of the shortest chapters—has a similar structure to chapter 2. In chapter 4 of the KEVA concerning the orthopedic disorders—one of the longest chapters—there are also pictures that depict the specific orthopedic disorder or problem. Last, there are some disorders, such as AIDS and melanoma, which can be found in more than one chapter. AIDS, for example, is in both chapters 1 and 2 of the KEVA, with different descriptions, varying levels of severity, and different percentages in the different chapters. Melanoma is in both chapters 2 and 6 of the KEVA, with different descriptions as well.
Examining the content of each chapter, one’s first impression is that it is medically oriented. From the first page until the last, the terms, definitions, and explanations used belong to a medical language equating disability with illness. Specifically, the reference to disability usually occurs only when there is a translation to a disability percentage. Before that point, there is no reference to disability but only to disorder or impairment and its characteristics in line with its severity. On the other hand, the subsection regarding the socio-medical aspects of the disease or impairment gains the attention of the reader, since the first term in socio-medical denotes social aspects. As Hatziharalabous states, “The new code (KEVA) was very analytical and medically oriented, which also contained social as well as occupational criteria. So it was considered that it covered all the insurance funds” (S. Hatziharalabous, interview, June 14, 2015).

But, what is the meaning of the social and occupational criteria highlighted by Hatziharalabous? Studying thoroughly all the sections of KEVA that contain the “prognosis—socio-medical aspects” subsection, two points can be made. First, even in the “socio-medical aspects” section, there is a medical understanding of disability as a condition that needs treatment. In what follows there is an extract from KEVA that illustrates this.

**Vestibular neuritis**

*Prognosis – socio-medical aspects*

The convalescence period varies depending on age. Recovery of 1-2 months is essential. Medication treatment for a few days.

(*Government Gazette, 1993, my translation*)

The second point is that for some diseases or impairments there is reference to “patient’s” age, occupation, education level, and so on (see below).

**Occupational Asthma**

*Prognosis – socio-medical aspects*

The fact that the factor which causes asthma attacks is present in the workplace makes the ‘patient’ unsuitable for that specific occupation. Provided that the ‘patient’ changes occupation or, at least, work position, then what is mentioned in the relevant chapter regarding pulmonary diseases about asthma is also valid here. There is a possibility that the insured person’s disability percentage is 80% for that particular occupation and 0% for any other occupation.
Low back pain, Sciatica, Spinal disc herniation
The disability percentage depends on the severity of the clinical and laboratory results in correlation to patient’s occupation, age, and educational level.

(Government Gazette, 1993, my translation)

What are the meaning and the purpose of these social and occupational criteria that are, in some cases, also included in the “disorder” description? Panagiotis Kampouridis, a psychiatrist and member of the Special Physicians’ Body of Health Committees of the IKA, claims that what is assessed by the health committees is both the “medical disability” as well as the work capacity of the insured (P. Kampouridis, interview, January 15, 2015). To illustrate the difference between medical disability and work capacity, Kampouridis gives the following example:

If you have vision loss in one eye, and you do not have vision loss in the other eye, then you have 25% of disability. If you are a professional driver, taking into consideration that you cannot renew your professional driving license, then your disability percentage is 67%. This means that your professional driving license is cancelled. But you can still have an amateur driving license.

(ibid.)

Thus, the role of the health committees in the disability assessment was twofold: first, they were the main responsible body for assessing the medical disability of the insured; second, in cases in which an applicant’s disability affected their work capacity, an extra percentage, up to 15%, was suggested for the insured (Government Gazette, 1992). However, this additional percentage was just a suggestion because it was up to the relevant social security fund to decide whether the extra disability percentage would be assigned to the disability claimant.

3.4 Constructing “disability fraud”
As discussed earlier in this chapter, one of the main and vigorous arguments that the conservative government of ND used to explain the reasons for the pension reform was the existence of a high number of “faked” disability pensioners. The establishment of a stricter disability classification system aimed to control the number of citizens who allegedly cheated
both the state and the social security funds. Thus, one could argue that when ND was in office, it was determined to put an end to the problem of disability fraud (see, e.g. Sioufas, 2013). Nevertheless, in the middle of 1992, almost two years since ND took power, a “scandal,” or to borrow the front page headline of Eleftherotypia, “a scandal...of special needs,” came to light (Eleftherotypia, March 6, 1992). According to the article, the “scandal” was associated with disability fraud. This time, however, the “disability fraud” did not refer to people with disabilities who received disability pensions without meeting the relevant criteria; rather, it concerned a number of citizens who were employed in the public sector as persons with disabilities, and the issue had to do with their qualifications for being appointed to those positions.

At this point, in reference to the events that took place early in the 1990s, I will explain why it is important to closely examine how the concept of the alleged “disability fraud” was constructed. As we will see later in this thesis, both governments—the conservative party of ND and the socialist party of PASOK, as they both succeeded each other in power during the period up until 2015—repeatedly used the notion of “disability fraud” to inform their rhetoric and to stress the need for reform of the disability classification system. The issue of disability fraud, as the members of the government used to call it, was the main issue that each attempt to develop a new disability classification system aimed to solve. However, as we will see, the construction of disability fraud is the outcome of the operation of the political system in Greece. That political system is characterized by an asymmetrical relationship between the voters and the political parties; that is, it is a political system of clientelism (Featherstone & Papadimitriou, 2008; Sotiropoulos, 1995, 2001; Venieris, 1994, 2006; Mavrogordatos, 1997; Trantidis, 2013, 2014). Thus, the presentation and discussion of the events mentioned at the beginning of this subsection will help us to unravel the origins of the notion of disability fraud as well as the impact of that notion on the construction of stereotypes in regards to persons with disabilities.

Following the newspaper coverage in February 1992, the minister of the presidency, Sotiris Kouvelas, brought to the parliament an amendment regarding the legalization of approximately 4,000 illegal recruitments of “persons with disabilities” in the public sector (I Kathimerini, March 6, 1992a). Members of the opposition and newspapers across the political spectrum labeled this initiative by Kouvelas a “scandal” (see, for example: I Kathimerini, March 6, 1992b; Eleftheros Typos, March 7, 1992;
Eleftherotypia, March 7, 1992; I Avgi, March 7, 1992; Rizospastis, March 7, 1992). However, the origin of this event goes back to the fall of 1991, when the former minister of the presidency, Miltiadis Evert, brought to the parliament a bill concerning the reorganization and reoperation of the public administration (Eleftheros Typos, October 22, 1991; see, also: To Vima, December 22, 1991). One of the issues that this bill expected to deal with had to do with persons with disabilities who were employed in the public sector.

Back in 1986, the socialist party of PASOK, as part of its social policy for supporting specific social groups, passed the Law 1648/1986, which aimed to protect persons with disabilities (Government Gazette, 1986; see also Parergon, pp. 284-286). According to this Law, persons with disabilities had the right to be appointed as temporary staff in different positions of the public sector (ibid.). Since the positions were temporary, the contracts were to end between May 31, 1990, and April 11, 1991 (Eleftheros Typos, March 7, 1992). As General Secretary Ioannis Anastopoulos, in the ministry when Evert was the minister, later claimed to the newspaper Eleftheros Typos, the political leadership of the Ministry of the Presidency wished to protect persons with disabilities who belonged to the above category (Eleftheros Typos, March 11, 1992). Therefore, Law 1943/1991, specifically Article 66, provided “the conversion of the contracts of 187 persons with disabilities to permanent contracts, only if their qualifications were in line with the Law 1648/1986” (ibid.; see also: Government Gazette, 1991a).

Despite the fact that the Law 1943/1991 concerned only persons with disabilities (Eleftheros Typos, March 11, 1992), there were gaps in it as well as in the Law 1648/1986—an issue that some institutions of the public sector took advantage of (Ta Nea, March 10, 1992), with the Hellenic Post (ELTA) one example. For instance, an article published in Ta Nea refers to the number of new recruitments at ELTA (Ta Nea, September 12, 1991). The journalist states that 758 applications had been submitted to the ELTA requesting inclusion under Article 66 from Law 1943/1991 (ibid.). The journalist further reports that the minister of the presidency, Miltiadis Evert, reacted to this by saying that it was impossible that half of the staff whose contracts were ending were persons with disabilities (ibid.). As a consequence, Evert sent the case to the justice department (ibid.).

On the other hand, the socialist party of PASOK claimed that the reason for this scandal had to do with the qualification criteria that were enacted by the Law 1943/1991 (ibid; Ta Nea, September 14, 1991, Sep-
According to the politicians of PASOK, instead of persons with disabilities being registered to the Manpower Employment Organization (OAED) for being eligible to be hired in the public sector as “persons with disabilities,” as required by the Law 1648/1986, a medical certificate by a primary medical health committee was also acceptable (Ta Nea, September 12, 1991). But, the politicians of PASOK questioned the objectivity of the primary prefectural medical committees, stating that they were the cause or source of this scandal (Ta Nea, September 17, 1991).

In an article that was published in To Vima (January 25, 1992), journalist Ioanna Mandrou refers to the results of the investigation that took place after Evert’s request: state officials, physicians, and, civil servants were brought to justice either because of their participation in illegal recruitments or because of their having issued fraudulent medical certificates. The same article describes some of the fraud cases. For instance, there was one case of a former employee at ELTA who was re-employed at ELTA as a person with disabilities because of the Law 1943/1991 (ibid.). As the journalist reports, the above employee submitted a medical certificate on which the prefectural health committees attributed to her a 28% of disability because she had a stiff right elbow, and in line with the Law 1943/1991, she was classified as a person with disabilities (ibid.). Based on this disability percentage, the above employee submitted a medical certificate on which the prefectural health committees assigned to her a 28% of disability because she had a stiff right elbow, and in line with the Law 1943/1991, she was classified as a person with disabilities (ibid.). However, when the case was referred to a secondary health committee, the above employee received a disability rating of 5% instead of 28%, and as a consequence, the members of the prefectural medical committee were prosecuted (ibid.).

Although parties to the above illegal recruitments were sent to justice, Sotiris Kouvelas, who succeeded Evert in the Ministry of the Presidency as of October 1991, brought to the Parliament, early in March 1992, an

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25 As will be discussed in Chapter 4, apart from the health committees of the social security funds, which assessed claimants’ eligibility for disability allowances, there were also prefectural health committees in the capitals of the prefectures which assessed and certified disability in order for disability claimants to be eligible for disability allowances and services by the welfare state. Since disability certifications from social security funds could not be used for any purpose other than disability allowances provided by social security funds, the prefectural health committees were responsible for issuing medical or disability certifications for any other use, e.g., applying for sick leave, applying for jobs for persons with disabilities, studying at the university, applying for a parking permit, and so on.
amendment legalizing all the illegal recruitments of persons with disabilities in the public sector (I Kathimerini, March 6, 1992a). The amendment also added two new qualification criteria for a citizen to be employed as a person with disabilities in the public sector. Because of the above amendment, the Law 1943/1991 was replaced by the Law 1648/1986 (Rizospastis, March 7, 1992).

In the spring of 1992, when Kouvelas brought the amendment to Parliament, the opposition reacted by accusing the government and the minister of the presidency of illegal recruitments (I Kathimerini, March 6, 1992a; Eleftherotypia, March 6, 1992; I Avgi, March 7, 1992; Rizospastis, March 7, 1992). Though this reaction by the opposition was somewhat expected, a point that needs attention is the reaction inside the ND party. As the newspapers reported, the amendment had consequences for the ND party, with conflicts either between the former and the current ministers of the presidency or between the government and ND members of parliament (Eleftherotypia, March 6, 1992; Eleftheros Typos, March 7, 1992; Eleftherotypia, March 7, 1992). For instance, in regards to the conflict between the minister of the presidency and ND members of parliament, a newspaper article published in I Kathimerini describes an event that took place in the parliament during the discussion of the amendment (I Kathimerini, March 6, 1992a). Specifically, the ND members of parliament threatened the government that they would not vote for the amendment unless the minister of the presidency changed one of the prerequisites concerning the last date that persons with disabilities were employed in their positions in the public sector (ibid.). Additionally, as also reported, some members of parliament from the ND party asked for new appointments to the public sector (I Kathimerini, March 6, 1992b).

With regard to the above discussion as well as the earlier discussion in this chapter, two points come to the surface and need more analysis. The first point concerns the relationship between the government and the opposition, or between the political parties of ND and PASOK. As we saw at the beginning of this chapter, the ND government accused the PASOK government of being responsible for both the “chaotic situation” of the social security system and the “privileged policy” that PASOK adopted, thus creating a number of fake disability pensioners, or “fake disabled”. In the event presented above, what is notable is that ND and PASOK changed positions: this time, it was the representatives of PASOK who accused the ND government of the illegal recruitments to the public sector, or of creating “fake disabled.” Even though this mutual recrimination
between ND and PASOK belong to what is called “petty politics,” what emerges here is an indirect attack against persons with disabilities, as both parties used the term “fake disabled.” To put it differently, both ND and PASOK, through their discourse, used the vulnerable and marginalized group of persons with disabilities as a means to gain the support or sympathy of their voters as well as to pass their political agendas, stigmatizing people with disabilities in the process.

The second point that comes to the surface has to do with the demand of the ND members of parliament for new appointments to the public sector. Political scientist Aris Trantidis (2014), who has studied the work of the ND government in the early 1990s, refers to the reaction of the ND members of parliament to the decisions of the ND government. According to Trantidis, the conservative party of ND, after its victory in the parliamentary elections in 1990, was determined to proceed with structural reforms such as “changing the country’s economic direction by reducing public deficits, selling or closing down ailing companies owned by the state” (Trantidis, 2013, p. 137) and, as discussed, reforming the pension system. Following Trantidis, who states that structural reforms are risky for any government that participates in a clientelist system (Trantidis, 2014), the policy agenda of ND resulted in conflicts inside the party (I Kathimerini, March 6, 1992a; I Kathimerini, March 6, 1992b; Trantidis, 2014). For instance, the initiative of Evert to send to justice the cases of “fake disabled” in the public sector because those disability recipients did not meet the qualification criteria was not accepted by ND members because it did not leave room for the politicians to use those positions in the public sector for clientelistic purposes (Trantidis, 2013).

Nevertheless, whether the reference to disability fraud was as part of the petty politics between the political parties of ND and PASOK or because of the clientelistic system and the way each political party attempted to create clientelistic networks among its voters, the issue is that the social group of persons with disabilities was stigmatized and associated with fraud—something that has had consequences in terms of how society interacts with persons with disabilities. For instance, the continuous discussion regarding the alleged fake disabled has enacted negative stereotypes against the oppressed social group of persons with disabilities.

3.5 Conclusion

Chapter 3 discussed the first attempt by the Greek state to develop a more concrete system for certifying disability. This attempt took place early in
the 1990s when the conservative government of ND was in office. Though this system was developed by the social security fund of the IKA and thus concerned only the IKA insured the rest of the large social insurance funds gradually sent their insured to the IKA health committees as well. Thus, that system became the reference point concerning disability assessment for compensation purposes until the early 2010s.

The purpose of this chapter was to shed light on how a disability classification system comes into being by opening the black box of the system. To that end, I adopted the theoretical/methodological themes of indeterminacy of the Past, material and texture, and practical politics, as proposed by Bowker and Star (1999). In applying the themes, my aim was to reconstruct the disability classification system by examining, for example, the political and social choices made by the system developers. In the following paragraphs, I will make some observations in line with the findings that emerged after the reconstruction of the disability classification system.

Beginning with the indeterminacy of the Past theme, we saw how the voices of two social groups evaluated the existing system for assessing and certifying disability benefits. As discussed, the politicians of the conservative government of ND applied a neoliberal agenda to proceed with structural reforms of the operation of the state. By using neoliberal elements, such as a neoliberal vocabulary, to generate fear in the public consciousness, they attacked the oppressed social group of persons with disabilities by labeling them as frauds. However, the attack on the social group of persons with disabilities should also be explained as part of the “petty politics” between the politicians of the ND government and the politicians of the PASOK government, which succeeded each other in power.

On the other hand, the evaluation offered by the social group made up of the representatives of IKA shows that the implementation of the existing system for assessing and certifying disability was vulnerable to external factors, such as politicians, who used the system to create new clients (in a clientelistic relationship) who would come from the group of disability benefits applicants. This clientelistic relationship is confirmed by the last section of this chapter regarding the construction of the concept of disability fraud within the political and social context of the country. Even though the ND government wanted “to put an end” to the endless cycle of alleged “disability fraud,” at the end of this chapter, we saw that the PASOK party accused the ND government of the recruitment of alleged “fake disabled” in the public sector. What emerges here is that politicians, conservative and socialist alike, used elements from the rights of persons with disabilities (selective
policies) to enlarge their network of voters and supporters, while, through their political rhetoric, they stigmatized the social group of persons with disabilities by enacting in society negative stereotypes of persons with disabilities, stereotypes such as “fake,” “a threat,” and “cheaters.”

Since the discussion refers to the relevant actors who had a say in the evaluation and the development of the disability classification system, the voice of the disability movement was not included in the former procedure. Recalling the discussion earlier in this chapter, the noninvolvement of the disability movement in the dialogue on the reform of the system for awarding disability pensions was a political choice made by the conservative government of ND and specifically by the minister of national economy.

Moving to the next two theoretical/methodological themes, that is, material and texture, and practical politics, we saw that the new disability classification system consisted of three material components: (i) a tighter disability classification scale; (ii) the Special Physicians Body of Health Committees of IKA; and (iii) the KEVA, or a new disability percentage table. Following Bowker and Star (1999), the aforementioned material components of the disability classification are a mix of physical entities and conventional arrangements. To be more specific, the first material component is the physical entity of the new disability classification scale. For the enactment of this disability classification scale, however, a convention was taken into consideration in order, for example, for the classification of severe disability to be linked with the disability percentages between 80% and 100%. That is, under the labels severe disability, ordinary disability, and partial disability, heterogeneous quantitative or qualitative characteristics are included and represent the health condition of the applicant. Through a process of encoding (Admon-Rick, 2014), all those heterogeneous elements are translated into a statistical rate, which in turn enacts disability as an object of governance (Porter, 1993; Rose, 1999).

The Special Physicians Body of Health Committees of IKA comprises the second physical entity of the new disability classification system. This body is a conventional arrangement that system developers made, and it reveals the hegemony of the medical professionals in the assessment and certification of disability. For example, if we focus on its name, the term “special physicians’ body” denotes a “new medical specialization” created especially for the disability assessment.

As for the KEVA, or the disability percentage table, which is at the core of the disability classification system, it is a physical entity in that it is a book, or a catalogue that includes and describes several disorders and impairments,
along with their symptoms, severity levels, and so on. On the other hand, the KEVA is a conventional arrangement in that specific characteristics of diseases or impairments have been considered and classified based on their severity and then translated into a figure or a disability percentage.

Lastly, another point that I would like to further discuss concerns the two material components that have to do with the classification of disability according to a new and tighter scale and the development of the KEVA. Starting with the first component, a new and tighter disability classification scale was introduced for the classification of disability beneficiaries. Similarly, in the case of the KEVA—either following the minister of health, welfare, and social security’s argument about the “innovative” character of the new disability percentage table or by following the arguments by the chairman of the ESAEA, the member of the physicians Body of IKA, and/or the policy maker from the Ministry of Health regarding the revised nature of the KEVA—the issue is that the new disability percentage table introduced a new translation of the health conditions into disability percentages. Because of the enactment of these physical components, the existing disability beneficiaries had to be reassessed and reclassified in order to fit the new system’s criteria.

On the one hand, disability beneficiaries had to be reassessed to continue receiving disability pensions, but on the other hand, the revisions to the disability classification scale and to the disability percentage table meant that the practice of disability assessment was not the same as before. Thus, many disability beneficiaries who had already been classified as disabled, suddenly did not fit the new standards set by the new classification system. It should be underlined here that the reason they did not fit was that there were changes to the disability standard and the assessment and certification practice—not because their health status was improved or, to borrow a term discussed earlier in this chapter, because their disabilities were faked. So, what I want to stress here is that changes to the standards for the disability classification have the power to suddenly classify someone as one who fits or does not fit into the classification system; but this reclassification because of the changes to the system, gives us room to ask and problematize What happens to the case that does not fit (Bowker & Star, 1999; see, also: Star, 1991), considering, as well, the continuous discussion regarding disability fraud.

In Chapter 3, we saw how the disability classification system developed in the early 1990s started to be implemented and, gradually used by the other social security funds, such as OGA. Nonetheless, in 1995, while the socialist party of PASOK was in power, after its victory against the conservative government of ND in 1993, representatives of the Ministry of Health and Welfare announced the development of a new disability classification system. According to the ministry, the reason behind the enactment of a new disability classification lay in the parallel operation of various systems for awarding disability benefits to disability claimants. Thus, the new attempt aspired to enact an integrated and single system for assessing and classifying disability in Greece for all disability claimants, regardless of their social security fund. The reference name for the new system was “Disability Card,” a name that, as we will see, had its roots in the disability movement. Taking into consideration the exclusion of representatives of the disability movement during the negotiations for the development of the system discussed in Chapter 3, this shift is essential, as it highlights a new era of the Greek disability movement’s participation in political discussions relevant to the rights and needs of people with disabilities.

Chapter 4 deals with the development of the disability card classification system, a system that was advertised as one that would replace all the existing disability classification systems and which, as stated, was closely linked to the disability movement. Specifically, this chapter aims to open the black box of the disability card system by examining why the existing disability classification systems were inadequate for further use, what the role of the disability movement was during the development process, through which practices the disability card classification system developed, and, last, what the factors were that prevented the disability card classification system from being implemented.

Chapter 4 consists of four sections. Similar to Chapter 3, I used the theoretical/methodological themes of the indeterminacy of the Past, material and texture, and practical politics to structure this chapter and to reconstruct the disability card classification scheme (Bowker & Star, 1999). Thus, the first section seeks to shed light on the reasons for the need for a new disability classification system. By giving voice to relevant actors, the emphasis is to explore why there was a need for a new disability classifica-
tion when the one that was developed for the general scheme of social security had only recently begun to operate, how the development of Greek social policy and politics has affected the operation of disability classification systems, and how persons with disabilities assess the operation of the disability classification systems according to their personal experiences. The second section focuses on the period before the announcement of the development of the new system for awarding disability allowances, seeking to present and discuss the political and social choices behind the announcement of the system as well as the role of the disability movement in the negotiation procedure. The third section puts the emphasis on the material components of the disability card classification system. By adopting the themes of practical politics and material and texture, this section talks about the practical politics during the development of the disability classification systems, and it describes and analyzes the two components of the systems—that is, the establishment of specific health committees and the disability card. Last, the fourth section talks about the operation of the disability card as a pilot project at the prefecture of Larisa and the reasons, according to the relevant actors’ points of view that the disability card classification system was inadequate for implementation throughout the country.

4.1 Evaluating the existing system(s) for awarding disability allowances: Multiple voices share their knowledge

As early as in 1995, the political leadership of the Ministry of Health, Welfare, and Social Security announced the establishment of a new system for awarding disability benefits. What was the purpose of the development of a new system for awarding disability, given that the system that was developed in the context of IKA and that concerned the general scheme of social security had only recently been implemented, in 1993? Following Bowker and Star’s (1999) advice that an understanding of the development of a classification system requires an exploration of the social and political choices embedded in the development procedure, this section seeks to shed light on the reasons that led the government authorities to reform the system for awarding disability allowances. I will implement the theoretical/methodological theme of indeterminacy of the Past to explore how the voices of relevant actors, such as policy makers, politicians, and persons with disabilities, evaluated the operation of the system(s) for awarding disability in the middle of the 1990s.
At the dawn of 1994, three disability classification systems for disability assessment operated in parallel. The first system, which discussed in Chapter 3, was for compensation purposes, such as disability pensions and disability allowances provided by the social security funds, and it operated under the supervision of IKA. The second system operated in the context of the welfare services, with the prefectural health committees responsible for disability assessment. The third system was operated by the Supreme Military Health Committee (ASYE) and concerned, mainly, em-

26 A clarification is necessary here. Despite the high number of different social security funds, the social security fund of IKA was and is the general scheme for social security issues. The rest of the social security funds operate in parallel with IKA. IKA was founded in 1934 and offers health insurance and pensions to employees in the private sector, covering the needs of 50% of the population. Together, IKA, the Agricultural Insurance Organization (OGA), and the Small Businesses and Trades Insurance Fund (TEVE) cover approximately 90% of the population (Stathopoulos, 2005). OGA was founded in 1961 and offered health insurance and pensions to farmers, covering 25% of the population. TEVE was founded in 1934 and offered health insurance and pensions to professionals and craftsmen, covering 13% of the population (ibid.). Also, there is the social security fund for civil servants, which covered 6% of the population, and for the remaining 5% of the population, there is a plethora of smaller social security funds that are linked to specific occupational fields and that offer insurance and compensation services to their insured (Stathopoulos, 2005).

27 Regarding the prefectural health committees, see also footnote 25.

28 The armed forces in Greece consist in the Hellenic Army, the Hellenic Navy, and the Hellenic Air Force. Each of these forces had its own health committee for the disability assessment. Specifically, the medical committee for the Hellenic Army was the Supreme Military Health Committee (ASYE), the medical committee for the Hellenic Navy was the Supreme Naval Health Committee (ANYE), and the medical committee for the Hellenic Air Force was the Supreme Air Force Health Committee (AAYE). Also, the Hellenic police has another health committee, and so on. However, ASYE was also responsible for assessing civil servants.
employees in armed forces as well as civil servants. Yet these three systems used different disability percentage tables for the translation of bodily conditions into numerical figures. As Vardakastanis (interview, September 4, 2015) underlines, disability health committees of IKA used the Regulation for the Disability Degree Assessment (KEVA), while the ASYE and the prefectural health committees used the disability percentage table enacted by the Law 1813/1988. For instance, insured people wanting to be assessed for insurance purposes usually had to be evaluated by the health committees of IKA, and if they wanted to be entitled to welfare disability allowances, such as a parking permit or free mobility with public transportation, then they had to visit the prefectural health committees (F. Karampetsou, interview, January 23, 2015).

There was a “lack of communication,” however, between these systems (S. Hatziharalabous, interview, June 14, 2015). Stratis Hatziharalabous, a head at the Department of Health Education and Prevention at the Ministry of Health, former employee at the Department of Disability at the Ministry of Health, and key actor in the development of the disability card classification system, explains this lack as follows:

Health committees were “two-speed.” Different regulations attributed different disability percentages. In the first system [IKA], there was a very detailed categorization of a health condition, which meant a very accurate disability assessment...while the other system [welfare state] was more general...The references, I would say, were more generalized and obsolete. So, there were two systems that did not operate simultaneously; and sometimes they confused disability claimants about the disability percentage

29 Also, another classification scheme that has been introduced concerns children with special needs and learning difficulties for their classification to the relevant educational unit and their assessment in terms of support for their educational needs. With the establishment of the Centers of Diagnosis, Assessment and Support (KDAY) in 2000 and then the Centers for Differential Diagnosis and Support (KEDDY) in 2008, children with special needs and learning difficulties were supposed to be assessed by specific committees belonging to the above centers. According to Leotsakou, who was chairman of the International Council for Education and Rehabilitation of People with Special Impairments and also had an organizational position at the Center of Differential Diagnosis and Support in Athens as a career counselor for children with visual impairments, the role of these committees is to assess children with special needs and learning difficulties in terms of what they need in the way of support (e.g., technical support) in order to be “independent and autonomous persons later in life” (interview, June 15, 2015).
that was attributed to them. Also, since a computerization system did not exist, disability pension and allowances beneficiaries could hide one certificate from the [issuer of the] other [certificate]. Thus, if a prefectural health committee cut a claimant, then the same claimant did not say anything to the health disability committees of the IKA...I remember there were many cases where disability applicants/claimants had two different certificates, one with 80% of disability and the other with 50% of disability. So, according to what they needed, they used the relevant certificate. (ibid.)

Like Hatziharalabous, Panagiotis Kouroumblis, a politician, former chairman of ESAEA, and general secretary of welfare when the disability card system developed, evaluates the existing system(s) for awarding disability allowances by focusing on both the operation of the health committees and the consequences of the continuous disability assessments on persons with disabilities and on the state (P. Kouroumblis, interview, June 10, 2015). According to Kouroumblis, “The medical committees that existed in prefectures, possibly under the pressure of local actors, were lenient enough. Also, it was a system that repeated the same thing.” (ibid.).

Further, he talks about the parallel operation of the existing disability classification systems, claiming that they did not offer anything to the state or to persons with disabilities but rather created hardships (ibid.). As he argues:

It [this situation] created a million working hours against the state. To say it another way, why reassess a blind person? What is it going to change after three years to be evaluated again? There were permanent disabilities that had no reason to be evaluated. Also, it was a hard time for persons with disabilities, too, as many working hours were lost when a relative had to escort a person with disabilities to health committees. (ibid.)

According to Kouroumblis, the health committees, particularly the prefectural health committees, were “lenient” (ibid.), a statement that intersects with that of Maria Mpratsiakou, a social worker and deputy secre-

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30 For instance, the meaning of the term “local actors” that Kouroumblis uses in this quote denotes political actors who participated in the local administration of the municipalities or prefectures. Regarding the operation of the public welfare institutions and its manipulation “for partisan purposes”, see, also Ferrera (1996, pp. 28–29).
tary at the primary health committees of the Municipality of Kalamata, regarding the vulnerability of the health committees (Mpratsiakou, interview, January 23, 2015). She says that, according to her experience, the physicians who participated in the staffing of the prefectural health committees were usually the same [and easy to identify], implying another way they were vulnerable.

A similar argument regarding the vulnerability of the health committees is made by Yiannis Vardakastanis, the chairman of the ESAEA. He argues, however, that “corruption and conflict could appear” in the health committees in general—not only in the prefectural health committees (Y. Vardakastanis, interview, September 4, 2015). He also refers to disability fraud as one of the consequences of the health committees’ vulnerability and to how the continuous discussion regarding fraud has affected persons with disabilities (ibid.)

### 4.1.1 The operation of the systems for assessing and certifying disability through the experiences and knowledge of persons with disabilities

The prior section described and discussed how actors from inside the system evaluated the operation of the system(s) for assessing and certifying disability. In this section, the emphasis is on persons with disabilities and their experiences and knowledge as the users of the system(s).

Vasilis Dimitriadis, who is paraplegic, a retired employee of Hellenic Railways Organization (OSE), and chairman of the Piraeus Association of Physically Challenged, describes his personal experience with health disability committees and his multiple disability percentages:

> I have had a 67% disability from the IKA, more than 80% for the tax office, and 100% for the tax-free car import. ...the certificate that I received from the primary health committee was 90%. I filed an objection, and the secondary health committee gave me 100%. ...All three together. Myself. Also, according to ASYE, I had 95% or 90% of disability—I think 95%. So I have had four or five disability percentages of more than 67%. ...When I wanted to study at the university, they asked me for a disability certificate. A health committee assessed me. The same health committee [as the previous], but, I had to be reassessed. ...When I applied for my work, I was assessed, again, by a health committee. Did I want to change my car? I would have to be assessed again by a health committee.
>

(V. Dimitriadis, interview, January 21, 2014)
Gerasimos Polis, paraplegic, retired civil servant and treasurer of the Piraeus Association of Physically Challenged, and Paraskevi (Vivi) Tsavalia, blind and general secretary of the National Federation of the Blind, offer similar accounts regarding the number of different disability certificates they have had (G. Polis, interview, January 21, 2014; P. Tsavalia, interview, May 22, 2015). Dimitriadis, Polis, and Tsavalia also stress the “lack of communication” from institution to institution as well its consequences on them.

As Tsavalia states:

One May I was assessed three times by the health committees. The first time was for taking my oral exams in the master’s program I attended, the second time for the tax-free car, and I cannot recall the purpose of the third time. In any case, I remember that within a month I was assessed three times.

(P. Tsavalia, interview, May 22, 2015)

Additionally, she wonders why she had to be assessed so many times, instead of receiving one certificate that would be valid for use and submission to other services and institutions (ibid.).

Focusing on the above accounts from persons with disabilities, what is notable is their emphasis on the number of disability certifications that had been awarded to them. Either by stressing the plurality of the different disability percentages that they had been attributed to them or by mentioning the frequency of the disability assessments that they had undergone, the main issue is why they had to be assessed so many times. At this point, considering all the above arguments from the relevant actors and users of the existing system(s), all these arguments denote that the problem with the way disability was assessed and certified was its fragmentation, a concept that will be discussed below.

### 4.1.2 The fragmentation of the welfare state

Although none of the above illustrations uses the concept of fragmentation, all of them denote that the problem with the existing disability classification systems was their fragmentation. The concept of fragmentation is not a new concept that arose because of the disability classification systems. Rather, its history is linked to the type of welfare system that was adopted and developed in the Greek context (Featherstone & Papadimitriou, 2008; Ferrera, 1996; Katrougalos, 1996; Katrougalos & Lazaridis, 2003; Petmesidou, 1996a, 1996b; Symeonidou, 1996). As Maurizio
Ferrera (1996) claims, the welfare system that has developed in Greece belongs to what he calls the “southern model of welfare.” To Ferrera, one of the fundamental characteristics of this model is that it is based on occupational status. That is, different social security schemes are developed according to the occupational status of the insured (ibid., p. 19). In Greece, for instance, as well as in Italy, the welfare system is characterized by high fragmentation. This means that there are various schemes depending on the applicant’s occupational category. For example, there is a general scheme for social security, the one provided by the IKA, and in parallel, there have been other schemes for farmers, civil servants, traders, physicians, and mechanical engineers, to name but a few, which have all operated simultaneously.

According to the General Secretariat for Social Security:

in the organizational structure of the [Greek social security] system, the key feature is its fragmentation, which is translated into the high number of public social security funds. In 2002, there were 170 social security funds, which were supervised by at least five ministries.

(General Secretariat of Social Security, 2016)

Tables 3 and Table 4, as they appeared on the web page of the General Secretariat of Social Security, illustrate the high fragmentation of the social security funds.

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31 Political scientist Maurizio Ferrera (1996) claims that the welfare states of the southern European countries of Portugal, Spain, Italy, and Greece have had similarities that are different from the other European welfare states. Thus, the “three worlds of the welfare state,” as proposed by Esping-Andersen (1990), cannot be applied to the southern European welfare states. Instead, because of the common traits among the welfare states in southern Europe, Ferrera proposes a new model, the “southern model of welfare.” According to him, there are four characteristics that Portugal, Spain, Italy, and Greece have shared in the development and operation of their welfare states. These characteristics are: “1) a highly fragmented and ‘corporatist’ income maintenance system, displaying a marked internal polarization...; 2) the departure from corporatist traditions in the field of health care and the establishment...of National Health Services based on universalistic principle; 3) a law degree of state penetration of the welfare sphere and a highly collusive mix between public and nonpublic actors and institutions; 4) the persistence of clientelism and the formations –in some cases- of fairly elaborated ‘patronage machines’ for the selective distributions of cash subsidies” (Ferrera, 1990, p. 17).
<table>
<thead>
<tr>
<th>Number of social security funds under the supervision of the Ministry of Employment and Social Security</th>
<th>Occupational Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Private sector employees</td>
</tr>
<tr>
<td>10</td>
<td>Bank personnel</td>
</tr>
<tr>
<td>12</td>
<td>Public enterprises personnel</td>
</tr>
<tr>
<td>6</td>
<td>Self-employed</td>
</tr>
<tr>
<td>11</td>
<td>Freelancers</td>
</tr>
<tr>
<td>6</td>
<td>Press personnel</td>
</tr>
<tr>
<td>1</td>
<td>Farmers/Peasants</td>
</tr>
<tr>
<td>17</td>
<td>Civil Servants</td>
</tr>
</tbody>
</table>

Table 3. Social security funds by occupation

(Ministry of Employment and Social Security, Social Budget, 2002, p. 349, as illustrated at the appendix II of General Secretariat of Social Security, my translation)

<table>
<thead>
<tr>
<th>1. Ministry of Employment and Social Security</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary insurance</td>
<td>23</td>
</tr>
<tr>
<td>Supplementary insurance</td>
<td>34</td>
</tr>
<tr>
<td>Health insurance</td>
<td>16</td>
</tr>
<tr>
<td>Welfare</td>
<td>19</td>
</tr>
<tr>
<td>Other Benefits (Manpower Employment Organization-OAED, Workers’ Housing Organization-OEK, OEE)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95</strong></td>
</tr>
</tbody>
</table>

| 2. Ministry of Defense                        | |
| Supplementary insurance                        | 3 |
| Welfare                                        | 3 |
| **Total**                                     | **10** |

| 3. Ministry of Economy and Finance            | |
| Supplementary insurance                        | 1 |
| **Total**                                     | **1** |

| 4. Ministry of Merchant Marine                | |
| Primary insurance                             | 1 |
| Supplementary insurance                        | 1 |
| Health insurance                               | 1 |
| Welfare                                        | 4 |
| **Total**                                     | **7** |

| 5. Ministry of Agriculture                    | |
| Public Utilities (Hellenic Organization of Agricultural Insurances – ELGA) | 1 |
| **Total**                                     | **1** |
Table 4. Social security funds by type of protection provided and supervisory body

<table>
<thead>
<tr>
<th>Type of Protection Provided</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Hellenic Parliament Welfare</td>
<td>1</td>
</tr>
<tr>
<td>7. Insurance Services Athens Water Supply and Sewerage Company (EYDAP) personnel, (health insurance)</td>
<td>1</td>
</tr>
<tr>
<td>8. Mutual Service Funds Mutual service funds for supplementary benefits</td>
<td>54</td>
</tr>
</tbody>
</table>

**Grand Total** 170

(Ministry of Employment and Social Security, Social Budget 2002, p. 349, as illustrated at the appendix II of General Secretariat of Social Security, my translation)

Table 3, shows the number of the insurance funds according to an applicant’s occupational status. As illustrated, for almost all the occupation categories there are more than one social security fund. Maro Pikramenou, a deputy head of the department of the General Secretariat of Social Security, explains that it was common for all employees to be insured in two social security funds, the first for their basic pension and the second, called supplementary social security fund, for receiving an extra monthly amount to their final pensions (M. Pikramenou, interview September 1, 2015). According to Pikramenou, an explanation of the high number of social security funds is linked with the existence of the supplementary insurance funds. Table 4 shows the fragmentation of the social security funds according to the supervisory ministry. As we can see, the Ministry of Labor did not have under its responsibility all the social security funds, as might be expected. Instead, other ministries also have social security funds under their supervision, both for primary and supplementary insurance funds. The plurality of the ministries that had responsibility for various social security funds also explains the lack of a single scheme of social policy and protection.

Political scientist Maria Petmesidou (1996a), who has studied the development and operation of the Greek welfare system, claims that the emphasis on the operation of the Greek welfare system is on “individuality” instead of “collective solidarity,” as is the case in other European
countries (ibid., p. 329). She further notes that both the “extensive state intervention” in the functions of the welfare state and the idea that “everything is matter of politics” leave room for the creation of clientelistic relations or, as she argues, “often lead to the open use of political means by the contending parties for getting direct access to benefits and resources” (ibid., p. 329). By clientelistic relations is meant that citizens’ access to the welfare state does not depend on their “needs and citizenship rights,” as could happen if the welfare state was built on the principle of “corporatist solidarity” (ibid., p. 329); instead, citizens’ access depends on “their political bargaining power and their position in the clientelistic clusters” (ibid., p. 329). Thus, because of the above functions, the social security system is highly fragmented.

In the case of the systems for assessing and certifying disability, as already indicated, this fragmentation has been translated into different disability classification schemes as well as into various disability allowances from social security fund to social security fund. For instance, Appendix IV contains a short list of the disability allowances that were offered by the social security funds of IKA, OGA, TEVE, and the welfare services. Despite some of the disability allowances being the same, the amount of money that the disability beneficiaries receive is not the same. For example, for a citizen who is insured at IKA and has been assessed with 60% of disability will receive half of the disability pension. However, the same does not apply to an insured in OGA or TEVE, since they will receive disability allowances and pension only if they have been assessed with more than 67% of disability (P. Kampouridis, interview, January 15, 2015). Different rules apply to different social security funds.

What emerges here is that because of the fragmentation of the systems for awarding disability benefits, it is possible for beneficiaries or individuals to not be aware of their rights and the benefits they are entitled to receive. Ferrera (1996, p. 28) describes the operation of the “public welfare institutions,” such as the social security funds, as “extensively manipulated for partisan purposes.” For example, he refers to the procedure for applying for pensions by stressing its complicated nature as well as the need of the applicants to know some “particular contacts” so as “to find their way through the legal and bureaucratic maze” (ibid., p. 28). In other words, the closer the applicants are to the “particular networks”, the more their chances to be informed about the benefits to which they are entitled (ibid.).

To summarize, this section sought to explore the reasons for the revision of the system for awarding disability allowances by giving voice to
relevant actors behind its enactment as well as to the experiences of persons with disabilities. Starting with the voices from the Ministry of Health, we saw that both Hatziharalbous and Kouroumblis evaluated the existing system for assessing disability by using terms from a social policy vocabulary, and specifically by mentioning the concept of fragmentation. For instance, Hatziharalabous described the operation of the health committees by stressing the production of multiple and different disability certificates, while, Kouroumblis also talked about the fragmentation of the disability classification system by referring to the consequences of that fragmentation on both the state and persons with disabilities.

Persons with disabilities, the second voice, evaluated the system by sharing their knowledge and experiences as the users of the system. Echoing Thill (2015), even though persons with disabilities talked about the fragmentation of disability classification, in their vocabulary was a hidden “expertise,” that of their personal experience of being the users of the system, and this brings a totally different knowledge from that of the political rhetoric and/or operational practicalities about the implementation of the system(s).

4.2 The scandal with alleged “fake disabled” and the involvement of the disability movement: Exploring the practical politics before the enactment of the disability classification system

While the discussion of the reform of the disability classification system aimed to solve the issue of its fragmentation, according to the data of this study, the cause of the revision is linked to a scandal concerning alleged fake disabled in the prefecture of West Attica. More specifically, in 1995 the new political leadership of the Ministry of Health and Welfare announced the initiation of an investigation in the prefecture of West Attica regarding the disability allowances the prefecture provided its citizens (Ta Nea, February 16, 1995). According to Manolis Skoulakis, Deputy Minister of Health and Welfare, the investigation concerned the disability certificates issued by the prefectural health committees of West Attica, particularly the disability certificates issued for importing a tax-free car, for applying for disability allowances, and for those as protected by the Law 1648/1986 (ibid.). The above event, however, brings to mind the discussion in Chapter 3, where the politicians of both the political parties PASOK and ND accused each other of the creation of fake disabled for enlarging their network of supporters/voters.
4.2.1 The involvement of the disability movement as a reaction to the scandal of alleged disability fraud

As reported by the newspapers, ESAEA reacted to the new scandal concerning alleged fake disabled by sending a letter to the ministry of health and welfare. In the letter, ESAEA agreed with the deputy minister’s initiative, and it further asked for an extended investigation in all prefectures of Greece (To Vima, February 26, 1995). To ESAEA, this investigation considered as a means to put an end to the “social, political, ethical and criminal scandal” of disability fraud (ibid.).

It is worth noting here the involvement of the disability movement in the debate regarding the alleged fake disabled through the movement’s initiative to send the letter to the Ministry of Health. Further to this, according to the content of this letter, what can be noted is a synergy between ESAEA and the state to “put an end” to the threat of “disability fraud.” As political scientists Giorgos Mavrogordatos (1988) and Kostas Lavdas (2005) inform us, this kind of collaboration or synergy between a confederation (i.e., ESAEA) and the state belongs to the system of corporatism.

As we saw in Chapter 1, corporatism is a political economy theory that explains the “interest mediation” between the state or the government and unions and employers (Mavrogordatos, 1988). Although Mavrogordatos and Lavdas, who have both studied the relationship between the state and various interest groups in the Greek context, describe this relationship either as state corporatism (Mavrogordatos) or as disjointed corporatism (Lavdas), to my understanding the study of the relationship between the state and ESAEA should be examined in the context of societal corporatism (Mavrogordatos, 1988). In what follows, I will discuss why I chose societal corporatism to explain and analyze the relationship between the state and the ESAEA.

As discussed in Parergon (pp. 284-289), the “big boost” to the formation of the disability movement was the change of the country’s political landscape in the 1980s, when the socialist party of PASOK succeeded the conservative party of ND in power (Y. Vardakastanis, interview, September 6, 2016). It was at that time that the socialist party of PASOK gave

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32 Mavrogordatos (1988) have studied the relationship between the state and unions such as the General Confederation of Greek Workers, The Hellenic Confederation of Professionals, Craftsmen & Merchants, Panhellenic Confederation of Unions of Agricultural Cooperatives, while Lavdas (2005) has studied the relationship between the state and the Hellenic Federation of Enterprises.
room to marginalized social groups, such as persons with disabilities, for demanding and claiming their own rights. Also, regarding the formation of the umbrella organization for representing persons with disabilities in the dialogues taking place on the Greek political scene, Vardakastanis argues that it was done because of the need of “self-organization,” “self-motivation,” “emancipation,” and “self-representation” of persons with disabilities to gain a strong voice and represent persons with disabilities in the negotiations with the governmental authorities (ibid.). As he further adds, persons with disabilities gradually started to have an active role in the political and social context of the country by being placed in positions of responsibility (ibid.).

The emphasis, however, on the “self”-oriented establishment of the confederation of persons with disabilities, together with the placement of persons with disabilities in positions of responsibility fit with what Mavrogordatos describes as societal corporatism (Mavrogordatos, 1988) and mark an attempt by the state to create networks with the disability movement. Also, considering the exclusion of the disability movement in the negotiations for the enactment of the disability classification that was discussed in Chapter 3, the synergy attempted by the ESAEA and the state for facing the problem of “disability fraud” should be explained under the context of societal corporatism.

4.2.2 The findings from the scandal with the alleged “fake disabled” and the announcement for the development of the “disability card” classification system

At the end of October of 1995, on the front page of Ta Nea, were the headlines “Jobbery of 1 Billion With Fake Disabled” (Ta Nea, October 24, 1995a) and “Seizure of 280 Records For Fake Disabled” (Ta Nea, October 25, 1995a), referring to initial results of the investigation mentioned above. Ntelezos reports that the investigation revealed a group of senior officers, from the prefecture of West Attica and the Post Office of Aigaleo, who “cheated” the state for five years and had already gained 1 billion drachmas (approximately 3 million euros) (Ta Nea, October 24, 1995b, October 25, 1995b). Specifically, the group created a system aimed at the welfare disability allowance for paraplegics and quadriplegics (Ta Nea, October 24, 1995b). The journalist also offers a description of how that system operated (Ta Nea, October 25, 1995b). According to the journalist, prefectural health committees of West Attica produced for a fee forged disability certifications that were then approved by the Directorate of Welfare at the prefecture of
West Attica. The post office in Aigaleo was responsible for collecting the disability allowances, which it then distributed to the members of the group (*Ta Nea*, October 24, 1995b, October 25, 1995b).

The political leadership of the Ministry of Health and Welfare, in order to offer a solution to the problems already described, proposed the development of a new disability classification system, which aimed at integrating the former systems as well as introducing the institution of the disability card, a name that was also used for referring to the new system. The idea of the disability card did not come from nowhere; rather, its roots go back to 1990.

More specifically, in 1990, the ESAAEA, after its establishment in 1989, organized its first conference. According to the structure of the ESAAEA, the “main tool” of the confederation for deciding what issues concern persons with disabilities is the Panhellenic Conference of the Representatives of the Federation and Organization of the ESAAEA (*Disability Issues*, 2005, pp. 11–13). Thus, during the conference, representatives of persons with disabilities jointly decide about issues that concern them (ibid.). During the first conference of the ESAAEA, the Board of ESAAEA proposed the establishment of the disability card. But what was the meaning of *disability card* for persons with disabilities, and why it was a point of concern for them?

In the interview I conducted with Vardakastanis, who has been the chairman of ESAAEA since 1993 and was on the board when the disability card was proposed, he claims:

> When we proposed it, we did not know exactly what it [disability card] would be. We said, “We want a disability card.” In general terms, we had a picture of what we wanted. But what was the meaning of the disability card...and how should it be established; the procedure that should be followed; the necessary legislation that should be enacted in order to operate it; if someone says today, twenty-four years later, that we knew, they are not telling the truth.

(Y. Vardakastanis, interview, September 4, 2015)

But, as Vardakastanis further argues, “We did not know, but we, the ESAAEA, passionately defended it. And because of this passion, we enacted it with Law 2430/1996” (ibid.).

Although during the conference proceedings the members of the disability movement did not have a clear image of what the purpose of the disability card was, Vardakastanis offers a later interpretation of what the disability
card means or meant for persons with disabilities. According to him, the purpose of the disability card was to help persons with disabilities with their transactions with the public sector (ibid.). Disability claimants, instead of having several disability certificates with them, would be able to use the disability card as identification, or an ID, for applying for various disability allowances, either in cash or in kind (ibid.). But, as Vardakastanis stresses, in order to have the disability card, it was necessary to have a single system for assessing and certifying disability (ibid.)

4.3 From a proposal to the enactment of the disability card classification system

The previous sections discussed the reasons there was a need for a change to the system(s) for awarding disability allowances, presenting the voices of different actors who had a say in or an experience of the implementation of the former system(s). Also, we saw how the disability movement, on its own initiative, began to be involved in the process for the configuration of the new and more integrated system for awarding disability allowances. This section focuses on how all these negotiations and debates led to the enactment of the material components of the disability card classification system. To that end, I adopted the theoretical/methodological themes of material and texture and practical politics, as proposed by Bowker and Star (1999), as the tools to help me to shed light on the material components of the disability card classification scheme.

In the summer of 1996, the Law 2430 regarding disability issues was enacted (Government Gazette, 1996). Through this law, the 3rd of December was established as the day for persons with disabilities (ibid., p. 2879). As for the disability classification system, Article 4 enacts the institution of the disability card (ibid., pp. 2879–2880). Particularly, according to the Law 2430/1996, it “established a lifelong or temporary disability card, depending on the disability degree” (ibid., p. 2879, my translation). In addition, based on a presidential decree that would be enacted in a period of four months after the enactment of 2430/1996, a single disability classification system would be enacted (ibid., p. 2880).

4.3.1 The practical politics in the enactment of the disability card classification scheme

According to the Law 2430/1996 and the Ministry of Health and Welfare’s announcement, the components of the disability card classification system would be enacted after the publication of a presidential decree (Government...
Gazette, 1996; To Vima, December 10, 1995). While in the development of the disability classification system that was discussed in Chapter 3 we saw that the system was formed after an announcement and invitation to social dialogue by the governmental authorities, in the disability card attempt there was no announcement or invitation to social dialogue between social groups that had an interest in the disability classification system.

Despite the fact that there was not any official announcement for a social dialogue, representatives of the ESAEA had a strong voice during the development period of this system compared to that of the former. The reason for this shift lies in the enactment of the Law 2430/1996. To be more specific, because of the Law 2430/1996, ESAEA had been recognized as a social partner by the Greek state; thus, as Vardakastanis claims, ESAEA has actively participated in social dialogues concerning disability issues since 1996. He further notes that the ESAEA is perhaps “one of the most powerful European confederations in the context of participation in institutional social dialogues” (Y. Vardakastanis, interview, September 4, 2015).

The development of the new disability classification system was under the responsibility of the Ministry of Health and Welfare, and although there was no invitation to social dialogue, according to the data, three social groups participated in the development of this system. These three social groups were (i) the political leadership of the Ministry of Health and Welfare; (ii) the policy makers from the Ministry of Health and Welfare, who were responsible for the enactment of disability card classification system; and (iii) representatives of the disability movement, according to Article 4, paragraph 1 from the Law 2430/1996 (Government Gazette, 1996).

Examining thoroughly the key actors who participated in this attempt, there is a common element that connects them. Specifically, in the first social group, the key actor was Panagiotis Kouroumblis, who was the general secretary of welfare, the former chairman of the ESAEA, and is blind. In the second social group, the policy makers that participated in the designing of the system were Stratis Hatziharalabous (interview, June 14, 2015) and Gerasimos Polis (personal communication February 10, 2016), both of whom worked at the Ministry of Health and Welfare; Hatziharalabous has a visual impairment, and Polis is paraplegic. Lastly, representatives of the disability movement constitute the third social group. Thus, the common element is that all the key actors were persons with disabilities themselves.

A comment should be added here regarding the actors of the first and second social groups. Kouroumblis’s identity was as half politician and
half person with disabilities, just as Hatziharalabous’s and Polis’s were as half policy makers and half persons with disabilities. In other words, the key actors in this attempt were hybrid actors (Latour, 1993). By hybrid actors, I mean that none of the above actors was solely a politician or a policy maker. Instead, they also had a second role, that of persons with disabilities themselves and members of the disability movement.

Comparing the development of this system with the system that was discussed in Chapter 3, there was a shift regarding the empowerment of the disability movement: whereas in the attempt to develop a disability classification system for saving social security funds persons with disabilities were ignored and excluded, in the disability card attempt, the disability movement had a decisive and vigorous voice in claiming the rights and needs of persons with disabilities because they were represented by different subject positions. The change in the political context, with the socialist party of PASOK in power instead of the conservative party of ND, was also an essential factor for the involvement of persons with disabilities in the policy-making.33

However, the role of Panagiotis Kouroumblis was considerable. Specifically, Kouroumblis was the first chairman of the ESAEA from 1990 to 1993, and he was the general secretary of welfare in the Ministry of Health and Welfare from 1993 to 1996.34 In the Greek political context, the position of the general secretary is a political position that is under the minister(s) or deputy minister(s) in each ministry. In other words, Kouroumblis’s placement in the aforementioned political position is associated with societal corporatism. Following Mavrogordatos (1988), the placement of a former chairman of a union or interested group into a political position is one of the characteristics of societal corporatism, and this placement has something to say about the influence of this interested group to the society. Back in Kouroumblis’s case, he was the former chairman of the ESAEA, he was member of PASOK, and he was appointed as the general secretary of welfare, a position that is not irrelevant to disability issues, since the aim of the welfare state is to support its

33 As discussed in Parergon (pp. 284-286), the socialist party of PASOK, since the 1980s, has been an ally to the disability movement, among other marginalized social groups, by giving them voice to claim their rights as well as by enacting several selective policies for persons with disabilities.

34 For more information regarding the role of Kouroumblis both for the development of the disability movement in Greece as well as his political positions and work see: http://www.kouroumplis.gr/biography/view/, retrieved June 16, 2016.
citizens and especially those social groups that are powerless compared to other social groups. So the adoption of the disability card, which was a request from the disability movement, did not seem like a coincidence; rather, it was associated with Kouroumblis’s political position.

4.3.2 The power of numbers in government’s rhetoric for the need of a new system for assessing disability

In 1997, a year after the announcement of the disability card attempt, daily newspapers devoted pages to presenting and discussing the development of the new disability classification system, and particularly to the government’s rhetoric regarding the need for such. Newspaper journalists, using headlines such as “Cuts to Disability Pensions,” “Crosscheck for ‘Fake’ Disability Pensions,” “Disability Pensions Under Scrutiny,” “Rechecked Disability Pensions,” and “Cards Only for Those Who Are Really Disabled,” associated the new disability classification system with fraud (Eleftheros Typos, May 23, 1997; I Kathimerini, May 23, 1997; Ta Nea, May 23, 1997, May 28, 1997; To Vima, May 25, 1997). Based on the content of the above articles, the government’s aim was to control the number of disability pension beneficiaries.

According to the newspaper coverage, this “initiative” was not solely linked to the government; rather, the International Monetary Fund (IMF), in its annual report on the Greek economy, requested a rechecking of the number of disability pension beneficiaries and of the amount of money the state spent for this purpose (To Vima, 25 May 1997). The IMF does publish reports on the national economies of its member states and proceeds with suggestions and recommendations for the course of their national economies, but according to the IMF “Annual report of the executive board for the financial year ended April 30, 1997,” in the section for Greece, there was no specific reference to disability pension beneficiaries, as the newspaper reported (IMF, 1997).

They [the IMF] welcomed the policy package announced in July 1996, which envisioned reductions in public employment, a review of extrabudgetary accounts, and a strengthening of financial control of public entities. Directors urged the authorities to enact further corrective measures promptly, especially on the expenditure side. ...They welcomed the authorities’ agenda for structural reform, which included rationalization of public spending, strengthened management of public entities, increased
Moreover, in the government’s rhetoric for the need for a stricter disability classification system, there was no reference to a specific disability percentage of disability pension beneficiaries, as by the ND government as discussed in Chapter 3; rather, there was a reference to the number of beneficiaries, which in 1995 was 436,000 (*Ta Nea*, May 23, 1997). As the deputy minister of finance claimed regarding the new disability classification system, “We need a transparent and reliable system, which would avoid any deception. The social policy concerns persons in need. It is not exercised through devastating benefits” (as quoted in *Ta Nea*, May 23, 1997, my translation). For the representatives of the Ministry of Health and Welfare, the implementation of the new system for awarding disability allowances aimed to control the “chaotic situation” of social welfare (*Ta Nea*, May 28, 1997).

Similarly, in 1998, while the disability card classification was still under development, the representatives of the Ministry of Health and Welfare proceeded with new announcements regarding the upcoming reform of the system for awarding disability benefits. They stressed the number of disability beneficiaries, claiming that in 1995 there were almost 92,000 disability beneficiaries receiving approximately 49 billion drachmas (about 140 million euros) from the state for disability benefits (*Eleftherotypia*, September 2, 1998). To the political leadership of the Ministry of Health and Welfare, that number of disability-allowance beneficiaries was misleading, as it was impossible that one fifth of the citizens in some prefectures of the country were disabled (ibid.). Thus, the development of this system belonged to a “series of measures” that the government took in order to “help” citizens in need and, on the other hand, to control those who “cheated” the state (*Ta Nea*, September 2, 1998) by requesting the existing disability beneficiaries to be reassessed in order to be granted a disability card (*To Vima*, September 6, 1998).

As noticed in the governmental authorities’ rhetoric, there is an emphasis on the number of disability beneficiaries rather than on statistics, as had been the case in the system discussed in Chapter 3, as well as on the reassessment of the existing disability beneficiaries for finding those beneficiaries who were “fake,” referring indirectly to the continuous debate in Greek society regarding the alleged fake disabled. Considering that the
The purpose of the disability classification systems is to support persons with disabilities or citizens who have diminished work capacity, the emphasis here on how the new system would “arrest” those disability beneficiaries who “cheated” the state offers room to challenge the government authorities’ rhetoric and to ask What work do disability classification systems do (cf. Bowker & Star, 1999).

A second point that I would like to make concerns the use of the number of disability beneficiaries for stressing the need for a new system for awarding disability allowances. The governmental authorities relied upon the power of numbers to persuade the public opinion about their political choice to reform the system for awarding disability allowances. In other words, the use of disability beneficiaries rates worked as a mechanism which offered the governmental authorities “the legitimacy for [proceeding with] administrative actions,” and through them disability claimants were “made governable” (Porter, 1993, p. 96) since the aim of the system was also to reassess and control which of the disability claimants were “fake.” Although the high number of disability beneficiaries was a core argument in the government’s rhetoric, Christos Nastas, who is the general secretary of ESAEA, challenges the government’s argument. To be more specific, in 2015, when I conducted the interview with Nastas, he claimed that the Greek state has never carried out any official statistical survey or measurement to know how many people with disabilities live in Greece or what type of disability allowances they have received (C. Nastas, interview, January 14, 2015). So what emerges here concerns the origins of the aforementioned number of disability beneficiaries. I will return later in this thesis to the origins of these “numbers,” or “disability statistics,” that the Greek politicians referred to.

4.3.3 Reconstructing the material components of the disability card classification system

After a period of three years (1996–1998), instead of the initially planned 4 months (S. Hatziharalabous, interview, June 14, 2015; To Vima, December 10, 1995), the new system was almost fully developed. In spring 1998, the presidential decree was submitted to the Council of State to be approved, and a few weeks later it was enacted as Presidential Decree 210/1998 (Government Gazette, 1998). Through the decree, the two components of the new disability classification system were set. According to 210/1998, these components were (i) the establishment of special health committees as responsible for the disability assessment of claim-
The aim was to establish specialized health committees that certify disability. ... Through the issuance of a timeless certificate, a person with disabilities would be able to use it without needing to be reassessed every time they need it, especially for disabilities that are permanent.

(P. Kouroumblis, interview, June 10, 2015)

The development of the disability card did not come out of nothing; rather, it was inspired by the existing disability classification system, with the introduction and improvement of some components. The following subsections, explore more analytically the two material components of the disability card classification system—that is, the establishment of the special health committees and the disability card.

4.3.3.1 Establishing the special health committees
The first component of this scheme was the establishment of the “special health committees” as the main authority responsible for the disability assessment of applicants. The establishment of special health committees for disability assessment was an essential issue during the negotiations for the development of the system discussed in Chapter 3; however, the new special health committees were not the same as the Special Physicians’ Body of Health Committees of IKA. To be eligible to staff the new health committees, a physician had to be employed by the National Healthcare System (ESY). Also, according to Article 2 of Presidential Decree 210/1998, the medical committees were established in each ESY hospital, annually and after a proposal by the hospitals’ scientific committees (Government Gazette, 1998).

The health committees would consist of three physicians who would belong to all levels and medical specializations of the ESY, plus their alternates. In addition, the above committees were divided into primary and secondary health committees. Primary health committees would be established in the ESY hospitals, and when a hospital had more than 400 inpatient beds, then two or more health committees could be created (ibid.). Secondary health committees would be established only at the district headquarters hospitals, and only heads of departments or senior registrars could participate, with priority to be given to the heads of departments.
Also, there would be three different types of health committee—surgical, pathological, and psychiatric—to assess applicants based on their applications (S. Hatziharalabous, interview, June 14, 2015). After the 2001 enactment of Ministerial Decision, Issue no P3a/F80/oik.907, there was a detailed description of the role of the health committees and of which cases or medical incidents belonged to each committee (Government Gazette, 2001). The members of the medical committees could request and receive support from specialized physicians during the disability assessment (Government Gazette, 1998).

Health committees would be responsible for assessing and providing the applicants with a medical report. Starting with a physical examination and/or taking into consideration more documents, such as medical records, lab tests, and diagnostic tests, which applicants would have submitted in advance, the members of the health committees would translate the bodily condition to a disability percentage. In other words, disability claimants would be “treated by professionals with medical training” in being classified as eligible or ineligible for having access to the welfare state and specifically for being granted disability allowances or benefits (Llewellyn & Hogan, 2000, p. 158).

Although there was reference to a disability rate that health committees would attribute to persons with disabilities, there was no reference to the establishment of a new disability percentage table during the development of this disability classification system. As Hatziharalabous notes, the KEVA was adopted by the disability card classification system (S. Hatziharalabous, interview, June 14, 2015) after the enactment of the Joint Ministerial Decision, Issue no G4g/F80/oik.314 (Government Gazette, 1999). Also, Hatziharalabous states that the disability percentage table that appeared in Article 22 of the Law 1813/1988 and was in use by the prefectural health committees would be abolished (ibid.). Regarding the KEVA and its adoption by the disability card system, Thodoris Kotsonis, Deputy Minister of Health and Welfare, points out that:

The use of the KEVA by the new health committees, as constituted by the Presidential Decree 210/1998, would help the members of the health committees to perform a more objective

35 For more information about the KEVA, see Chapter 3.

36 For a relevant discussion regarding the ‘objective’ role of the systems for assessing and certifying disability, and the use of positivistic terms to associate the development and operation of the disability classification(s), also, see, Chapter 3, pp. 96-98.
disability assessment and to document their views based on recent and valid scientific data.

(Ministry of Health and Welfare, 2000)

After the disability assessment procedure, the members of the health committees would provide applicants with a report. According to Article 2 of Presidential Decree 210/1998 and Article 23 of the Law 2556/1997, the report should describe in detail:

i) the illness or disorder,
ii) the type of disability,
iii) the disability percentage,
iv) whether the disability was permanent or temporary, and
v) if it was temporary, the date of expiration

(Government Gazette, 1997, 1998)

Then the medical report that applicants received would be used as a certificate (Government Gazette, 1998, p. 2696). The report would have a reference number, and it would be issued in three copies signed by the hospital director (ibid., p. 2696).

Persons with disabilities who disagreed with the disability percentage that was attributed to them would have the right to object within a period of fifteen days after receiving the certification from the primary health committee (ibid., p. 2697). The welfare directorate in prefectural administrations would also have the right to object (ibid.). According to Article 2, Presidential Decree 210/1998, in cases of objection, secondary health committees were responsible for reassessing the applicants, whereupon the decision was definitive (ibid.). Then persons with disabilities, having in hand their medical certification, would visit the local welfare directorate in the prefectural administrations to which they were registered to receive their disability cards.

Lastly, considering the increased responsibilities of health committees as well as the need for keeping records of disability certifications and decisions, policy makers proposed one more element that could improve the smooth operation of health committees. This element was the establishment of the “special secretaries” in each hospital institution. According to Hatziharalabous, the role of the special secretaries was to support the work of the health committees (S. Hatziharalabous, interview, June 14, 2015), and the chairman of the administrative board of each hospital was responsible for establishing these secretariats by staffing them with the

The above description of the first material component of the disability card classification system reveals the adoption of the medical approach to disability. The establishment of health committees as the main authority for disability assessment and the choice of hospitals as the location where the disability assessment should take place were crucial factors for the new system of awarding disability. Taking together the role of health committees, their categorization into surgical, pathological, and psychiatric, and the choice to make hospitals the site for all disability assessment, what can be observed is that disability, with regard to compensation and access to welfare state, is approached as a “condition which needs…” ‘treatment’” (Llewellyn & Hogan, 2000, p. 158). Following Bowker and Star’s (1999) arguments regarding the symbolic role of classification schemes and Drake’s (1999, p. 35) statement regarding the way governments express their “ideologies, values, and beliefs” about “the understanding of disability” through the design of disability/social policies, the enactment of the disability card classification system symbolizes, as well, the way the socialist party of PASOK conceptualized disability issues through the lens of the medical approach to disability.

4.3.3.2 The disability card as the second component of the new classification system

The second component of the disability card classification system concerned the type of disability card. As mentioned, since 1992 representatives from disability movement had been asking for a disability card. To the chairman of ESAEA, a disability card should be used by persons with disabilities like an ID card (Y. Vardakastanis, interview, September 4, 2015). Instead of being continuously reassessed either by the health committees of the social security funds or by the prefectural health committees and submitting different types of documents and certifications, the disability card could be used as a unique ID for all transactions with the state (ibid.).

Seven years after the ESAEA’s proposal, the disability card was established. According to Article 3 of Presidential Decree 210/1998, two types of disability card could be awarded to persons with disabilities: either a gray temporary disability card or an orange permanent disability card (Government Gazette, 1998). People with disabilities would be entitled to receive a disability card only if their disability was more than 67% based on the certificate they received from the health committees (ibid.; see, also: ANTONIA PAVLI  Creative disability classification systems  137
According to Ministerial Decision, issue no P3a/F80/OIK.907/2001, an applicant with more than two disabilities would also be able to apply, but only two of the disabilities could be calculated (counted) for the final disability percentage (Government Gazette, 2001).

The calculation of the disability percentage would be based on the following algorithm:

\[
\begin{align*}
\text{a.} & \quad \frac{(B+5) \times (100-A)}{100} = (B\%) \\
\text{b.} & \quad (A\%) + (B\%) = \text{multiple disability percentage}^{37}
\end{align*}
\]

where A and B are the bodily conditions or disability in decreasing order. That is, disability A is the main disability, or the one with the higher percentage, and disability B is the second disability, or the one with the lower disability percentage. The final disability percentages sum is divided by 5. In cases where the disability percentage is different, then it should be increased to the next multiple of five (ibid., p. 5330). In other words, the above algorithm would have the power to translate the “input data,” that is, the combination of the disability percentages for disabilities A and B, into “the desired outcome”—the disability percentage for disability B (Gillesspie, 2011, p. 167). Then, on the basis of this procedure, physicians would attribute a total disability percentage to claimants, or in other words, the operation of the above algorithm enacts disability as an object of governance (Porter, 1993).

At this point, given the above references to the algorithm for the calculation of multiple disabilities and the disability percentage of the 67% as the “key disability percentage” for a disability claimant’s being granted a disability card (Government Gazette, 1998) and having access to the welfare state (I Kathimerini, September 2, 1998; To Vima, September 6, 1998), it is worth noting how the governmental authorities relied upon the quantification of disability as a technique to govern disability beneficiaries (Rose, 1999). Either through the procedure of encoding (Admon-Rick, 2014; see

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37 In line with the above algorithm, the calculation of a multiple disability percentage would concern only two disabilities. In cases of more than two disabilities, it was possible to note the extra disability(ies) on the medical certificate without adding it into the final disability percentage (Government Gazette, 2001).
also: Chapter 3, pp.), where the bodily condition is translated into a numerical figure, or through a specific algorithm for the calculation of multiple disabilities, or through the choice of a specific disability percentage (67%) required to access to the welfare state, we saw in all the above cases how the use of numbers or the quantification of disability “have become indispensable to the complex technologies through which government is exercised” (Rose, 1999, p. 199).

Lastly, the Ministerial Decision, Issue no P3a/F80/OIK.907/2001, also offers a detailed description of the characteristics of the disability card, from dimensions and instructions on how to fill in the relevant information (e.g., all the information should be written in capital letters) to specific characteristic concerning the authenticity of the card (e.g., the emblem of Greece on the back view of the card) (ibid., p. 5335).

### 4.4. Testing the system: The case of Larisa

After the enactment of the presidential decree with the components of the disability classification system, the government and particularly the Ministry of Health and Welfare announced that the new system for disability assessment would initially operate as a pilot project in the prefecture of Larisa. Hatziharalabous notes that the choice of Larisa was based on two factors: first, Larisa prefecture is a “middle-sized prefecture” of Greece, and second, Larisa had both “rural and urban development” (S. Hatziharalabous, interview, June 14, 2015). In 2000, the new disability classification system began operating in Larisa. Though the system was supposed to run for six months, it ran until 2002 (ibid.). Larisa prefecture, however, continued to use the system until approximately 2011 (ibid.). As Hatziharalabous jokingly puts it, “Larisa has had its own disability classification system, and the rest of Greece another” (ibid.). Also, Vardakastanis mentions that there have been some 8500 people with disabilities from the Larisa prefecture who have received a certification that says “disability card” (Y. Vardakastanis, interview, September 4, 2015).

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38 Appendix V contains an illustration of how the disability card would look based on the details that appeared in Ministerial Decision, Issue No 3a/F80/oik.907/2001. The illustration depicts the temporary disability card, which would be gray. However, the only difference between the temporary and permanent disability cards concerns their color, with the temporary one issued in gray and the permanent one issued in orange. All the other details would be the same.
In the fall of 2001, one year after the implementation of disability card in Larisa, representatives of the Ministry of Health and Welfare presented the first feedback from the operation of the new system. According to Deputy Minister of Health and Welfare Dimitris Thanos, the pilot run showed that 10% of disability beneficiaries in Larisa prefecture were “faked disabled” (To Vima, September 20, 2001). Also, he further argued that “we estimate that 10% of the total population who declares themselves disabled are not [disabled]” (as quoted in: To Vima, September 20, 2001, my translation).

For the representatives of the government, the results of the pilot run were used to enhance their rhetoric that many citizens received disability allowances and benefits without meeting the eligibility criteria (ibid.; Rizo-spastis, September 20, 2001). On the other hand, for the policy makers who had developed the system, the pilot run revealed the weaknesses of the system and what should be done to improve it.

4.4.1 Evaluating the nonimplementation of the disability card

In the previous section, we saw that the disability card classification system was tested as a pilot project in the prefecture of Larisa. Although the system was not further implemented, the actors who had been involved in the development process had the opportunity to collect useful information regarding the system’s weaknesses because of the pilot project. Since this section seeks to discuss the reasons that the disability card was not implemented, its purpose is similar to the first section of this chapter, which examined the reasons that there was a need for the revision of the existing disability classification system(s). Thus, while at the beginning of this Chapter I used the theoretical/methodological theme of indeterminacy of the Past to give voice to the relevant actors and users to evaluate the existing practice for the assessment and certification of disability, in this section I will use the same theme, this time for giving voice to the actors involved in the development process so as to evaluate why the system did not operate well.

Beginning with Hatziharalabous, the policy maker who designed the system he says that the main weakness of the system concerned the number of health committees that were supposed to operate in each hospital (S. Hatziharalabous, interview, June 14, 2015). In his view, instead of having three medical committees for assessing disability beneficiaries, one or two would be enough (ibid.). As he explains:

Instead of having one health committee in each prefecture, we would have one to three in each hospital. If you consider that
there were 127 hospitals and that each would have up to three health committees, then it means that, finally, you would have more than 300 [health committees]. On the one hand, this practice would share the applicants, separate them based on the relevant specialization, and reduce the high number of applicants [on waiting lists]. On the other hand, indeed in Larisa, this system did not work. It was only one hospital. But if we implemented this system in other prefectures, such as Thessaloniki, where there are ten hospitals, or in Athens, where there are 30 hospitals, the system would operate much better.

(S. Hatziharalabous, interview, June 14, 2015)

The basic idea of the system was to use hospitals as the place where the disability assessment procedure would be done. However, this choice would affect the smooth operation of the hospitals, particularly the outpatient clinics. Since the physicians who would participate in the health committees for the disability assessment would also be physicians at these hospitals and would work in the hospitals’ outpatient clinics, it would almost certainly have an impact on the operation of the outpatient clinics (ibid.).

Vardakastanis, on the other hand, claims that the weakness of the aforementioned system was that the holders of the disability card would have difficulties using it for services and institutions beyond those belonging to the Ministry of Health and Welfare (Y. Vardakastanis, interview, September 4, 2015). To give an example, he states that if a person with disabilities from the prefecture of Larisa wanted to use the disability card in transactions with the customs or tax office, the card would not be accepted (ibid.). Vardakastanis’s example reveals the lack of communication between ministries or between departments or institutes in the same ministry.

As political scientists Nikos Hlepas and Panagiotis Getimis (2010) point out, because of the existence of the clientelistic state, it “offered enough space to sectoral interests that promoted an ongoing fragmentation of political and administrative structures along the lines of specific sectors and functions” (ibid., p. 411). As we can see, similar to the operation of the welfare state, the key future of the public administration was its fragmentation; a fragmentation which, to Hlepas and Getimis, was translated as an obstacle both to the smooth operation of the public administration and to the collaboration between “different sectoral policies” (ibid., p. 413).

Taking into consideration all these weaknesses that the new system faced during the pilot run until 2002, Hatziharalabous argues that the next step was to contextualize them into a new presidential decree (S.
Hatziharalabous, interview, June 14, 2015). But, he further states, the presidential decree should be ready and enacted two years later because of legal issues (ibid.). Further, Vardakastanis claims that in order for the disability card to have authority, then five to seven relevant ministries should enact a joint legislation through which the specific characteristics of the card as well as the ways it could be used would be defined (Y. Vardakastanis, interview, September 4, 2015).

To sum up, in this section we heard from two voices using terms from different vocabularies to evaluate the nonimplementation of the disability card classification system. The first voice belongs to the policy maker Hatziharalabous, who had the responsibility for designing the classification system. Hatziharalabous adopted a more, let us say, technical vocabulary to evaluate the weakness of the system (e.g., the number of health committees, the choice of hospitals as the site for the disability assessment procedure, and the consequences of that choice on the smooth operation of outpatient clinics). The second voice belongs to the chairman of the ESAEA, who evaluates the nonimplementation of the system using terms that belong to a political vocabulary. Though, he referred in his example to the award of the disability card, which is a technical element of the disability card classification system, his evaluation pinpoints structural weaknesses in the state’s operation, specifically in the state’s bureaucracy.

In March 2004, there were parliamentary elections. The conservative party of ND succeeded PASOK in power and decided to not implement the disability card as the new disability classification system. Instead, the political leadership of the Ministry of Health and Social Solidarity, as it was renamed in this period, announced its intention to adopt and adapt WHO’s International Classification of Functioning, Disability and Health (ICF), which will be discussed in the following chapter.

4.5 Conclusion
Chapter 4 discussed the development of the disability card classification system—an attempt that lasted almost ten years, from 1995 to 2003, with the socialist party of PASOK in power all those years. In the end, the disability card classification scheme was not implemented. Comparing the development processes of the systems described in Chapter 3 and in this chapter, both systems followed a similar procedure. However, in the disability card attempt, new elements were noticed. The empowerment of the disability movement and its involvement in the procedure of designing the
systems as well as the pilot stage for testing the system constituted some of the innovative characteristics in this attempt.

As I pointed out at the beginning of this chapter, for the reconstructions of the Disability card classification system, I adopted the theoretical/methodological themes of *indeterminacy of the Past*, *material and texture*, and *practical politics*. The purpose of adopting these themes was to shed light on the “political…and social choices” made in the enactment of the disability classification system before it was transformed into a black box (Star & Bowker, 2010). In the following paragraphs, I will thus make some critical reflections on some points that have been discussed throughout this chapter.

After applying the *indeterminacy of the Past* theme, we saw how different ‘voices’ that have an interest in the operation of the disability classification system proceeded with their own evaluation for the latter. On the one hand, we saw how policy makers, politicians, and employees of the Ministry of Health and Welfare as well as in the municipalities evaluated the previous disability classification system(s), by using terms which come from the social policy vocabulary. For example, the informants stressed the issue of fragmentation of the disability classification systems as well as the systems’ vulnerability to clientelistic relations among the members who participated in their operations.

In the same discussion, we saw the views of persons with disabilities, as the users of the system, and their evaluation based on their experiences as the “objects” of disability assessment. They used a different vocabulary or terminology: that of *personal experience* and what it means for them to be assessed. Bowker and Star (1999, p. 6) argue that “for any individual, group, or situation, classification and standards give advantage or they give suffering”; indeed, the operation of a disability classification scheme “gives advantage” to persons with disabilities when they are granted disability allowances, but it simultaneously “gives suffering” in terms of the frequency of disability assessments and the consequences of that frequency on persons with disabilities. I want to stress two things here. First, beyond the knowledge of policy makers, politicians, and scientists concerning how a disability classification system should be developed and implemented, there is also hidden knowledge, or an *expertise* (e.g., Thill, 2015; see also, Galis, 2011), the comes from the disability claimants, and that knowledge and expertise should also be taken into consideration in the policy-making. Second, the experiences of persons with disabilities—how they feel during the
disability assessment as well as what it means to be assessed—allow us to problematize about the consequences of the classification schemes to them.

Another point I would like to discuss here concerns the role of the disability movement and its involvement in the development of the disability card classification system. Unlike the system described in Chapter 3, in the disability card attempt there was a remarkable shift regarding the role of the disability movement in the policy-making. The enactment of the legislation in which ESAEA is recognized as a social partner by the Greek state and the input of persons with disabilities themselves to the development of a system for assessing and certifying disability signify one of the first and essential moments in the involvement of the disability movement in policy-making and in the socio-political context of the country.

Following Marx and McAdam (1994), the disability movement in the mid-1990s should be assessed as a successful movement because it gained a strong voice in policy-making by enacting new legislation through which the disability movement was recognized as a social partner of the state. Also, after applying the theme of practical politics to explore how the disability card classification system developed, what emerges is the hybrid role of the key participants. Having a double identity as persons with disabilities and as members of the Greek disability movement or as a politician (the general secretary of welfare) or as policy makers, their very participation signifies a change in the “public opinion and behavior” towards persons with disabilities (ibid).

Moving to the material and texture theme, we saw earlier that the disability card classification scheme was a composition of different material components. Bowker and Star (1999) state that a classification system is a composition of physical entities and conventional arrangements. In the case of the disability card, we saw that the health committees responsible for assessing disability claimants comprised one physical entity of the system; the choice of physicians as those with the authority to assess disability was a conventional arrangement made by the system developers, denoting that disability was conceptualized by the state as a disease where physicians could “cure” disability through their training. Further to this, the choice of hospitals as the site of disability assessment is another element that confirms the conceptualization of disability as a disease.

The choice of the numerical figure 67% is the second physical entity mentioned by the disability card classification system. Although the percentage of 67% is just a figure, it is, at the same time, a conventional arrangement made by the system developers and thus by the state for award-
ing access to the welfare state. By that, I mean that the percentage of 67% has the power to *create* the object of disability, since, for the system developers, the concept of disability, and how somebody would be classified as able or disabled, does not depend on the bodily or cognitive condition as such. Instead, it is the translation of the bodily and cognitive condition into a figure, specifically the translation to reach the limit of 67% in order to be classified and recognized by the state as disabled and thus eligible for welfare allowances.

The disability card, or the type of ID that would be awarded to disability claimants with a total disability of more than 67%, is a *physical entity* since it is a piece of paper or plastic. But the award of the disability card to disability claimants signifies that these claimants meet the criteria or standards set by the new system and that the claimants are therefore classified and recognized as persons with disabilities. In other words, though the disability card is a piece of paper or plastic, its award embeds several *conventions* and *choices* made by the developers. Also, I would like to add here that the award of the disability card is a convention between the state and the disability movement, since the idea of the disability card belonged to the disability movement, as noted earlier. Thus, the issuing of the disability card denotes the *synergy* between the state and the disability movement.

At the end of the previous paragraph, the choice of the word *synergy* was not accidental; rather, I chose this word to comment about the *synergy* between the disability movement and the state. Bowker and Star (1999) talk about the symbolic role of the classification scheme, and in the case of the classification system discussed in this chapter, what is noticed is the understanding of disability in the context of the medical model. On the other hand, Robert Drake (1999, p. 35) claims that enactments of disability policies are “concrete expressions of their ideologies, values, and beliefs, and each administration creates and promotes policies that resonate with its own particular understanding of disability.” So the development of the system for assessing and certifying disability as part of the state’s social policy represents how the socialist party of PASOK, which was in office, understood disability. But, earlier in this chapter we saw that the disability movement was involved in the policy-making, an element which is linked to the social approach to disability. What emerges here is a conflict in how the socialist government of PASOK understood or approached disability issues in the 1990s, which leads to the following question: How did the PASOK socialist government develop a social/disability policy based on the medical approach
to disability, while in terms of policy-making, it adopted elements from the social approach to disability?

To my interpretation, this shift regarding the participation of the disability movement in policy-making should not be explained within the context of the conceptual disability models. Instead, the political economic theory of corporatism, which is one of the characteristics of how the political context operates in Greece, can help explain the relationship between the PASOK government and the disability movement. The adoption of the medical approach to disability in the development of the disability card classification system and the participation of hybrid actors who belonged to the social group of persons with disabilities in the design of that system do not leave room to argue that the PASOK government made a shift by approaching disability issues from a social-model perspective. Further, following Mavrogordatos (1988), the placement of the former chairman of a confederation (ESAEA) to a political position as the General Secretary of Welfare is a characteristic that fits with societal corporatism. In other words, what emerged or became visible after the reconstruction of the disability card classification system is the participation of ESAEA in networks created by the state and for planning and implementing policy.

In 2004, after its pilot use in the prefecture of Larisa, the disability card system was almost ready to replace the previous disability classification system(s) (see Chapters 3 and 4). In March 2004, however, the conservative party of ND won the parliamentary elections in the country, and although the disability card classification system was almost ready to be implemented, the ND government cancelled it. The new government, specifically the political leadership of the Ministry of Health and Social Solidarity, announced their intention to develop a new disability classification system, which was the adoption of WHO’s *International Classification of Functioning Disability and Health* (ICF). According to the political leadership of the Ministry of Health and Social Solidarity, the aim of this new system was twofold: on the one hand, to provide persons with disabilities a card through which they would avoid the bureaucratic procedures and which would facilitate their transactions with the public sector (*Eleftheros Typos*, November 4, 2004; *I Kathimerini*, November 4, 2004), and on the other hand, to provide a tool to control the alleged “fake disabled” (*Eleftherotypia*, November 4, 2004). The procedure for the adoption and adjustment of the ICF into the Greek context lasted approximately four years in which many events, workshops, meetings, and so on, took place. However, after the translation of the ICF into the Greek language and its adjustment to the Greek context, the system was not implemented.

Chapter 8 deals with the design process for the adoption of the ICF disability classification system in Greece, which was the third attempt in a period of fifteen years. By reconstructing the ICF attempt, the aim is to shed light on the factors that made the previous system(s) inappropriate for further use, the role of the change on the political stage in the development of the new system, the role of the disability movement in the design process, the practices through which the ICF system was adjusted, the new notions that were introduced for the conceptualization of disability, and the reasons that the system was not implemented.

Chapter 8 consists of five sections. Similar to Chapters 3 and 4, for the structure of this Chapter I adopted the theoretical/methodological themes of *indeterminacy of the Past, material and texture*, and *practical politics* (Bowker & Star, 1999). The first section thus seeks to shed light on the initial discussion for the adoption of the ICF, or the functionality card project, as the ICF attempt was called, in Greek social policy. This section
seeks to show why the existing system(s) for awarding disability allowances (those discussed in Chapters 3 and at the beginning of Chapter 4) were not sufficient for further use and to investigate the new government’s rhetoric for the need to adopt the ICF. The second section explores the practical politics behind the development process of the ICF project, examining the role of the disability movement in the development procedure, how the political leadership of the Ministry of Health and Social Solidarity “advertise” the new disability classification system, and the role of system developers. The third section describes and analyzes the material components of the ICF project. The fourth section, on the other hand, focuses again on the practical politics during the development of the ICF, discussing the “disability–functionality” debate as well as the role of disability statistics. Since this project was not implemented, the fifth and final section seeks to shed light on the reasons or factors that prevented the ICF project from being the new disability classification system in the Greek social security and welfare system.

5.1 Evaluating the past with the knowledge of the present: Multiple actors evaluate the existing operation of the system(s) for assessing and certifying disability

Similar to what was done in Chapters 3 and 4, I will start the reconstruction of the adoption and adaptation of the ICF classification scheme in the Greek context by exploring the reasons behind the necessity for the enactment of a new system for assessing and certifying disability. Following Bowker and Star’s (1999) suggestion that our current knowledge operates as a tool to reevaluate events and situations of the past, this section seeks to shed light on how the actors who participated in the ICF attempt evaluated the existing conditions regarding the assessment and the certification of disability in the Greek social security system. To that end, I will adopt the theoretical/methodological theme of the indeterminacy of the Past proposed by Bowker and Star to present and discuss how the actors who participated in this attempt evaluated the existing disability assessment based on their knowledge, including what kind of vocabulary the actors in this attempt used to evaluate the existing system for assessing disability.

After an eleven-year period of PASOK being in office (1993–2004), ND won the parliamentary elections on March 7, 2004, and replaced PASOK in power. This shift on the political stage of the country brought changes in the operation of the state. The new government wanted to apply its
own political agenda during the period it was in office. One of the reforms, according to the deputy minister of health and social solidarity, Giorgos Konstantopoulos, concerned the field of social solidarity (as social welfare was renamed). Among other things, it aimed to reform the existing disability classification system(s) (Institute of Social Protection and Solidarity, 2007).

Stathis Triantafyllou, a psychologist and the coordinator of the ICF project in Greece, states, “In [spring] 2004 I received a call from the Ministry of Health and Social Solidarity to assist [the Ministry] on issues relevant to disability” (interview, May 27, 2015). As Triantafyllou notes, the new political leadership of the Ministry of Health and Social Solidarity wanted to reform the existing system(s) for awarding disability allowances (ibid.). Thus, the ministry, specifically the deputy minister of health and social solidarity, instructed Triantafyllou to explore the current situation regarding disability assessment (ibid.).

Following this communication with the deputy minister of health and social solidarity and until the fall of 2004, Triantafyllou’s mission -either by contacting with scientists or policy makers who had designed the previous system(s) or by observing how the disability card system operated in the prefecture of Larisa (see Chapter 4 for the relevant discussion)- was to prepare a file where he should describe the current state of the disability assessment procedure as well as to propose a new system for assessing and certifying disability (ibid.). According to Triantafyllou, the investigation revealed, first, the use of disability percentages to translate the bodily condition or disability to a percentage, and second, the lack of a welfare file for persons with disabilities. More specifically, Triantafyllou mentions that:

in Greece…we use the quantification system [Barema], which, to us, is somehow of little value. By that is meant that it [the system] attributes a disability percentage of how physically challenged you are, e.g., 40%. If you have a mental disorder, then you may add 15% to the scale, and so on. Our findings have shown us that the whole story in Greece [the system under discussion] creates a fictitious disability. In what sense? If, for instance, someone who is physically challenged is assessed with 45% or 50% of disability, then they will notice that they need an extra 17% of disability in order to reach 67%, which is the base at which benefits policy start in Greece…Well, the majority [of persons with disabilities], with the encouragement of medical society, have attempted to reach this percentage…Talking to physicians…from the Eginitio hospital and everywhere, they in-
formed us that many people visited them asking for depression or psychosis medical certificates. So, in this way, they reached the 67% of disability. In other words, it is a system that forces the person with disabilities to become more disabled.

(S. Triantafyllou, interview, May 27, 2015)

Triantafyllou questions the use of the quantification system for disability assessment, saying that it is a system that allows for the creation of “fictitious disability,” which, for him, “was and is the problem in Greece” rather than “disability fraud” (ibid.).

Regarding the welfare file he says:

A record did not exist, let’s say a welfare file, of the person with disabilities. In the sense that everyone went to the IKA committees of physicians, and they had a medical certificate from one physician who certified that the person was either physically challenged or had this [or that], and so on.

(ibid.)

At this point, before I continue with the evaluation of the system, it is worth commenting on the figure of 67% that Triantafyllou mentioned above as the key percentage for someone to be entitled to disability allowances. As discussed in Chapter 3, since 1990 a triple classification of disability had been introduced (implemented in 1991) based on the severity of disability. Specifically, disability was classified into (i) severe disability (80% to 100%), (ii) ordinary disability (67% to 79.99%), or (iii) partial disability (50% to 66.99%) (Government Gazette, 1990).

According to Kampouridis, a psychiatrist and member of the Special Physicians’ Body of Health Committees of the IKA, the fact that there are three categories does not mean that everyone classified under one of the categories will receive a disability allowance or pension (P. Kampouridis, interview, January 15, 2015). Apart from the insured of IKA, eligible for receiving disability pensions when classified in any of the above three categories (with different amounts of disability pensions), people—that is, the insured at other social security funds (such as OGA and TEVE) or those unemployed or indirectly insured and receiving support from welfare services—needed to be classified at more than 67% of disability in order to receive benefits (ibid.).

Back to Triantafyllou’s evaluation of the current state of disability assessment, he refers to the disability card classification system. He points
out that during the time that he spent to investigate the existing disability classification system(s), he went with Venetsanos Mavreas to Larisa to examine how the disability card classification system operated as a pilot project. As he states:

Before I took this project, they told us that there was a pilot project that ran in Larisa for issuing a disability card, and we went there to investigate it...This pilot project was nothing special, in the sense that they were four or five physicians, one secretary who did not have a computerized system, and outside there was a long queue of seventeen or twenty-five [disability claimants], and the assessment lasted...on average three to five minutes. Thus, the second issue, instead of the fictitious disability that persons with disabilities had to declare, was that the complete disability assessment was not a serious disability assessment.  
(S. Triantafyllou, interview, May 27, 2015)

Venetsanos Mavreas, a professor of psychiatry at the University of Ioannina and the scientific coordinator of the ICF project, after the observation that he made together with Triantafyllou regarding the pilot operation of the disability card in Larisa, underlines that the pilot operation was not something “innovative” (V. Mavreas, interview, May 28, 2015). To him,

The disability card was a pilot project that ran only in Larisa...[in the sense] that there could be a disability classification system, but without replacing the previous policy regarding the disability assessment. ...It was not an innovative issue in regards to the assessment; rather, it was a means to control the issue [disability assessment] administratively.

(ibid.)

Similarly to Triantafyllou, Mavreas criticizes the way that disability assessment was performed by stressing the administrative purpose that was embedded in it, rather than its scientific purpose.

Considering the essential role the disability movement played in the attempt described in Chapter 4, a question arises here whether the disability movement was involved in the evaluation process. Here, thus, the attention turns to the disability movement by giving voice to its representatives and examining whether they were involved in the evaluation process. Though someone might expect that the disability movement would have a say in the development of the new system for assessing disability, this did
not happen, according to the chairman of the ESAEA (Y. Vardakastanis, interview, September 4, 2015). However, I will further refer to the involvement or lack of involvement of the disability movement in the adaptation of the ICF in a while.

Summarizing, this section discussed why there was a need to revise the existing system for assessing and certifying disability by giving voice to different actors. The first voice comes from the representatives of the new government of ND, which wished to update the aforementioned system. Nevertheless, the government of ND, rather than evaluating the existing system themselves, chose a scientist to perform the evaluation on their behalf. Despite the fact that the political leadership of the Ministry of Health and Social Solidarity did not have a direct role in evaluating the system, the choice of a scientist instead of policy makers to perform the evaluation denotes the government’s preference for and reliance on scientific authority and prestige for producing an objective and scientific evaluation. The second voice comes from a scientist, that is, Triantafyllou, who was chosen to do the evaluation on behalf of the government. Triantafyllou retold the story of the existing system for assessing disability using terms that belong to a scientific-positivistic vocabulary—such as “quantification of disability,” “little value,” “lack of credibility and reliability,” and “lack of scientific status”—for challenging the operation of the system. In the same vein, Mavreas, who worked together with Triantafyllou, also challenges disability assessment procedure’s lack of scientific status. As for the third voice, that is, the disability movement, it remained silent during the evaluation procedure.

5.2 The practical politics behind the adaptation of the ICF

The prior section examined the reasons that the existing system for awarding disability allowances was inadequate for further use. As already stated by Triantafyllou, the deputy minister of health and social solidarity also assigned him to propose a new system for replacing the already existing one. Bowker and Star (1999, p. 44) claim that for the enactment of a classification scheme, events such as “negotiations, organizational processes, and conflict”, or what they call practical politics, also take place. This section thus focuses on what happens after Triantafyllou’s proposal by examining the practical politics behind its development.

Following the deputy minister’s request that he proposed a new system for assessing disability, Triantafyllou proposed the adoption of the ICF classification system as the most suitable to replace the former system(s)
(S. Triantafyllou, interview, May 27, 2015). Specifically, he explains his choice by saying that “[t]he ICF was the second classification system regarding disability together with ICD-10...if the system was going to be updated, then it should be developed based on an international practice, and based on the ICF” (ibid.).

The deputy minister of health and social solidarity, 39 agreed with Triantafyllou’s proposal, asking him to continue with the adoption and adaptation of the ICF (S. Triantafyllou, interview, May 27, 2015). Simultaneously, the deputy minister asked Triantafyllou to be placed as the chairman of the Institute of Social Protection and Solidarity (IKPA) (ibid.), 40 an institute that had the responsibility for developing the ICF.

At this point, considering the deputy minister of health and social solidarity’s proposal to Triantafyllou that he be placed as the chairman of IKPA, it is worth explaining what this placement means in terms of the operation of the Greek state. As I stated at the beginning of this chapter, the new discussion for the revision of the existing system for awarding disability allowances started after the victory of ND in the parliamentary elections early in 2004. The new political leadership of the Ministry of Health and Social Solidarity wanted to implement its own political agenda by proceeding, among other things, with reforms to the welfare state.

Following Sotiropoulos (2004, p. 409), one of the characteristics of public bureaucracies that are under the influence of clientelism is the replacement of all the top administrative posts—either because of elections or because of the reshuffling of cabinets by “appointees of the governing elite.” In the case discussed in this chapter, we saw that the political leadership of the Ministry of Health and Social Solidarity got in touch with Triantafyllou and assigned him to evaluate the current state of the disability assessment in Greece (S. Triantafyllou, interview, May 27, 2015). Triantafyllou explains that he was chosen by the deputy minister because he was known for his work in disability and welfare issues (ibid.). The proposal to be placed as the chairman of the IKPA, an institution which was

39 After a personal communication that I had with the Minister of Health, when the ICF attempt started to be developed, I was informed that the ICF attempt was under the responsibility of the deputy minister of health and social solidarity (N. Kaklamanis, personal communication, May 26, 2015).

40 The establishment of IKPA replaced the former National Welfare Council (ESYKF), which had the main responsibility for helping the Ministry of Health and Welfare in the designing of welfare policies (Government Gazette, 2003).
responsible for helping the Ministry of Health and Social Solidarity in the
design of welfare policies (see, e.g., Government Gazette, 2005), falls un-
der Sotiropoulos’s argument.

5.2.1 Announcing the adaptation of the ICF

The first official announcement by the government regarding the upcom-
ing reform of the disability classification system took place in September
2004. Prime Minister Costas Karamanlis, during his speech at the Thessa-
loniki International Trade Fair (DETH)\(^{41}\), revealed the government’s initi-
ative to reform the disability classification system (To Vima, September
12, 2004). Two months later, in November 2004, the deputy minister of
health and social solidarity, together with the chairman of IKPA and co-
ordinator of the ICF Stathis Triantafyllou, who had a hybrid role in that
he had both a scientific and political position, announced that the Minis-
try of Health and Social Solidarity decided to replace the existing disability
classification system(s) by adopting and adapting the ICF (Eleftherotypia;
November 4, 2004; I Avgi, November 4, 2004; I Kathimerini, November
4, 2004). The project was called “functionality card,” much like the pre-
vious system was called “disability card” (I Kathimerini, November 4,
2004). As its name indicates, the new system shifted the focus to functions
instead of disabilities.

In line with the newspaper coverage, the aim of the adaptation of the ICF
was twofold: on the one hand, to track down those disability claimants who
were fake disabled and receiving disability pensions and allowances by the
state (Eleftherotypia; November 4, 2004; I Kathimerini, November 4, 2004;
Eleftheros Typos, November 4, 2004; I Avgi, November 4, 2004), and on
the other hand, to provide persons with disabilities with a card through
which they would avoid bureaucratic procedures (Eleftheros Typos, No-
vember 4, 2004) and which would facilitate their transactions with the pub-
lic sector (I Kathimerini, November 4, 2004). However, in order for persons
with disabilities to receive the functionality card, they needed to be reas-
sessed in the context of the ICF (Eleftheros Typos, November 4, 2004; To
Vima, November 4, 2004).

\(^{41}\) Thessaloniki International Trade Fair (DETH) is an annual exhibition that has
taken place in Thessaloniki early in September since 1926. Traditionally, the prime
minister, during his speech on the first day of the exhibition, would announce the
government’s political plan for the following year.
A comment should be added here regarding the government’s rhetoric, specifically its reference to “disability fraud” as one of the main reasons for the reform of the existing disability classification system(s). What is especially notable, recalling the discussions in Chapters 3 and 4, is that this rhetoric reminds us that the same argumentation referring to disability fraud had been used repeatedly, either by the conservative party of ND (see Chapter 3) or by the socialist party of PASOK (see Chapter 4) in the announcements and negotiations for the development of the previous disability classification systems. In this attempt, for example, the political leadership of the Ministry of Health and Social Solidarity, which belonged to the conservative party of ND, wanted to “purge the landscape of the so-called disabled” (To Vima, November 4, 2004; I Kathimerini, November 4, 2004).

According to the initial plans of the Ministry of Health and Social Solidarity, the ICF would be ready in approximately eighteen months from the day of the announcement (Eleftheros Typos, November 4, 2004). The following quote, for instance, by the deputy minister of health and social solidarity, depicts the government’s determination to develop and implement the ICF system: “[this is] neither [to impress] nor just a promise, but in a short time persons with disabilities will be able to receive it [the functionality card]” (as quoted in I Kathimerini November 4, 2004, my translation). But was the government’s determination enough for the ICF disability classification system to replace the existing disability classification system(s)? I will return to the government’s determination later in this chapter.

Moreover, compared to the previous attempts for the development of a disability classification system, two new elements were introduced during the presentation of this project. The first element concerns the reference to the financial resources through which the project would be financed, and the second element concerns the implementing body that would be responsible for developing and designing the project. Specifically, the implementing body would be neither the Ministry of Health and Social Solidarity nor the Ministry of National Economy, as was the case in previous attempts (see Chapters 3 and 4). Instead, it would be the Institute of Social Protection and Solidarity (IKPA), which was enacted by the Law 3370/2005 and was a public law entity operated under the supervision of the Ministry of Health.

42 The financial resources for the adaptation of the ICF came from (i) the European project called “Information Society,” which was managed by the Ministry of Economy and would finance the 75% of the total cost of the project (To Vima, November 4, 2004), and (ii) national resources (I Kathimerini, November 4, 2004).
Creative disability classification systems and Social Solidarity (Government Gazette, 2005). In 2006, Presidential Decree 55 was enacted. It describes in detail the scope, the responsibilities, and the financial resources for IKPA’s funding as well as issues relevant to the staffing of IKPA (Government Gazette, 2006).

The staff who participated in the development of the ICF project were neither policy makers nor employed at the Ministry of Health and Social Solidarity. Rather, there was a call by the Ministry of Interior, Public Administration and Decentralization inviting relevant scientists to express their interest by submitting their application to work on the ICF project (S. Triantafyllou, personal communication, December 21, 2016). As emerged from the above discussion, the main actors who participated in the adjustment of the ICF were the political leadership of the Ministry of Health and Social Solidarity and external actors. The external actors were scientists; they were not employed by the Ministry of Health and Social Solidarity, but they had employment contracts with the IKPA.

With this attempt, a new scheme emerged regarding the development procedure for the new disability classification system. That is, the political leadership of the Ministry of Health and Social Solidarity assigned the complete development of the ICF to an institution such that, although the institution was under the responsibility of the Ministry, the Ministry still had a secondary role during the development process. As Hatziharalobous underlines, it was only the deputy minister of health who was informed about the ICF project and not any other service at the Ministry of Health and Social Solidarity (S. Hatziharalobous, interview, June 14, 2015). Hatziharalobous explains that:

> due to all procedures taking place at the IKPA, it did not come to the Ministry; it worked at the IKPA’s committees. It [IKPA] was a body of the Ministry [of Health and Social Solidarity]. While [in the case of] the disability card [project], I had it at the Ministry. …It [the ICF project] was running [only] at the office of the Minister [the deputy minister of health and social solidarity] and then they invited me [to his office] to take a look at it. …I do not know if it [the Ministry] had been notified [by IKPA]. This is a major issue, since it did not allow the ministry’s services to get involved. It assigned it [the ICF project] to a body outside of the [ministry’s] services.

(ibid.)

To sum up, two new elements were introduced in the adaptation of the ICF project that differed from the earlier attempts to create new classifica-
tion systems discussed in Chapters 3 and 4. Specifically, first, there was a change to the agency where the design process was carried out, with the public law entity of the IKPA to be the responsible body for the adjustment of the ICF; and second, in terms of the actors who participated, the role of representatives of the Ministry of Health and Social Solidarity was downgraded while new actors—scientists instead of policy makers—were responsible for the adjustment of the ICF.

5.2.2 Involved or not? The role of disability movement in the adjustment of the ICF

Having in mind the description already presented and discussed regarding the choice of the ICF as well as the social groups that participated in the announcement of this new attempt, the absence of representatives of the disability movement is obvious. The absence raises questions and runs into conflict with the discussion in Chapter 4. Specifically, as we saw in Chapter 4, ESAEA, after the enactment of the Law 2430/1996, was recognized as a social partner by the Greek state, so ESAEA had a voice in the discussions on disability issues (Government Gazette, 1996). Nevertheless, at the upcoming adaptation of the ICF as the new system for assessing and certifying disability, ESAEA was absent both in the investigation of the existing disability assessment procedure and in the official announcements by the state. For instance, when the coordinator of the ICF (Triantafyllou) described the events that took place before the choice of the ICF, he did not refer to ESAEA or to other disability organization(s). As he explains, the involvement of the disability movement in this early process was not considered necessary (S. Triantafyllou, personal communication, December 21, 2016). Vardakastanis points out that “when the story of the ICF started, we were suddenly informed that there was a decision to adopt the ICF” (interview, September 4, 2015). Besides, he claims that there was not any official invitation to a social dialogue; instead, it was the disability movement that imposed it (ibid.).

Vardakastanis recalls his experience in the discussions for the development of the ICF by the WHO in the late 1990s, when he was elected chairman of the European Disability Forum (ibid.). According to him, at the end of the 1990s when the WHO developed the ICF, representatives of the disability movement actively participated in the shaping of the ICF. That is why, as he further states, the social factors were also included in
Moreover, he mentions that in the description of the ICF, there is a reference to the role of the disability movement, and specifically to their participation in the development of the ICF (see also: Hurst, 2003). Motivated by the above reference, representatives of the Greek disability movement reacted negatively to their exclusion from the discussions for the adoption of the ICF in 2004 and 2005 (Y. Vardakastanis, interview, September 4, 2015).

It is worth noting here that this exclusion brings to mind the discussion in Chapter 3 of when the conservative party of ND, which was also in office during the ICF attempt, decided to reform the disability classification system without inviting representatives of the disability movement to the social dialogue. Vardakastanis focuses on this exclusion by comparing the events that took place in the early 1990s and in the middle of the 2000s (ibid.). As he states:

We talk about 2004; it was not the same as 1992 [1990–1992]. In 2004, we spoke of a coherent movement in Greece, a coherent organization with social and political prestige, with a recognition by a Law, and so on. In other words, the sociopolitical context of the disability movement in 2004–2005 has nothing to do with 1992. If in 1992 it was in its infancy, in 2004 it was in adolescence.

( ibid.)

Even though the disability movement had authority in Greek society, the system developers who participated in the initial stage of the ICF adaptation did not deem the involvement of the disability movement necessary (S. Triantafyllou, personal communication, December 21, 2016). However, for the disability movement, this exclusion was “inconceivable”; therefore, “they enforced the social dialogue,” which took place at the end of 2005 (Y. Vardakastanis, interview, September 4, 2015). As Vardakastanis says, the disability movement did not challenge the “scientific competence” of the scientists who were responsible for designing the system (ibid.). Rather, he refers to the state, and particularly how the state implemented the systems for certifying disability: “When in a country you have a flawed [disability] certification system, yes flawed, and you want to make a deep and structural change, then you should discuss with those

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43 Regarding the involvement and the role of representatives of the disability movement in the development of the ICF by the WHO, see also Hurst (2003) and Fougeryrollas & Beauregard (2001).
that it concerns” (ibid.). Thus, representatives of ESAEA got in contact with the deputy minister of health and social solidarity to request a national dialogue about the adaptation of the ICF (ibid.).

5.2.3 The ICF project and the reliance on scientific authority

The design process for the adaptation of the ICF in the Greek welfare state followed a different strategy from the attempts discussed in Chapters 3 and 4. As we saw, it was decided that the agency responsible for designing the ICF adaptation would be an institution, IKPA, instead of the Ministry of Health and Social Solidarity, and the services of the Ministry would not be informed about the progress of the ICF project. Furthermore, the main entity that had knowledge about the progress of the ICF project was the deputy minister of health and social solidarity. As for the actors who participated in the design process, they were scientists who, initially, were not employed at the Ministry but signed temporary employment contracts with the IKPA. Thus, policy makers were replaced by scientists who had experience with disability and/or welfare issues. In addition, the disability movement was absent during the initial discussions for the adoption of the ICF, with the government of ND not taking into consideration the Law 2430/1996, which recognizes the role of ESAEA to participate in social dialogues relevant to disability issues.

Here, it is worth commenting on the events that took place from the initial discussions for the adaptation of the ICF to the period before the ICF project started to be adapted to the Greek context. As indicated, the main actors who participated in this first round of discussions and negotiations for the revision of the disability classification system were the deputy minister of health and social security, on behalf of the state, and the coordinator and scientific coordinator of the ICF project, whereas the disability movement was absent. We can describe this relationship as follows: a “nonspecialist,” the deputy minister of health and social solidarity, assigned or “relied on scientists and experts”, the coordinator and the scientific coordinator of the ICF, to “produce and evaluate the knowledge on which decisions can be based,” that is, the implementation of the ICF for assessing and certifying disability of persons with disabilities (Callon, 2003, p. 33). The above description, however, does not show anything other than that the scientists, or experts, had the key role in the establishment of the ICF and worked, somehow, isolated in the IKPA, and set aside the disability movement point of view.
However, what is already described is what Michel Callon calls confined science to stress the total hegemony of scientists in the production of knowledge by being isolated from lay people, that is, the disability movement (ibid.). Keeping in mind that the disability movement had a strong presence from different subject positions in the enactment of the disability classification system described in Chapter 4, here there was a shift, with scientists playing a key and unique role in the whole attempt, at least at this first stage.

5.3 Adjusting the ICF classification system to the Greek context: Exploring the ICF material components

After the official announcements by the deputy minister of health and social solidarity and the chairman of IKPA, the adoption and adjustment of the ICF in the Greek context started to be developed. The coordinator of the ICF (Triantafyllou) states that the first step in the development of the ICF concerned the communication between the Greek side and the WHO (S. Triantafyllou, interview, May 27, 2015). The Greek side expressed its interest in adopting the ICF as Greece’s new disability classification system, and the WHO gave its permission (Greek Parliament, 2005).

The ICF coordinator explains that the project had two stages: the first stage concerned the translation of the ICF into the Greek language, and the second stage concerned the designing of the “strategic plan” for the operation of the ICF, or, in other words, the way that the disability assessment procedure should be carried out (ibid.). As for the staffing of the functionality card project, 45 scientists from various scientific fields participated and were separated into four teams based on their occupational orientations (ibid.). Specifically, these four teams consisted of the following: (i) physicians, such as neurologists, psychiatrists, orthopedics, and so on, with the scientific coordinator (Mavreas) of the ICF project to be the leader of this team; (ii) rehabilitation professionals, such as speech therapists, occupational therapists, and physiotherapists, to name but a few; (iii) sociologists and lawyers; and (iv) computer scientists, who were responsible for designing of the information system (ibid.). Figure 1 offers an illustration regarding the way that the ICF project developed in the Greek context.
During the first stage, only members of the first and second team worked in parallel for the translation of the ICF, whereas in the second stage, that is, the designing of the “strategic plan,” all teams worked for the development of the ICF and needed to accomplish various tasks (V. Mavreas, interview, May 28, 2015). In the following subsections, I will discuss each of these two stages more analytically.

### 5.3.1 The translation of the ICF into the Greek language

The first step for the adaptation of the ICF scheme was the translation of the ICF into the Greek language. In line with the ICF scientific coordinator, the translation of the ICF was the outcome of cooperation between the members of the team of physicians and the team of rehabilitation professionals (ibid.). The ICF coordinator describes the translation procedure as follows:

> We continued with the translation [of the ICF] based on the guidelines by the WHO for parallel translation. That is to say,
we had two groups that translated in parallel, and in the end we did a matching in order to check in which terms there was a contradiction...we had twenty or thirty terms, if I remember correctly, and we created a forum with eminent physicians from the medical society, and so on, in order to produce the most appropriate translation.

(S. Triantafyllou, interview, May 27, 2015)

The scientific coordinator (Mavreas) adds that the WHO proposed that fifteen terms be retranslated (V. Mavreas, interview, May 28, 2015), and the coordinator further states that there were six more problematic terms on the Greek side (Greek Parliament, 2005). After receiving the suggestions by the WHO, the translation team worked further to complete the translation (S. Triantafyllou, interview, May 27, 2015; V. Mavreas, interview, May 28, 2015). Then, when the WHO approved the translation as complete, IKPA published the Greek version of the ICF (S. Triantafyllou, interview, May 27, 2015).44

The translation of the ICF was a crucial factor for the smooth operation of the new system. Recalling the disability classification system that was going to be replaced by the ICF, that is, the system discussed in Chapter 3, note that at the core of the disability assessment procedure was the use of the KEVA, where each illness or impairment, based on each severity, was translated into a disability percentage. So, what were the differences that the ICF introduced regarding the classification of illness and impairment?

Browsing the ICF scheme, and, simultaneously bearing in mind the structure and operation of the KEVA, a first difference concerns the structure of the book. Instead of having ten chapters that were divided either based on the types of disorder or medical specializations or body organs, the ICF consists of four sections. Then, each section is divided into several chapters, from five to nine. After starting to read the first pages of each chapter, there is a general description regarding the scope of the chapter and then a specific classification of the different types of, for example, mental functions. In contrast to the KEVA, there is no reference to a specific illness; instead, there is a more general description of health functions. Also, functioning does not translate into a disability percentage; rather, there is a code before the name of the specific function(s). The

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44 Despite the translation of the ICF into the Greek language, IKPA also published a book on how the ICF could be used in practice, with many examples, as well as a shorter version of how the ICF could be used.
same structure, that is, the code before the name of the function, and so on, is observed throughout the ICF classification scheme.

The translation of the ICF constituted the key procedure of its implementation in the Greek welfare state. Considering that the aim of the ICF was and is the formation of a common language for classifying disability, it shows that the translation procedure did not give room for flexibility to the administrative and research bodies responsible for adjusting the system, which we saw as well as in the Greek case. On the contrary, the translation of the terms should be in line with the WHO guidelines. Disability activist Rachel Hurst (2003) refers to the difficulties or the barriers with the translation of the ICF from one language into another. She states, “In the field of disability we have the added problem that many languages do not have any words that coincide with the concepts within the ICF” (ibid., p. 575). Taking together the lack of flexibility regarding the translation of the ICF terms and the lack of some ICF terms in other languages, one might rethink or question whether it is possible to talk about a common language for classifying and assessing disability.

5.3.2 The designing of the “strategic plan”
The second step for the development of the ICF concerned the designing of the strategic plan. During this phase, each of the four teams had a specific task to accomplish. Specifically, the first two teams, physicians and rehabilitation professionals, were responsible for preparing the protocols to be used during the disability assessment procedure. According to the scientific coordinator, these protocols concerned (i) the application that disability claimants ought to submit, (ii) the protocol in regards to the medical record, and (iii) a draft of the subfolder of the medical record because of the lack of a digital medical record in the Greek healthcare system (V. Mavreas, interview, May 28, 2015). Additionally, the protocols preparation concerned the adjustment of the ICF checklist (ibid.). These protocols were the protocols that the disability assessment committee and the committee for the investigation of functionality should fill in after the completion of the evaluation (Institute of Social Protection and Solidarity, 2007). The scientific coordinator also adds that the Greek side had included one more section where the evaluators had to provide a more comprehensive disability assessment linked to the pension provisions (V. Mavreas, interview, May 28, 2015).

Because of the adoption of the ICF, a new classification of disability was introduced based on how severe the disability was (ibid.). In the new
 categorization scheme, disability is classified into five new categories, as follows:

- **Category 0**: No disability. There is no a functional limitation or disability.
- **Category 1**: Mild disability. There is observed only some intolerance that occurs because of the health problems from which an individual suffers. There is a limited functionality restriction in a few activities, but without creating dependence on others.
- **Category 2**: Moderate disability. There is observed a clear activity limitation, and, often, there is a need for the use of technical aids.
- **Category 3**: Severe disability. There is a significant restriction of activities, which creates the need of another person in some activities.
- **Category 4**: Complete disability (total disability). There is a total dependence on another person(s). Almost all activities are limited to a great extent. (Disability Issues, 2005-2006b, p. 12, my translation)

Comparing the above classification scheme with the classification scheme discussed in Chapter 3, what we can notice is that the new classification of disability is done with reference to sociomaterial aspects instead of to numerical figures. To give an example, based on the classification scheme described in Chapter 3, someone will be classified with a severe disability if they are attributed a disability percentage between 80% and 100%. In the case of the ICF classification scheme, someone will be classified with a severe disability if “there is a significant restriction of activities, which creates the need of another person in some activities” (Eleftheros Typos, September 29, 2005). As we can see, with the new scheme for the classification of disability, new notions are adopted, such as activity, functionality, dependency, and technical aids. But the transition to the new classification scheme and the use of sociomaterial aspects instead of numerical figures for classifying a person under one of the above classes offers room to problematize what happens to the case that does not fit (Bowker & Star, 1999) because of a change to the criteria or to the standards for someone to be classified under one of the above categories.

The task for the members of the third team, consisting of sociologists and lawyers, concerned legislation issues, e.g., to prepare the relevant law(s) that would be necessary when the ICF disability classification system was ready for operation (V. Mavreas, interview, May 28, 2015). Also,
the members of the third team were responsible for communicating with the representatives of the disability movement (S. Triantafyllou, interview, May 27, 2015).

As mentioned, representatives of the disability movement were ignored during the initial discussions about the upcoming reform of the disability classification system. The coordinator of the ICF, refers to the collaboration between the ICF developers’ team and representatives of disability organizations in his briefing on the “disability–functionality card,” as the project was later renamed, at the Inter-Party Committee for Tackling Problems concerning People with Disabilities in the Greek Parliament (Greek Parliament, 2005). Specifically, he states that after a collaboration with the ESAEA, the ESAEA was asked to invite its members to submit a memorandum in which they could express their points of view in regard to the ICF and to participate in the national conference where they would further discuss the implementation of the ICF (S. Triantafyllou, personal communication, December 21, 2016). As for the collaboration between the ICF developers’ team and representatives of the disability movement, I will discuss it in the following section.

Last, the members of the fourth team, the computer scientists, were responsible for designing a database where all relevant information of the ICF would be gathered (V. Mavreas, interview, May 28, 2015). The importance of this team is depicted in Triantafyllou’s description of the ICF project at the briefing in the Greek parliament (Greek Parliament, 2005). Specifically, he says that the ICF project, or the functionality–disability card, had two parts. The first part was the designing part, which included the translation of the ICF, the investigation of the existing situation through collaboration with the disability organizations, and the development of the action plan for the implementation of the ICF, and the second part concerned the development of the information system (ibid.). Figure 2 depicts the tasks that each team was responsible for during the development of the ICF.
5.4 From disability statistics to the functionality vs. disability debate

In fall 2005, a year after the first announcement for the upcoming adaptation of the ICF, during a press conference, the political leadership of the Ministry of Health and Social Solidarity together with the Chairman of the IKPA and coordinator of the ICF project informed the public about the progress of the ICF adaptation. The political leadership of the Ministry of Health and Social Solidarity stated that early in 2006 the functionality card system would be ready for operation (Eleftheros Typos, September 27, 2005). Additionally, they announced that the operation of the “functionality card” would put an end to the alleged “fake disabled” (ibid.; I Kathimerini, September 27, 2005b; Ta Nea, September 27, 2005) and that, because of the implementation of the functionality card, “the landscape would be cleared” by the “fake disabled” (Eleftheros Typos, September 27, 2005).
Following the newspaper articles, both the minister and the deputy minister of health and social solidarity linked the implementation of the new system for assessing disability with controlling the number of the alleged fake disabled who illegally received benefits from the state (ibid.; *I Kathimerini*, September 27, 2005a; *Ta Nea*, September 27, 2005). Also, they referred to specific prefectures of Greece, such as Aitoloakarnania, Dodecanese, and Piraeus, where the percentage rates of disability beneficiaries were “unreasonably high” and for which the Ministry of Health and Social Solidarity had created a “black list” (*I Kathimerini*, September 27, 2005b). Also, they stated that because of the operation of the ICF, people with disabilities in Greece would need to be reassessed by the new disability assessment procedure; only if they met the new criteria would they continue receiving disability allowances.

Comparing the above announcement with the announcements one year earlier, in November 2004, what is noticed is a shift in the priorities of the Ministry of Health and Social Solidarity. Though at first the emphasis was on how to improve the lives of persons with disabilities by, for example, facilitating their transactions with the public sector, at this point, through the government’s reliance on *disability statistics*, the emphasis became how to control and punish the allegedly faked disabled. As for the real persons with disabilities, no reference was made to what they would gain after the implementation of the ICF. Again, similar to Chapters 3 and 4, what emerges here is the way the governmental authorities used statistics to build their rhetoric for persuading the public about the insufficient operation of the existing system for assessing disability.

While the representatives of the Ministry of Health and Social Security stressed the issue of the alleged fake disabled as one the main causes for the revision of the systems for awarding disability allowances, in the same press conference, the coordinator of the ICF project (Triantafyllou) explained how the new disability classification system would be used. He said that the disability assessment would not be based on the diagnosis but would focus on the consequences of the disability to persons with disabilities in their daily life (ibid.).

What emerges here is a differentiation with regard to the arguments of the political leadership of the Ministry of Health and Social Solidarity and of the system developers. For the political leadership of the Ministry of Health and Social Solidarity, the key issue behind the enactment of the ICF was the “the battle against the numbers;” the argument was framed around the alleged “fake” disabled and how the implementation of the
ICF would reduce this number (van Oorschot & Boos, 2000, p. 343). For the system developers, however, the key issue was the change in disability assessment by adopting a more scientific procedure and by assessing disability as interactions with environmental factors.

5.4.1 The functionality vs. disability debate

As already noted, in the initial announcements for the reform of the existing disability classification system, the disability movement was excluded. But, as Vardakastanis argues, the disability movement negatively reacted to this exclusion and imposed a dialogue (Y. Vardakastanis, interview, September 4, 2015). The national conference took place in November 2005 at Zappeion (ibid.). According to Vardakastanis, the disability movement agreed with the Ministry of Health and Social Solidarity on the need for a new disability classification system, but the replacement of disability by functionality was a point of conflict (ibid.). As Vardakastanis claims, the emphasis should be on “disability and on the barriers for someone to claim his/her rights” (ibid.).

The debate between functioning, or functionality, versus disability, was not only a point of conflict on the local level. On the contrary, it was a point of conflict and concern and at the international level. This section thus focuses on the debate between functioning and disability. Starting with a short presentation of the WHO’s view regarding functioning for persons with disabilities, this section seeks to shed light on some aspects of this debate as it happens in international context; then it will focus on the Greek case by referring to the discussion during the national conference for the adaptation of the ICF. So what does functioning mean, and why did the disability movement react negatively to its use?

5.4.1.1 Defining “functioning”: The WHO view vs. the persons with disabilities view

According to Bickenbach (2012b), the concept of functioning constitutes the “foundation for the...ICF.” He states:

For the WHO, functioning is a set of specific domains of human functioning—once again, body functions and body structures and the things people do and the things people are or aspire to be...The WHO understand functioning to be a continuous concept, that is, a concept of “more or less,” measurable along a continuum from complete (or total) functioning to complete absence of (or no) functioning. In other words, when people expe-
rience difficulties in functioning, the result is a disability, in the WHO sense of the word.

(ibid.)

In the same discussion, Triantafyllou notes that the concept of functioning aims to identify the abilities of persons with disabilities for their inclusion in society (S. Triantafyllou, interview, May 27, 2015). He uses the example of multiple sclerosis (MS):

You have an illness. You have MS. Well, you have the illness, which can be degenerative, perhaps not getting better. It is a given condition. But with the functionality...the state, first, ought to assess you correctly and, second, to tell you what you can do. And this is the functionality.

(ibid.)

The concept of functioning aims to put the emphasis on the abilities that persons with disabilities still have and how they will be able to use them (ibid.; Bickenbach, 2012b). Or, under the ICF view, “patients are not so much concerned to know the medical facts; they want to know if they will be able to walk or see their friends across the street or get a job” (Bickenbach, 2012b, p. 3).

What is discussed above is the view of the WHO as well as professionals who work in this field with regard to the concept of functioning. However, disability activists and scholars in disability studies and the disability movement, both nationally and internationally, have a different point of view. Scholars in disability studies recognize the attempt that has been to redefine disability by putting the emphasis on environmental factors and how such factors affect persons with disabilities (Albert, 2005). However, they stress that, even though there is a shift in how disability is defined, the dominance of the medical or individual model still exists (Barnes, 2003). As Barnes further states, at the core of the ICF is the individual body and how it is functioning (ibid.): although the concept of participation exists in the ICF, it does not refer to or interpret it in relation to social factors; rather, participation is assessed in relation to the individual body (ibid.).

As for the disability movement, it has been skeptical about the replacement of disability by functionality (Hurst, 2003). For Hurst, the assessment of functionality does not ensure that a person with disabilities will receive the support that s/he needs. The scientific coordinator of the ICF in Greece, who had also participated in the ICF development by the WHO,
says, in relation to the international disability movement’s skeptical reaction to the use of *functioning* instead of *disability*, that it was because they were afraid that the replacement of the concept of *disability* by *functioning* would be translated into a loss of their benefits (V. Mavreas, interview, May 28, 2015).

In the same vein, in a study conducted in Cyprus regarding the adaptation of the ICF, Symeonidou (2014) refers to the way the Cypriot disability movement reacted to the use of the concept of *functioning*. She claims that there was disagreement among disability activists, disability organizations, and the umbrella organization that represents persons with disabilities (ibid.). According to Symeonidou, while disability activists claimed that the implementation of the ICF and the emphasis on functioning was not in line with the social approach to disability; some members of disability organizations (e.g., people with physical impairments) believed that the new scheme would be beneficial for their disability category, since they might gain more disability benefits and services than in the past (ibid.). The umbrella organization of persons with disabilities in Cyprus, on the other hand, was against the implementation of the ICF because of the emphasis on functioning during the disability assessment (ibid.).

Similarly, in another study from Sweden, Lundälv et al. (2015) point out that, while disability organizations were not involved in the debate about the adaptation of the ICF in Sweden,45 representatives of disability organizations feared that the medical and social professionals “could misuse” it—for example, by asking them questions unrelated to their needs (ibid., p. 3298).

In the Greek context, representatives of the disability movement were also skeptical of the concept of *functioning*. Christos Nastas, the general secretary of ESAEA, recalls the role of the disability movement in the discussions for the adaptation of the ICF:

> Our objections had to do with functionality, which is a very important aspect, but you cannot assess functionality individually. You cannot assess me in front of a committee or in an office as to how functional I am because this [assessment] does not represent reality. If you want to assess me, if and how functional I

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45 The study has limitations in that the number of participants was small. It is worth adding here that the implementation of the ICF in Sweden, according to the authors of this study, is used only by the Swedish National Board of Health and Welfare and not as part of social policy.
am, then, as a committee, you should assess me according to how I move on the streets, how I participate in school, how I use my computer...because functionality is not only one thing—it is a set of things that should be assessed.”

(C. Nastas, interview, January 14, 2015)

Likewise, Paraskevi (Vivi) Tsavalia, general secretary of the National Federation of the Blind, expresses her second thoughts about the concept of functionality. She offers the following example:

If you are in your house...then you are not functional. You need the help of another person for taking you out...You will take 100% disability, and you are eligible for an escort. The other, the wretched, who goes to their job, who studies at the university, has their own difficulties and does not have someone to read to them, since the allowances in Greece—such as attending the university and having your book—are not given.... No, it tells you, “You are studying at the university, you are functional. I will evaluate you with a lesser percentage.

(P. Tsavalia, interview, May 22, 2015)

So, for Tsavalia, the concept of functionality had to do with the cuts to disability allowances, since the assessment of functionality would not consider the real needs of persons with disabilities (ibid.).

What is notable in the above quotes is that both Nastas and Tsavalia challenge the meaning of functioning during the disability assessment by questioning how it is possible for functioning to be assessed by a specific committee and in a specific space. By using examples either from their interactions with the environment or from social activities, Nastas and Tsavalia highlight that functioning—in the sense that the ICF presents the concept of functioning—is impossible to assess. Rather, the emphasis is on the individual (medical model) and not on the individual’s interactions with environmental and social aspects (social model).

Taking the opportunity from the functionality–disability debate and how it has been approached by the WHO and persons with disabilities, it should be added here that this debate started in a period when there was a shift in terms of the welfare state. Specifically, since late in the 1990s, a neoliberal policy agenda had been adopted for the reform of the welfare states and, consequently, of the systems for awarding disability benefits, moving thus from compensation-oriented schemes to occupational-oriented schemes (Marin, 2003). The purpose of the occupational-oriented
schemes has been the reintegration of disability claimants to the labor market by putting the emphasis on their remaining abilities and functions (see, e.g., van Oorschot & Boos, 2000; Marin, 2003; OECD, 2003).

However, it is worth adding here that the “functionality–disability” debate, and specifically the emphasis on the functions and abilities in order for someone to be integrated into the labor market, has similarities with the old disability approach and the debate between disability and normalcy. Following Barnes (1998), after the industrialization, the new factory-work system did not leave space for persons with disabilities to participate in production because they lacked the necessary capacities to be classified as valid. As a result, persons with disabilities were labeled as “invalids” because they could not participate in production (Zola, 1982). Considering the current neoliberal policies in the reforms of the welfare states, which placed at the center the abilities and not the disabilities of persons with disabilities for the purpose of eligibility for welfare allowances, the introduction of the concept of functioning appears to restore the old debate between normalcy and disability by other means.

5.4.1.2 The national conference for the adoption of the ICF
In November 2005, after an initiative from the disability movement, the national conference for the adoption of the ICF took place in Zappeion, where the disability movement shared its views. As presented by Vardakastanis, the disability movement agreed on the one hand with the adoption of the ICF, since it is a classification scheme that takes into consideration the socio-political perspective on disability (Disability Issues, 2005-2006a, pp.8–9). But, on the other hand, the disability movement argued that the adoption of the ICF should not be translated to cuts to the disability allowances that persons with disabilities received in Greece (Y. Vardakastanis, interview, September 4, 2015). In other words, any kind of dialogue should start without affecting the existing conditions with respect to disability allowances (ibid.). Vardakastanis, in an article published in the ESAEA’s magazine Disability Issues concerning the discussion of the adoption of the ICF, summarizes the disability movement’s views as follows:

i. The ICF system should be adopted and integrated without deductions and limitations;
ii. The new system should not lead to cuts [of the disability allowances] and should attribute to persons with disabilities...what they should really have to equally participate in the society to the extent allowed by their disability...;
iii. The disability movement should participate in the whole process, both through the Confederation, as a common component, and though the disability associations, which represent specific disabilities and have specialized knowledge of specific disability categories.

*(Disability Issues, 2005-2006a, p. 9, my translation)*

A second issue raised by ESAEA concerns the name of the card that would be issued to persons with disabilities. As previously discussed, the Ministry of Health and Social Solidarity and IKPA and the newspapers referred to the functionality card that persons with disabilities would receive after the reassessment of their disability. However, ESAEA did not agree with the term *functionality card*, because:

the concept of “functionality” is not recognized by the Constitution of Greece. The choice of the term should be associated with the Constitution of the country. The Constitution of Greece, in Article 21 paragraph 6, recognizes the concept of disability, when it talks about persons with disabilities.

(ibid.)

As Vardakastanis notes, the deputy minister of health and social solidarity accepted the above request by the ESAEA (Y. Vardakastanis, interview, September 4, 2015); since then, November 2005, the new card that persons with disabilities would receive would be referred to as a disability card or a functionality/disability card (see, e.g.,: *I Kathimerini*, September 22, 2006; *Eleftherotypia*, October 30, 2006; November 26, 2006; Ministry of Health, 2016).

The above argument by representatives of the disability movement brings to the fore one more dimension of the functionality–disability debate, that is, the shift to *functioning* and the replacement of the concept of *disability* with that of *functionality* would have consequences for persons with disabilities and their vested rights. Disability claimants would be reclassified and certified in terms of their remaining functions and abilities rather than their disabilities. But their rights, and consequently their disability allowances, exist with reference to *disability* and not to *functioning*. Disability claimants, because of the change to the classification scheme, suddenly would not meet the prerequisites to be granted disability allowances. What the representatives of the disability movement wanted to add here is that the replacement of the term *disability* by *functionality* would also have consequences for persons with disabilities in
terms of administrative and bureaucratic levels, since the reclassification of
persons with disabilities based on their functions would not be recognized by
the Greek state.

5.5 From the government’s determination to the non-
implementation of the ICF

Despite the fact that the government was determined to proceed with the
reform of the system for awarding disability allowances, in the end, the ICF
attempt was not completed. At the beginning of this chapter, I started the
reconstruction of the ICF by employing the theoretical/methodological
theme of indeterminacy of the Past to explore the reason why there was a
need for reform to the disability classification system. My aim was to pre-
sent, by giving voice to the relevant actors of the ICF project, how those
actors evaluated the existing system(s) for assessing disability and why they
thought the system should be reformed. In this section, I will use the same
theoretical/methodological theme, but this time my aim is to evaluate, by
giving voice to the relevant actors who were involved in the development of
the ICF, why the system, finally, was not completed or implemented.

At the beginning of this chapter, we saw that the ND government was
determined to develop and replace the previous disability classification
system(s). In the middle of 2005, the political leadership of the Ministry of
Health and Social Solidarity forecast the operation of the new disability
classification system for the first semester of 2006. However, as it emerges
from the newspaper coverage, the above announcements did not apply,
and some of the press criticized the Ministry of Health and Social Solidari-
ty’s announcements.

For instance, in an article published in Ta Nea in July 2006 with the ti-
tle “Support Centers Only on Paper,” Charalambakis reports that alt-
ough the Ministry of Health and Social Solidarity announced the upcom-
ing implementation of the functionality/disability card, it could not be
operated on time because of financial issues (Ta Nea, July 12, 2006). A
few months later, in an article published in the newspaper Eleftherotypia,
the journalist describes the promises for the functionality/disability card as
a “joke” (Eleftherotypia, November 26, 2006). Skordilis criticizes the
Ministry of Health and Social Solidarity announcements regarding what a
person with disabilities would gain in Greece because of the new disability
classification system, stating that if people believed the government’s initi-
atives, then they might think that “a paradise” would emerge for people
with disabilities (ibid.). But as he further underlines, the infrastructure that
the new system would need was such that it was impossible to be ready for the estimated date (ibid.).

Early in 2007, in another newspaper article published in Eleftherotypia, the journalist challenges the government initiatives for the operation of the new disability classification system, stressing the “anxiety” of the political leadership of the Ministry of Health and Social Solidarity because the Ministry “did not implement its commitments” and the “lack of preparation by the public sector to facilitate persons with disabilities” (Eleftherotypia, January 21, 2007). It is worth noting here the title of the above newspaper article: “‘Fake’ Disabled, ‘Fake’ Promises” (ibid.). The journalist, by making a pun on the word fraud—or monkeys, which is the Greek word used to describe something metaphorically as fake—censures the government for its rhetoric and the repeated use of “fake disabled” in its announcements for the reform of the disability classification systems (ibid.). Last, in another article published in summer 2007, there is a direct critique of the political leadership of the Ministry of Health and Social Solidarity for its lack of determination to implement the ICF project (Eleftherotypia, August 26, 2007).

The newspaper coverage pinpoints different factors contributing to the ICF project’s nonimplementation. To sum up, these factors were (i) the lack of or the delays in the financial coverage of the project; (ii) the lack of preparation and planning from the political leadership of the Ministry of Health and Social Solidarity concerning how to implement the project, and (iii) the insufficiency of the public sector to implement it. Last, as we saw at the beginning of this Chapter, although the government was determined to implement this project, in the end, as it emerges from the newspaper articles, the political leadership was not so determined to implement the ICF system. But what were the reasons and factors, according to the key actors, that this attempt to establish the ICF system failed?

To the coordinator of the ICF project, there were three reasons for the nonoperation of the ICF: (i) there was a lack of collaboration and cooperation between the relevant ministries and institutions that had an interest in the operation of the ICF, (ii) the role of IKA and its negative reaction to the replacement of the existing disability classification system, and (iii) a lack of interest by the political leadership of the Ministry of Health to operate the ICF system (S. Triantafyllou, interview, May 27, 2015). He states:

> At the end of 2008, I prepared the folder [of the ICF] with the Greek translation, the strategic plan, we published an application
guide for explaining how the system should be operated...and I submitted the material to the deputy minister of health and social solidarity and he [the deputy minister] asked me what he needed to do. Even though it was not my responsibility, I replied to him that we should arrange a meeting, a consultation, with ESAEA...and with representatives of the institutions that were involved in this system, which were the Ministry of Health, the Ministry of Labor, the Seaman’s Home, the Ministry of Transport...the Ministry of Defense. ...He [the deputy minister] agreed, and he said to invite them. We invited them, but we did not manage to have a consultation with all [the representatives of the above ministries].

(ibid.)

As for the role of IKA, the coordinator of the ICF shares his personal experience of when he met the representatives of IKA as follows:

When I was at the IKPA, I had two meetings with the deputy governor of IKA as well as with physicians of IKA, which were unpleasant enough. The reason was that they did not want any change to the system. I heard many things. I heard that “we are doing fine with the system that we have”, that “the ICF protocols are much extended and we do not have time because outside there are 20 to 30 people, and we do not have time to operate this type of [disability] evaluation.” Someone who was a director of one of the IKA’s branches mentioned that they had such an experience...that “we can see from the door their [the claimant’s] problem; we do not have to do anything else.”

(ibid.)

Last, regarding the role of the political leadership of the Ministry of Health and Social Solidarity, the coordinator of the ICF says that:

When the project was ready, all of us we were willing to work and we had the complete plan, and we stated that we had 60 disability assessment centers in Greece, and we had to do the training [of the physicians and rehabilitation professionals], and indeed there was money to subsidize all these [training] seminars, and so on, [but] I had no support from the political leadership...There was an indifference, and sometimes [it was] unreasonable.

(ibid.)
The scientific coordinator of the project also claims that there were three reasons for the nonoperation of the ICF in the Greek social security and welfare system. According to him, these reasons were (i) the Greek state, which is conservative and not open to changes, (ii) the role of social security funds and the political leadership of the Ministry of Health and Social Solidarity, and (iii) the disability movement (V. Mavreas, interview, May 28, 2015). As he further explains:

The services of the public sector in Greece...are guided by conservatism. They hate, somehow, changes; because, since the system is going to be changed, they would have to adjust and be educated on the new conditions...The political leadership [the government and the Ministry of Health and Social Solidarity] is very sensitive to the political cost if the disability movement is negative. Even though, at the beginning, they [political leadership] promoted [it], they stepped back...Second, the social security funds, particularly the IKA, which was always negative to any change in the KEVA...and then the other social security funds followed. I remember one deputy governor of IKA who said “I can estimate the [disability] percentage of a person with disabilities from the door.”...So, if I can estimate that someone has schizophrenia or manic depression from the door, there is no need to ask him/her anything. And third, the disability movement, which was skeptical and afraid that it [the disability movement] was going to lose the privileges and benefits given to them by the existing system.

(ibid.)

In regards to the relationship between the political leadership of the Ministry of Health and Social Solidarity and the social security fund of IKA, Mavreas says:

the deputy minister of health and social solidarity, because of the reaction, was trapped, I will say the word, by the IKA. [The IKA’s response was] “Disability card? We are issuing it tomorrow, with the percentages, etc. What do you want with the ICF?”

(ibid.)

Both the coordinator and the scientific coordinator of the ICF argue that the reasons for the nonimplementation of the ICF were the lack of interest and support by the Ministry of Health and Social Solidarity, the
The chairman of ESAEA refers to another factor responsible for the ICF project’s nonimplementation. According to him, this factor lies in the “wrong approach” that both the coordinator and the scientific coordinator of the ICF adopted when they started to design the ICF project (Y. Vardakastanis, interview, September 4, 2015). “They began as the country did not have anything. There was not any experience. No one has done anything. And they appeared as the ones who brought the truth and the prophecy” (ibid.).

Vardakastanis asserts that the whole attempt was unsuccessful because the evaluation of the existing situation for the disability assessment was insufficient (ibid.). He states:

If the experience that brought us to the disability card had been evaluated, then the first thing that should be done in 2004 was the enactment of a law for the disability card. ... And which was the element that was pulling the system? The disability card. That is why we did it. Well, to legislate the disability card and then around it [the disability card] to develop the system that would issue the card. ...Because, it is a different thing to adopt the ICF and to apply it [the ICF] in a country with a lack of relevant legislation and procedure, and another thing to implement it [the ICF] in a country that already has a procedure.

(ibid.)

Stratis Hatziharalabous, a policy maker who worked on the development of the disability card system, states that the even though the ICF model was excellent, the existing conditions in Greece were such that Greece “was not ready” for the implementation of the ICF model (S. Hatziharalabous, interview, June 14, 2015). Hatziharalabous emphasizes the financial resources that would be needed because of the implementation of the ICF, especially whether the state had the ability to offer this amount to their citizens and whether persons with disabilities were willing to accept it (ibid.). He says:

I said to them, “Well, proceed to the aftermath; [I] said to the Ministry that this system requires 7 billion euros—do we have them? Or will we stay at the 3 billion euros of the allowances?”
Are they going to abolish the allowances in order to provide an operating model of benefits and then it [the state] says to the person with disabilities...I will give you 8000 euros instead of 3000 euros to allow for functional inclusion? Will the person with disabilities accept it? Will the disability movement accept it? No, they will not accept it. They will want the allowances and these benefits as well...If I have a document which says that I have to do psychotherapy, I have to buy a computer...I have to purchase a guide dog for the blind, and this means for the state an expense of 15,000 euros instead of 5,000 euros each year, where will the state find money to give?

(ibid.)

Also, for Hatziharalabous, a second factor contributing to this system’s insufficiency to operate concerns the legislation that needed to be updated and enacted (ibid.). Specifically, he refers to a modification study that he ran: according to the results, approximately “eighty ministerial decisions and acts should be changed, something that would not be done in at least ten years” (ibid.). For Hatziharalabous, the lack of financial resources as well as the difficulties and time-consuming procedures to update the existing legislation to suit to the ICF disability classification system were the reasons that the ICF was finally not implemented in Greece.

Summarizing, this section presents the voices of different actors who were involved, in one way or another, in the adaptation of the ICF classification system. The first voice belongs to newspaper journalists who, obviously, were not involved in the development of the system but who, through their articles, somehow participated in the development process, playing a role of mediator between the state and system developers and public opinion. The journalists evaluated the nonimplementation of the ICF by adopting a critical lens against the government and by pinpointing the weaknesses of this attempt. The second voice comes from the coordinator and scientific coordinator of the ICF project, who evaluate the nonimplementation of the ICF in terms belonging to a political vocabulary. While at the beginning of this chapter, we saw both the coordinator and the scientific coordinator evaluate the current situation regarding the system for awarding disability allowances by using terms from a scientific vocabulary that was up-to-date with the current trends and discussions about disability, here, in their evaluation for the nonimplementation of the ICF, they underline how the feature of state operation was a barrier to putting the ICF into use.
The representatives of the disability movement are the third voice that has a say in the evaluation of what happened and why the adaptation of the ICF was not completed. The chairman of ESAEA claims that insufficient planning for the evaluation of the current condition of the system for awarding disability allowances was the reason that the ICF project was not finished. Hatziharabous, the fourth voice, also stressed the lack of planning, using terms suited to a finance vocabulary. Specifically, Hatziharalabous focuses on the lack of planning on the part of system developers regarding the financial resources that the ICF system would need for its implementation and the consequences of these new needs for the expenses of the welfare state and particularly for the policy planning benefits.

5.6 Conclusion

Chapter 5 talked about the attempt at adaptation of the ICF to Greek social policy, an attempt that started in 2004, after the victory of the conservative party of ND in the parliamentary election, and lasted until 2008 to 2009. The purpose of this chapter, like Chapters 3 and 4, was to open the black box of the ICF project and to shed light on the attempt to develop this system, since in the end the system was not implemented. To that end, I used the theoretical/methodological themes of indeterminacy of the Past, material and texture, and practical politics (Bowker & Star, 1999) to explore the political and social choices that were embedded in this attempt. In the following paragraphs, I will focus on and discuss some issues that emerged after the reconstruction of the attempt to adapt the ICF.

To begin with the indeterminacy of the Past theoretical/methodological theme, we saw how the results of the parliamentary election early in spring 2004 and the change in the political context of the country, with the ND political party succeeding the PASOK political party in power, opened the discussion for a revision to the system for assessing and certifying disability. The new political leadership of the Ministry of Health and Social Solidarity, rather than proceeding with the integration of the disability card classification system (see Chapter 4), chose to start the revision process from scratch. Specifically, they assigned a scientist to evaluate the then-current situation for awarding disability allowances, denoting, simultaneously, their expectation of a scientific evaluation of the operation of the then-current system.

The reliance on the power of scientific authority, however, was not limited to only the evaluation stage; rather, in the whole attempt, it was the scientists who had a central role in the adaptation of the ICF. Whereas the
designing of the systems discussed in Chapters 3 and 4 happened within the walls of a ministry and with the participation of policy makers, the ICF attempt took place in another place, somewhat isolated from the Ministry of Health and Social Solidarity and without the participation of policy makers. Following Drake’s (1999) argument that the designing of disability policies embeds and reflects the ideologies of the governmental authorities concerning the way they understand and approach disability issues, the emphasis on the system developers’ scientific backgrounds as well as the “isolated” environment or place in which the system would be developed shows, in my interpretation, that the conservative party of ND approached disability issues through a medical understanding.

Moving to the practical politics theme and considering the essential role that the disability movement had in the attempts prior to the ICF project, I discussed the fact that at the beginning the disability movement was not considered an actor that should participate in the early discussions about the ICF by the political leadership of the Ministry of Health and Social Solidarity or by the system developers. However, on its own initiative, the disability movement demanded to have a position and a say in the negotiations for the adaptation of the ICF. For instance, the debate about the functionality-disability issue belonged to the disability movement’s initiative, and it brings to the surface the consequences of the replacement of the concept of disability by functionality. So, though the ICF classification system was not implemented, the disability movement intervention against the concept of functionality signifies their successful involvement in the policy-making.

With regard to the exclusion of the disability movement in the early discussions about the adoption of the ICF, a comment should be added here regarding the relationship between the disability movement and the ND party. In Chapter 4, I argued that the disability movement and the socialist government of PASOK, which was in power during disability card classification system, achieved a synergy during the development of that system. Here, on the other hand, we saw that after the shift in the political landscape of the country in 2004, with the conservative party of ND in power, this kind of synergy between the ESAEA and the new government of ND did not exist, despite the fact that since 1996 the ESAEA had been recognized as a social partner by the Greek state for issues relevant to disability.

Also, the hegemony of numbers, specifically of disability statistics, was one more issue that emerged after the opening of the black box of the ICF project. The high rate of disability beneficiaries, reference to which denoted, indirectly, that the high rate was associated with the existence of alleged
fake disabled, was the “battle” that the implementation of the ICF aimed to solve. Following Porter (1993, p. 93) and his claim that “every statistical estimate has the potential to become a new thing,” what is highlighted here is how the statistical rates of disability beneficiaries became the driving force behind the revision of the system for assessing disability, setting aside the disability claimants and their needs in terms of support.

The emphasis on the decrease in the numbers of disability beneficiaries, and simultaneously, the absence of any reference to disability claimants and what the latter would gain after the implementation of the new system for assessing and certifying disability in terms of disability benefits, for example, makes room for rethinking and problematizing what work disability classification systems do (cf. Bowker & Star, 1999). At this point, I would also like to remind the reader that until 2015, when I did the data collection, there was not an official census regarding the number of persons with disabilities in Greece an issue that I will discuss further in the following chapter.

Moving to the material and texture theme, we saw that the core components in the adaptation of the ICF were the exact translation of the ICF into the Greek language and the new classification of disability into five new categories, compared to three in the previous system. Comparing the content of the ICF with the content of the KEVA, what is noticed is that disability is not described only in the medical context; rather, sociomaterial elements are also taken into consideration. Similarly, in the new five-scale disability classification system, disability is not translated only into a numerical figure or a percentage that represents the bodily loss. On the contrary, for the classification of someone in one of the above categories, a different convention was used. That convention classifies disability in one of the five disability categories with reference to sociomaterial aspects instead of solely medical aspects. In other words, the aforementioned disability classification represents a transition to another model for understanding disability that bridges the medical and the social approaches to disability. Echoing Bowker and Star (1999) and the symbolic role that the classification systems include, the classification of disability through a sociomaterial perspective denotes an intention on behalf of the state to approach disability through a different lens than the medical one; stemming, however, from the 2000s neoliberal policies in welfare state.

Lastly, returning to the indeterminacy of the Past theme, but this time to explore why the ICF project failed to be implemented, what emerges here is that almost all the actors that participated in the ICF project evalu-
ated the project by underlining that the reasons for its nonimplementation have to do with the operation of the state and with lack of planning. Specifically, regarding the state’s operation, we saw that in almost all actors’ evaluations there was reference to the lack of political determination on the part of the governmental authorities as well as to the insufficiency to proceed with reforms in the operation of the state. Following Ferrera (1996) and Sotiropoulos (2004), the above insufficiencies that prevented the implementation of the ICF are structural characteristics of the operation of the Southern European states, in terms of the development of the welfare state and public bureaucracies, and have their roots in the political economic theory of clientelism.

After almost fifteen years of attempts to revise the system for assessing and certifying disability, the system described in Chapter 3 was still in use at the beginning of 2009. The only difference was that, from the mid-2000s, more social security funds sent their insured to IKA\textsuperscript{46} health committees to be assessed to receive disability allowances. Thus, gradually, the disability classification system operated by IKA became a point of reference for disability assessment in Greece. The economic crisis, which started in 2009, brought many reforms to the operation of the Greek state. Specifically, the inclusion of the country under the financial support mechanism by the European Commission (EC), the International Monetary Fund (IMF), and the European Central Bank (ECB) was accompanied by a demand for radical structural reforms and austerity in the public sector. One of the reforms demanded concerned the pension system. As discussed in Chapter 3, the system for awarding disability benefits belongs to the context of the pension system, and though there was initially no clear reference to the need for revising the system of awarding disability benefits, the pension scheme reform soon included reform of that system as well.

On the one hand, as we will see, because of the economic crisis, the Greek state needed to reform the pension system as part of the austerity-driven policies to be implemented for reducing its public cost. On the other hand, the disability movement offers a different point of view regarding the reform of the disability classification system. Chapter 6 deals with the development of the system for assessing and certifying disability. Specifically, by opening the black box of that system, this Chapter aims to shed light on the following: the reasons for this new attempt to develop a new disability classification system; which social groups participated in the development stage; what the role of the disability movement was; and how the economic crisis affected the enactment of the disability classification system.

Chapter 6 consists of three sections. The first section offers a short introduction regarding the outbreak of the economic crisis in Greece and the inclusion of the country under the financial support mechanism of the EC,

\textsuperscript{46} IKA is the largest social security fund in Greece. See also footnote 13.
the IMF, and the ECB. The second and the third sections discuss the development of the new disability classification system. For the structure of the second and third sections, the theoretical/methodological themes of *indeterminacy of the Past, material and texture*, and *practical politics* as proposed by Bowker and Star (1999) have been adopted. Specifically, the second section seeks to show the reasons behind the enactment of the new disability classification system or, in other words, why there was a need to reform that system. The involvement of the disability movement and the government’s actions are also explored. The third section describes and analyzes the material components of the new disability classification, that is, the Centers for Certifying Disability (KEPA) as well as the Single Table for the Determination of the Disability Percentage (EPPPA). The analysis goes further by examining the *practical politics* involved in the negotiations and/or conflicts between the key actors in the development of the system’s components.

### 6.1 The financial crisis of 2007–2008 and the outbreak of the economic crisis in Greece

Before I start with the presentation and analysis of the disability classification system that was developed at the beginning of the 2010s, this section offers a short introduction of the financial crisis of 2007–2008 and the consequences of the financial crisis on national economies worldwide. Then the discussion focuses on Greece and the outbreak of the economic crisis late in 2009, exploring how the discussion for the pension scheme reform, which included and the revision of the system for awarding disability benefits, emerged.

The financial crisis of 2007–2008 caused turbulence, to use a more journalist’s term, in national economies worldwide. Institutions such as the IMF and the Organization for Economic Co-operation and Development (OECD), as well as the EC proceeded with recommendations and advice to their member states to adopt measures for protecting their economies (see, e.g., IMF, 2009a, 2009b, 2009c; OECD, 2009; European Commission, 2009). For example, late in 2008 the EC (2008) adopted the European Economic Recovery Plan—which was a coordinated policy as a response to the consequences of the financial crisis on the EU’s economies—and asked its member states to implement it. Similarly, OECD (2009), through its report *Sickness, disability and work: Breaking the barriers. A synthesis of findings across OECD countries* recommended
that its member states proceed with reforms of their welfare states in order to meet the challenges of the 2007–2008 financial crisis.

As an “aftermath” of the financial crisis of the 2007–2008, an intense debate emerged in Greece in the spring of 2009 regarding Greece’s economic condition (I Kathimerini, May 10, 2009). The debate referred to the budget deficit and public debt rates of the country, with the EC and the IMF expressing their concern about the course of the Greek economy (ibid.). The EC, for instance, expressed its concerns regarding the public deficit rate and the inefficiency of the Greek government to take measures to control it (I Kathimerini, July 7, 2009), while, the IMF foresaw “an explosive increase” of the Greek public deficit and debt (I Kathimerini, July 23, 2009). As a result, the EC, the IMF, and the OECD made recommendations to the Greek government for taking radical cost-cutting measures to reduce the expenses of the public sector, and among other things, for the first time, they recommended a reform of the pension scheme (I Kathimerini, July 7, 2009, July 23, 2009, August 1, 2009).

The continuous upward revisions of the public deficit rates by the Greek governmental bodies47 and the lack of trust in the statistical data provided by the Greek authorities48 resulted in a shift in the involvement of the EC in the development of the Greek economy, which gradually put the Greek economy and particularly the government’s actions “under the supervision of the European Commission” (To Vima, October 22, 2009). Thus, the EC, adopting the neoliberal slogan there is no alternative, exerted pressure on the Greek government to proceed with structural reforms to the operation of the Greek state, with the pension scheme reform to be included. For example, in an article published in To Vima under the title “Irresistible Pressure from the EC to Take Measures,” the journalists quote a statement

47 As political scientist Manos Matsaganis notes regarding the public deficit rates, when the discussion started, governmental authorities expected the public deficit rates to be around 3.7% of GDP for 2009. However, later in the fall of 2009, the expected rate was revised to 12.5% and finally ended up at 15.8% (Matsaganis, 2012). Regarding the continuous upward revisions of the public deficit rate by the Greek authorities, as reported by the newspapers, see, for example, To Vima, September 17, 2009, September 28, 2009, October 4, 2009a, October 9, 2010; I Kathimerini, October 13, 2009; To Vima, October 20, 2009; I Kathimerini, November 3, 2009.

48 This event is also known as ‘creative statistics’ or ‘creative accounting’ of the Greek economy to describe the misreporting of the statistical rates by the Greek authorities (e.g., To Vima, November 15, 2009).
from the chairman of the ECB about the measures that the Greek state should implement for cuts to the public sector. According to the chairperson of the ECB, “You cannot give allowances when you do not have funds to pay pensions” (as quoted in *To Vima*, November 11, 2009, my translation). This statement is a direct criticism of the operation of the existing Greek welfare state, denoting, as well, what was to follow regarding the reform of the welfare state. Even though the pension scheme reform was recommended earlier by the EC, the IMF, and the OECD, this time it was demanded after “irresistible pressure” by the EC, since the Greek pension scheme was in the worst condition compared to the other European countries (*To Vima*, November 11, 2009; see, also, *Eleftherotypia*, November 8, 2009).

6.2 The pension scheme reform and the revision of the system for awarding disability benefits: “Multiple voices” behind the development of the new disability classification system

The previous section described how the critical economic situation of the country forced the governmental bodies to proceed with radical structural reforms in the state’s operation, with the pension scheme reform to be one of these reforms. The purpose of this section is not to discuss the whole pension scheme reform. Rather, it seeks to shed light on the enactment of the disability classification system, which was part of the aforementioned reform, and specifically, on the reasons that the previous disability classification system(s), which operated since early in the 1990s, should be revised. Bowker and Star note that “we are constantly revising our knowledge of the past in light of new developments or events in the present” (Bowker & Star, 1999, p. 40). Inspired by this statement, I will use the theoretical/methodological theme of indeterminacy of the Past, as proposed by Bowker and Star (ibid.), in order to explore how different social groups, using their current knowledge, assess and explain the reasons for the need of a revision to the then-current disability classification system, which had been in use since the early 1990s. For instance, this section will explore what kind of “terminology” the different social groups used to explain the weakness of the then-current system for certifying disability.
6.2.1 The social dialogue for the pension scheme reform and the establishment of the Ad Hoc Committee for the pension scheme

In the middle of November 2009, and after the demand by the EC, Minister of Finance Giorgos Papakonstantinou and Minister of Labor and Social Security Andreas Loverdos met to discuss the pension system reform. After this meeting, both the ministers announced the initiation of a “quick” social dialogue between the state and the social partners to reform the pension system to make it sustainable (Ta Nea, November 13, 2009; To Vima, November 13, 2009; Eleftherotypia, November 13, 2009). As the minister of finance claimed, “In the 2009 budget, there were severe financial problems with the funding of the social security funds” (To Vima, November 13, 2009, my translation). The minister of labor and social security further stated that “in 2009 the ‘black hole’ of the pension system had expanded, and the [PASOK] government received a pension scheme with enormous problems and financing needs” (ibid., my translation).

In December 2009, the minister of labor and social security announced the establishment of an Ad Hoc Committee for the pension scheme reform (Ministry of Labor and Social Security, 2010). The purpose of the Ad Hoc Committee was, through a social dialogue with the representatives of the scientific community, social partners, and representatives of the Ministry of Labor and Social Security, to submit its findings for “solving the problem” with the pension system (ibid.). The members of the Ad Hoc Committee were the following:

**Chairman**

- Angelos Stergiou – Professor of Social Law, Faculty of Law, Aristotle University of Thessaloniki

**Members**

- Chariton Kiriazis – Vice-Chairman, Hellenic Federation of Enterprises (SEV)
- Dimitris Kiriakis – Actuary, Director-General of Self-Employed Workers’ Insurance Organization (OAEE)
- Athanasios Lopatatzidis – Expert/Specialist of Health Care Management
- Vasilis Margios-Xafelis – Actuary
- Dimitris Mpourlos – Lawyer; Expert/Specialist of Insurance
- Patrina Paparigopoulou – Assistant Professor, Faculty of Law, National and Kapodistrian University of Athens
- Savvas Rompolis – Professor, Panteion University
Studying both the announcement by the Ministry of Labor and Social Security (Eleftherotypia, November 26, 2009) and the presentation of the committee’s members in the Ad Hoc Committee’s report (Ministry of Labor and Social Security, 2010), what can be noticed is an emphasis on the scientific background or the field of expertise of the Committee’s members. For instance, when the establishment of the Committee was announced, it was said that the Committee members should be representatives of social partners, such as the General Confederation of Greek Workers (GSEE), the National Confederation of Hellenic Commerce (ESEE), the Hellenic Federation of Enterprises (SEV), and the Hellenic Confederation of Professionals, Craftsmen & Merchants (GSEVEE) (ibid.). However, in the above list, for only one member was there a direct reference to the institute that he represented—that is, the representative of the SEV. Also, in the Committee’s conclusion it is mentioned that Romanias and Robolis represented the GSEE, but this information is missing in the committee’s presentation. Thus, the emphasis was on the “scientific expertise” of the Ad Hoc Committee’s participants rather than on the institutions they represented.

The first meeting of the Ad Hoc Committee was held early in December 2009, with the minister of labor and social security setting the issues for discussion. In the initial announcement for the pension scheme reform there was no reference to the reform of the system for awarding disability pensions (see, e.g., Eleftherotypia, November 15, 2009), but after Committee’s first meeting one of the points of the pension scheme reform concerned the revision of the system for awarding disability pensions (I Kathimerini, December 9, 2009).

6.2.2 The involvement of the disability movement in the enactment of the new disability classification system
At some point, someone might claim that the origins for the revision of the system for awarding disability pensions lie in the pension scheme reform as part of the austerity-driven policies that the Greek state was to implement because of the economic crisis. The disability movement, however, has a
different point of view. In the interview that I conducted with the chairman of ESAEA, which is the umbrella organization for persons with disabilities in Greece, Vardakastanis did not link the system’s revision with the economic crisis (Y. Vardakastanis, interview, September 4, 2015). He argued that the whole discussion started after the Greek media’s publication of a new case of alleged disability fraud in the prefecture of Piraeus—an issue which, as we saw earlier in this thesis, was a continuous controversy between the state and persons with disabilities. Briefly, early in February 2010 the Prefect of Piraeus announced the findings of an investigation that he had completed regarding the disability beneficiaries of Piraeus Prefecture (Eleftherotypia, February 1, 2010). The investigation showed that there were 19 cases of “fraudulent blind [people]” who received disability allowances after they “counterfeited the stamps, names, and physicians’ signatures” (ibid.; I Kathimerini, February 2, 2010).

The publication of this new “scandal” of alleged disability fraud was accompanied by negative reactions by the disability movement. In an article published in Eleftherotypia with the headline “The Term ‘Disability Fraud’ Is Vulgar and Racist According to Organizations of the Disabled,” the disability movement stressed that the “continuous” and extended use of the term “disability fraud” has had consequences for both persons with disabilities and their families (Eleftherotypia, February 4, 2010; see, also: ESAEA, February 3, 2010). According to the disability movement, the “attack” against people with disabilities could be viewed on many levels (Eleftherotypia, February 4, 2010):

First, on the moral [level]. The continual use and diffusion of the term “disability fraud” by the media during the last year is not painless for persons with disabilities and in their fights for equal conditions in a more emancipated society. In practice, it reproduces the deep racist stereotypes of past eras.”

(ibid., my translation)

To Vardakastanis, this event was the reason for the initial discussion with the Ministries of Health and Social Solidarity and Labor and Social Security for the development of a new disability classification system (Y. Vardakastanis, interview, September 4, 2015):

In January [February] 2010, the prefect of Piraeus, Yiannis Michas, published an announcement of the existence of “disability fraud” in Piraeus. Then we sent a joint letter to the Minister of
In this joint letter, the representatives of the ESAEA expressed the disability movement’s position for the reform of the new disability classification system. Some of the ESAEA’s proposals were the following:

- Introducing transparency institutions for the protection of persons with disabilities,
- Establishment of a National Register for persons with disabilities,
- Changes to the system for the establishment and operation of the disability medical committees,
- A single system for certifying disability,
- A single disability percentage table, which should be awarded by a committee and could be used for all purposes, such as disability allowances, tax exemptions, income support,..., and so on.

(ESAEA, February 3, 2010, my translation)

On February 18, 2010, the representatives of the disability movement met Deputy Minister of Labour and Social Security Giorgos Koutroumanis to discuss the disability movement’s position regarding their welfare rights as well as their proposals for the reform of the disability classification system (ESAEA, February 18, 2010). According to a press release from ESAEA, the deputy minister of labour and social security agreed, on the one hand, that it was essential for the Ministry to develop a synergy with the disability movement about the issues that concerned persons with disabilities (ibid.). On the other hand, about the disability classification system, he stated that in the following days representatives of the Ministries of Health and Social Solidarity and Labour and Social Security as well as representatives of the disability movement would have a meeting for discussing issues relevant to the reform of the disability classification system (ibid.). What emerges here is that the disability movement, on its own initiative, began to play an active role in the formation of the new system for assessing and certifying disability by developing a synergy with the governmental bodies.
Moreover, it should be noted that the political leadership of the Ministry of Labour and Social Security showed a willingness to grant the disability movement’s request to “open” the dialogue for the reform of the system for awarding disability benefits. This brings to mind the discussion in Chapter 4 about the development of the disability card classification scheme. As we saw in Chapter 4, there was a synergy between the PASOK government, which was in power from 1993 to 2004, and the disability movement for the development of a classification scheme in adopting elements proposed by the disability movement and through the involvement of hybrid actors, who were simultaneously politicians and policy makers and persons with disabilities and members of the disability movement.

In the attempt now under discussion, as in the one discussed in Chapter 4, PASOK was again in office, and it was willing to develop a synergy with the disability movement for the revision of the system for awarding disability benefits. To my interpretation, this synergy between the ESAEA and the political leadership of the Ministry of Labour and Social Security is linked with societal corporatism, which, as I claimed earlier, describes the relationship between the ESAEA and the state, especially when the socialist party of PASOK was in office (see, for example, Chapter 4, pp. 124-125 and Pergamon, pp. 284-286). As indicated, the development of the new system for certifying and classifying disability would emerge after negotiations between the state and the disability movement. The “legal arrangements,” that is, the development of the new disability classification system, were not “imposed by force from the state,” which is characteristic of state corporatism; rather, “they emerge through negotiations and eventual agreement” between the state and the disability movement (Mouzelis, 1986, p. 75).

In February 2010, a new committee was thus established which was responsible for discussing the revision of the disability classification system (Y. Vardakastanis, interview, September 4, 2015). The members of the committee came from the Ministries of Labour and Social Security and Health and Social Solidarity as well as from the disability movement (ibid.), while Nastas, the general secretary of the ESAEA, adds that in the discussions for the preparatory text for the revision of the disability percentage table, representatives of the IKA also participated (C. Nastas, interview, 14 January 2015). The committee’s mission was to prepare the text, which later appeared as Articles 6 and 7 in the Law 3863/2010. The committee completed its mission in March, and, as Vardakastanis states, the new legislation regarding the new disability classification system was supposed to be enacted in March 2010, before the vote by Greek parlia-
ment on the First Economic Adjustment Programme between Greece and the EC, the IMF, and the ECB; however, for some reason there was a delay (Y. Vardakastanis, interview, September 4, 2015). I will return to the topic of this delay in a while.

Before I continue, it is worth noting that when I conducted the interview with Vardakastanis, he stressed that the reform of the new disability classification system, at least at a legislative level, was an initiative by the disability movement (ibid.). Here I would like to make a comment regarding the role of the disability movement in the enactment of the revised disability classification system and particularly on Vardakastanis’s emphasis on the role of the disability movement to enact the “legislation” of the system. As mentioned previously, there are similarities with the disability card classification system. Although in the disability card classification system the disability movement participated in its development with different subject positions (e.g. hybrid actors) which sounds like a beneficial situation for the disability movement, in the system described above, the disability movement asserts that the enactment of the legislation for the systems for awarding disability benefits to persons with disabilities is closely connected with them. The key word here is the word “legislation.” To my interpretation, Vardakastanis’s emphasis on this word is not accidental but aims to say something regarding the involvement of the disability movement in the policy-making.

So far, we saw that the involvement of the disability movement in the enactment of the disability classification systems in Greece has gone through various stages, from total exclusion to being recognized as a social partner by the Greek state on issues regarding disability. In the classification system discussed above, and as stressed by Vardakastanis, we saw that the disability movement was involved as a key actor in the enactment of legislation concerning persons with disabilities. Following Marx and McAdam (1994) as well as Oliver (1997), who adopts Marx and McAdam’s argument, in my interpretation, the emphasis on the active role that the disability movement played in the enactment of the legislation for the new disability classification system aims to show the empowerment and efficacy of the disability movement in the policy-making and especially in the development of social policy.

49 According to Marx and McAdam (1994), the second criterion for the evaluation of whether a social movement is successful or not refers to the power of a social movement to enact a specific legislation related to the context that the social movement represents (see also the discussion in Chapter 1, pp. 34-39).
of a system which “defines” the relationship between the state and persons with disabilities in terms of access to the welfare state.

6.2.3 The Ad Hoc Committee's findings towards an employment-oriented approach to assessing disability

Despite the fact that the text for the reform of the disability classification system had already been prepared by the representatives of the disability movement and the Ministries of Health and Social Solidarity and Labor and Social Security, the Ad Hoc Committee, which was assigned to submit its conclusions for the reform of the pension system, continued its work, publishing its findings on March 16, 2010 (Ministry of Labor and Social Security, 2010).\(^5\) In regard to the point that concerned the reform of the system for awarding disability pensions, the Committee’s findings, as well as its proposals, were the following:

The [existing] system is a passive system that produces persons with disabilities, and many times, the persons with disabilities pretend or overemphasize their [health] conditions. The reform should be focused on two areas: control (for avoiding misuse) and rehabilitation, that is, the process of aiming and helping individuals with an anatomo-physiological impairment, at the mental, physical and social levels, to reach the best possible level. In order to face the problem [that is the operation of the existing system for certifying disability], priority should not be given to a tightening of the system. Instead, a vigorous way proposes [the adoption of] vocational rehabilitation and prevention.

(ibid., pp. 77–78, my translation)

As we can see from the above quote, the findings of the Ad Hoc Committee have similarities with the conclusions of the ICF coordinators discussed in Chapter 5, as well as with the OECD (2009) report *Sickness, disability and work: Breaking the barriers. A synthesis of findings across OECD*

\(^5\) It should be added here that though the Ad Hoc Committee continued to work on examining the then-current pension scheme and proposing what should be done to improve or reform it, Giorgos Romanias and Savas Robolis, both representing GSEE in the social dialogue, left the committee after the meeting that took place on February 9, 2010 (Ministry of Labor and Social Security, 2010). Romanias explained that he left the Ad Hoc Committee because of his disagreement with raising the age limit for employees to apply for pension and because the criteria that would be introduced with the new pension scheme would be against weaker members of the society (*Eleftherotypia*, February 10, 2010).
Creative disability classification systems

countries which recommends a shift in the systems for awarding disability benefits by focusing on the integration of persons with disabilities to society and the labor market, instead of classifying and transforming disability claimants as passive beneficiaries of disability allowances. Recalling the material that I have already studied and analyzed up until now, it is the first time that the concept of rehabilitation was added to the context of disability assessment as well as how persons with disabilities will be “functional and useful to the body of society” (Moser, 2000, p. 208).

To summarize, in what was discussed above, we listened to three different “voices” retelling the story of why there was a need for a revision to the existing disability classification system, each using a different “terminology.” The first voice comes from the representatives of the government, who, though they did not have a direct participation in the discussion for the revision of the existing disability classification system, retold the story by using a neoliberal vocabulary, e.g., shrinking of the welfare state, structural reforms, cost-cutting measures, and emphasis on experts’ involvement in policy-making. The second voice comes from the disability movement, which offered a different explanation regarding the revision of the disability classification system. The disability movement retold the story for the need of a new system for certifying disability in terms of the continuous use of the term “disability fraud” and the negative stereotypes of this allegation on persons with disabilities and their families as members of Greek society. Last, the third voice belongs to the members of the Ad Hoc Committee, which revised the knowledge regarding the disability assessment and, based on the current scientific and political trends, proposed a shift in the way that the Greek state approaches disability in terms of compensation by introducing the concept of rehabilitation and the inclusion of disability beneficiaries into the society, or, in other words, they used a “workfare state” vocabulary.

Nevertheless, looking closely at the above three “voices” and their explanations for why there was a need for a new system for assessing and certifying disability, their stories not only give explanations for the upcoming reform of the system but also describe different types of disability experience. Following Diedrich (2005), Moser (2006), and Galis (2011), the disability experience should be looked at in the “material context of realities”—for example, policy-making issues, different practices, specific cultures, and so on—rather than only as a personal experience. In the above descriptions, what is noticed is that the aforementioned “voices” refer to disability by describing a different disability experience. Specifically, the
first voice describes the disability experience as a policy-making issue; the second voice offers a description drawing on the personal experience of persons with disabilities and, specifically, on the stigmatization of persons with disabilities as the alleged fake disabled in the Greek society; and the third voice refers to the disability experience (through the lens) of a politico-scientific practice.

6.2.4 Delays in the pension scheme reform and the inclusion of the country under the financial support mechanism

As already discussed, the Committee that was responsible for preparing the legislative text for the enactment of the new disability classification system had completed its task, as did the Ad Hoc Committee that was responsible for investigating the weaknesses of the existing pensions scheme, but the pension scheme reform was postponed. According to the data of this study, there were two reasons for this delay. As reported in the newspapers, the first reason had to do with the consequences of the new pension scheme reform for the PASOK government. According to the journalist, society’s negative reaction against the new measures that would be enacted (through the new pension scheme legislation), the adverse reactions from inside of PASOK, and the negative opinion polls concerning the PASOK government were the reasons the Ministry of Labour and Social Security took a step back and did not submit the draft law to Greek parliament for its enactment (Eleftherotypia, March 8, 2010). Rather, the Minister of Labour and Social Security preferred to redesign and further negotiate some parts of the pension scheme draft law (ibid.).

The second reason was the inclusion of the country under “The Economic Adjustment Programme for Greece”51 by the EC, the IMF, and the ECB late in April 2010 (I Kathimerini, April 23, 2010; Eleftherotypia, April 24, 2010; To Vima, April 24, 2010a; 24, April 24, 2010b; see also: To Vima, April 24, 2010c; April 24, 2010d). Because of the financial support mechanism, the Greek parliament, before voting for the pension scheme reform, had to vote on and pass “The First Economic Adjustment Programme for Greece,” which was enacted on May 6, 2010 (To Vima, May 7, 2010). Consequently, since then, the state’s structural reforms, such as the pension scheme reform, have not been an issue that only con-

51 Regarding the financial support by the EU and the adjustments programmes, see http://ec.europa.eu/economy_finance/assistance_eu_ms/greek_loan_facility/index_en.htm, retrieved October 1, 2016.
cerned the Greek government; instead, the tripartite committee, or troika, which consisted of representatives from the EC, the ECB, and the IMF, have had a strong voice in any kind of reforms. As for the postponed draft law for the pension scheme reform, it was first reviewed by the troika, and then, after some readjustments, it was submitted to parliament (To Vima, May 24, 2010).

The ESAEA, after studying the new draft law, sent a letter to the Minister of Labour and Social Security in which the ESAEA presented their proposals, suggesting the rewriting of some points in Articles 6 and 7 (ESAEA, May 13, 2010a). In general terms, ESAEA argued that the changes to the pension scheme towards persons with disabilities and their families were positive and that the changes were in line with what the government had already promised them (ESAEA, May 13, 2010b).

On July 7, 2010, the Law 3863/2010, which has to do with the pension scheme reform, was enacted with the Articles 6 and 7 to describe the changes to the disability classification system (Government Gazette, 2010a). Specifically, Article 6 talks about the establishment of the Center for Certifying Disability (KEPA) as the only authority in Greece for certifying disability, while Article 7 refers to the revision of the existing Regulation for Disability Degree Assessment (KEVA) (ibid.). These two institutions, that is, the KEPA and the new disability percentage table, are the two material components of the new disability classification system and will be discussed analytically in the following section.

6.3 From the negotiations to the material: Shedding light on the components of the disability classification system

The previous sections focused on the initial discussions for the need of reform to the pension scheme in order to make it sustainable. As we saw, the political leadership of the Ministry of Labor and Social Security established an Ad Hoc Committee to explore the current condition of the pension system and to submit its conclusion to the Ministry after a given period. The disability

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52 For example, ESAEA noted that the addition of one more sentence in Article 6, paragraph 4, regarding the accessibility of the place that the disability assessment procedure will be done was essential. Also, they proposed the addition of one more paragraph which would explain the procedure for the cases in which claimants/persons with disabilities, because of the severity of their health conditions, would not be able to visit the disability medical committees (ESAEA, May 13, 2010b). As for Article 7, which refers to the revision of the KEVA, the ESAEA suggested its restatement by proposing how the Article 7 should be written (ibid.).
movement, even though it was not invited to the social dialogue for the pension scheme reform, took its own initiative and “opened” the dialogue for the revision of the system for awarding disability benefits and had a key role in the legislative procedure. Last, the inclusion of the country under the financial stabilization mechanism and the introduction of new social groups such as politicians and technocrats from the EC, the IMF, and the ECB to the negotiations for the reform of the pension system affected the development of the disability classification system.

While in the previous section the emphasis was on the identification of the reasons that the existing disability classification system was not appropriate for further use as well as on the negotiations for the development of the new disability classification system, in this section the emphasis is on the system’s materiality, or on the system’s components. As discussed, after the enactment of the Law 3863/2010, the new disability classification system consisted of two new components. That is, the establishment of the KEPA as the only authority in Greece for certifying disability, under the supervision of the social security fund of IKA, as well as the replacement of the KEVA by the Single Table for the Determination of the Disability Percentage (EPPPA). In line with Star and Bowker (2010, p. 233), who advise that, for a complete analysis of the development of “a given infrastructure”, such as a disability classification scheme, it is essential to study the “political, ethical, and social choices” that were considered, the analysis of the above components includes the politics that took place during their development process. Thus, in what follows, I will describe and analyze more analytically each of these two components.

6.3.1 The establishment of the Centers for Certifying Disability (KEPA) and the role of physicians as “certifying agents” in the disability assessment procedure

The first component of the new disability classification system was a specific innovation that would be responsible for certifying disability. This innovation, called KEPA, in line with the Law 3863/2010, was to be the only authority in Greece responsible for certifying disability. As already discussed in Chapters 3, 4, and 5, one of the essential problems with the existing disability classification system(s) was their fragmentation, an issue that the incomplete attempts of the disability card classification system (Chapter 4) and the functionality/disability card classification system (Chapter 5) aspired to resolve. After the fifteen years that the above attempts lasted, however, it was the establishment of the KEPA that intro-
duced a single system for certifying disability. But what was the purpose of the KEPA?

According to the Law 3863/2010, the physical entity of the KEPA is a new innovation and is under the supervision of the Directorate of Disability and Occupational Medicine of the social security fund of IKA (Government Gazette, 2010a). The aim of the KEPA was to replace all the other existing health committees for certifying disability. As stated earlier in this thesis, almost each social security fund had its own committee for certifying disability. Similarly, the welfare services, which was responsible for providing uninsured and insured with disability allowances in cash and in kind had its own practice for assessing disability. After the establishment of the KEPA, all the other procedures for assessing and certifying disability were abolished. However, the implementation of the KEPA did not concern the existing health committees for the disability assessment of those who worked in the armed forces or the police, to name but a few (ibid.). Last, the starting date of the KEPA was supposed to be on January 1, 2011, but, as we will see later in this chapter, there was a delay, with the starting date to be moved to September 1, 2011 (ibid.).

Hence, the KEPA was the institution that was responsible for certifying disability. As for who would have the authority to assess the claimants for disability benefits, similarly with the previous system of the IKA (see Chapter 3), it was the physical entity of the Special Physicians’ Body of Health Committees. Nevertheless, in the case of the KEPA, there were a few changes to the criteria for a physician to be able to staff the above body as well as how it should be operated. For example, physicians who had been employed by other social security funds of the National Healthcare System (ESY) or physicians who worked in the private sector could apply and participate in the aforementioned body (Government Gazette, 2010a). Pediatricians, radiologists, microbiologists, and dentists, however, could not apply (ibid.). Also, the Directorate of Disability and Occupational Medicine of the IKA would be responsible for the training of a physician to join the body (ibid.). Last, a seven-member committee would decide if the candidate physicians met the relevant criteria to join the body (ibid.).

The health committees have a triple role in the disability assessment: (i) to award a disability percentage to disability claimants for the purpose of eligibility for disability pensions; (ii) to classify claimants as able or disabled; and (iii) to award a disability percentage to disability claimants for all the disability allowances, both in kind and in cash, when a disability percentage certification was necessary (ibid.). Because of the upcoming revision of the
existing disability percentage table, the health committees used the KEVA when the KEPA first started to operate; however, as we will discuss later, as soon as the revised disability percentage table was ready, then the health committees would start to use it (ibid.). Based on the above triple categorization regarding the duties of physicians during the disability assessment, what is noticed is that physicians have been made into “certifying agents” or “gatekeepers,” as Stone (1979) calls them, in that they use their medical knowledge to assess and certify disability of persons with disabilities for having access to the welfare state.

The establishment of the KEPA as well as the formation of the Special Physicians’ Body of Health Committees as parts of the first component of the new disability classification system reveal that the medical approach to disability was adopted for the development of the new disability classification system. The system developers, who, as already mentioned, were representatives of the state, the social security fund of IKA, and the disability movement, treated and approached disability as a medical problem. For instance, the implementation of the KEPA is located at the local branches of IKA, which, in the past, operated as local hospitals for the insured of IKA. In addition, the physicians who participate in the health committees assess the claimants “by making diagnostic decisions [...] [to] determine which applicants receive the organization’s benefits” (Stone, 1979, p. 227). Thus, the assessment of the disability for compensation purposes is treated as a medical problem. Following Conrad (2007, p. 5), the assessment of disability which leads to the welfare state is “defined in medical terms, described using medical language, understood through the adoption of a medical framework, or ‘treated’ with a medical intervention.”

As noted, the starting date of the KEPA was on January 1, 2011; until the middle of March 2011, however, the KEPA was not implemented (ESAEA, March 15, 2011b). ESAEA, in a letter to the alternate minister of labor and social security, refers to the delay of the operation of the KEPA and underlines the consequences of this delay to persons with disabilities, since on April 1, 2011, the existing health committees would be abolished (ESAEA, March 15, 2011a). According to the ESAEA letter, the delay in the operation of the KEPA, as well as the abolishment of the existing health committees, would have negative consequences for disability beneficiaries since the beneficiaries would not be eligible for receiving their disability pensions and allowances (ibid.). Through the Law 3996/2011, the Ministry of Labor and Social Security, as a response to the ESAEA’s request, extended the operation of the existing health committees until
September 1, 2011, which was the new starting date for the operation of the KEPA (Government Gazette, 2011d).

In parallel with the development of the KEPA, newspapers reported the upcoming changes to the system for awarding disability pensions and allowances. The newspapers’ emphasis was either on the characteristics of the new system—mostly on the presentation of the KEPA as the new authority for certifying disability (Ta Nea, February 1, 2011, April 4, 2011; Eleftherotypia, July 13, 2011; To Vima, July 22, 2011)—or on the consequences of the new system for disability pension beneficiaries—that is, reassessments of current disability pension and allowances beneficiaries (Ta Nea, April 29, 2011, June 6, 2011 June 14, 2011). For instance, journalists used headlines such as “400,000 Disability Pensions under Scrutiny,” “How Pensions Will Be Cut,” and “Autumn Cuts to Disability Pensions,” to name but a few. Journalists also informed the public about the upcoming operation of the KEPA as well as about the tighter criteria for receiving disability allowances (Ta Nea, June 6, 2011, June 14, 2011, July 22, 2011). As we can see in the headlines of the above newspaper articles, the word “cuts” and “under scrutiny” have a dominant role in describing the purpose of the new system for certifying disability, denoting, as well, an adoption by the media of the government's rhetoric regarding the cuts to disability pensions.53

Also, in the content of the above articles, there was a reference to the goal of the political leadership of the Ministry of Labor and Social Security that, after the reassessment of the disability claimants, the total percentage of disability pensions would be decreased to approximately 10% until 2015 compared to 14%, as in the case of the period before the operation of the KEPA (Ta Nea, June 14, 2011). As the journalist claims, the reductions to the percentage of disability pensions (out of all pensions) was one of the

53 After finishing the data collection and studying the material from the newspaper, what I noticed was a lack of newspaper articles that referred to persons with disabilities point of view by presenting and discussing, for instance, the possible consequences of the new system for awarding disability to them. The newspaper of the communist party Rizospastis, was an exception by reporting some articles covering the persons with disabilities perspective, as well as, Eleftherotypia.
measures included in the Medium Term Fiscal Strategy Program\textsuperscript{54}, which was enacted by the Greek parliament on June 29, 2011, as the Law 3985/2011 (ibid.; \textit{Government Gazette}, 2011b). The journalist also reports that, because of the reduction in the rate of the disability pension beneficiaries, the government would save 625 million euros (\textit{Ta Nea}, June 14, 2011). As we can see here, the emphasis on the presentation of the new system for awarding disability benefits is associated with the percentage of disability pension beneficiaries as well as the goal of the government to reduce this percentage until 2015. There was no other reference to persons with disabilities or disability beneficiaries as subjects. Instead, the emphasis was on the quantification of the disability pensioners, resulting in their being transformed into an \textit{object of governing}.

On September 1, 2011, the KEPA started its operation (\textit{Ta Nea}, September 1, 2011a, September 1, 2011b; \textit{To Vima}, September 1, 2011; \textit{Eleftherotypia}, September 1, 2011). The day before, the newspapers informed the public about the establishment of the new disability classification system and what was going to change regarding the disability assessment procedure (\textit{Ta Nea}, August 31, 2011; \textit{To Vima}, August 31, 2011; \textit{Eleftherotypia}, August 31, 2011). Similarly with what was discussed above, the titles that the journalists chose to accompany their newspaper articles contained words and expressions such as \textit{reassessments}, \textit{changes}, \textit{cuts}, \textit{disability pensions under scrutiny}, and so on, to describe the purpose of the new disability classification system, rather than referring to what a person with disabilities would gain from the new “reclassification.”

\textsuperscript{54} The \textit{Medium Term Fiscal Strategy Program} is the second memorandum or the second bailout package that the Greek government signed with the EC, IMF and ECB. Though it started to be negotiated/discussed between the Greek government and the troika since the summer of 2011 it was enacted early in the spring of 2012. After the enactment of the First Economic Adjustment Program (first memorandum) between Greece and the EC, IMF and ECB, the structural reforms that the Greek government had to enact they showed signs of deceleration, according to the reports of the troika. Thus, the enactment of the second memorandum aimed to “ensure the durability of fiscal consolidation” of Greece and specifically in the decrease of the public deficit rate (p. 2). For further information about the \textit{Medium Term Fiscal Strategy Program}, see: European Commission. 2011. \textit{The Economic Adjustment Program for Greece: Fourth Review}. Brussels: Directorate-General for Economic and Financial Affairs Publications. Retrieved April 10, 2017, from http://ec.europa.eu/economy_finance/publications/occasional_paper/2011/pdf/ocp82_en.pdf.
6.3.2 The practical politics in the development of the KEPA: The role of disability statistics

Up to this point, there had been a presentation of what KEPA was about as well as of the role of physicians in the disability assessment. However, as we saw in the above subsection, for the first time since the early discussion for the development of the KEPA, there was a reference to the rate of disability pension and the goal of the political leadership of the Ministry of Labor and Social Security to decrease this rate. This section thus focuses on the period once the KEPA was operational, and it sheds light specifically on the way the governmental bodies used disability statistics to build their rhetoric regarding why there was a need to revise the disability classification system.

A few days after the KEPA began to operate, the political leadership of the Ministry of Labor and Social Security officially announced the implementation of the new disability classification system. The minister of labor and social security talked about the new system for certifying disability by underlining its characteristics, for example the integration of all the previous systems for awarding disability benefits into one (Eleftherotypia, September 6, 2011; I Kathimerini, September 6, 2011). Apart from the operational features of the KEPA, the minister of labor and social security also referred to the system’s aim, which was the reduction in the current rate of disability pensions. Particularly, the minister of labor and social security, referring to the statistical data from the three biggest social security funds in Greece (IKA, OGA, and OAEE), stressed the high number of disability pension beneficiaries (ibid.); simultaneously, he stated that no one knew the exact number of disability pension beneficiaries and how many of them had received disability pensions illegally (Eleftherotypia, September 6, 2011). Table 5 shows the statistical data that the minister of labor and social security mentioned.

<table>
<thead>
<tr>
<th>Social Security Fund</th>
<th>Number of Disability Pensions Beneficiaries</th>
<th>Rate of the total pensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>IKA</td>
<td>135,702</td>
<td>11.7%</td>
</tr>
<tr>
<td>OGA</td>
<td>126,152</td>
<td>16.58%</td>
</tr>
<tr>
<td>OAEE</td>
<td>32,595</td>
<td>10.06%</td>
</tr>
</tbody>
</table>

*Table 5. Statistical data regarding disability pension beneficiaries (2010)*

*(I Kathimerini, September 6, 2011)*
The expectation of the ministry of labor and social security was a decrease in the rate of disability pensions from 13.8% to 10% in 2015 and 8% in 2020 (To Vima, September 5, 2011). Table 6 shows the expected reductions to the rates of disability pensions from 2010 to 2015 per social security fund.

<table>
<thead>
<tr>
<th>Social Security Fund</th>
<th>2010</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>IKA</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>OGA</td>
<td>16.58%</td>
<td>12%</td>
</tr>
<tr>
<td>OAEE</td>
<td>10.06%</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Table 6. Expected reductions in the percentage of pensions that are disability pensions from 2010 to 2015 per social security fund*  
*(I Kathimerini, September 6, 2011; Eleftherotypia, September 6, 2011)*

As it turns out, the rate of disability pensions was at the center of the presentation of the new system for assessing and certifying disability. There was no reference to persons with disabilities. Instead, the whole discussion centered on the statistical rates, which created persons with disabilities as *objects of governing*, rather than as subjects, and how the implementation of the new system should decrease the existing statistical rate; in other words, the emphasis on the rate of disability pensions as well as on their reduction reveals the power of rates or numbers to *control subjects* (Porter, 1993).

Considering what was discussed at the beginning of this chapter regarding the *creative statistics* (for example, see: pp. 186-189 and footnote 48) and the misreporting of the budget deficit rate by the Greek authorities in 2009, a question that arises here is how reliable the rates are that the Ministry of Labor and Social Security relied upon? The reason that I am raising this issue concerns an event that took place late in 2010 and in 2011 when the Ministry of Labor and Social Security announced an upcoming pensioners’ census.

Briefly, in 2010 and mainly in 2011 the ministry of labor and social security admitted that they did not know the exact number of the pensioners per social security fund (To Vima, August 26, 2010, September 9, 2010; Ta Nea, October 18, 2010; To Vima, October 31, 2011a). To be more specific, the above statement had to do with the old-age pensioners who had passed away and whose pensions their relatives were still receiving.
(Ta Nea, September 9, 2011). Therefore, as the newspaper reported, the social security funds, through announcements or circulars, asked all pensioners to be registered (instead of specific categories of pensioners). The social security funds started to undertake a pensioners’ census. The OGA was the first fund to begin, followed by OAEE, IKA, and the smaller social security funds (Agricultural Insurance Organization, 2010; To Vima, September 7, 2010, June 20, 2011, September 26, 2011). The initial findings of the pensioners’ census show that 8,000 pensioners from OGA and 20,907 pensioners from IKA did not register, and this resulted in a change in the percentage of pensioners receiving disability pensions (To Vima, August 11, 2011a, August 11, 2011b).

Furthermore, in the OECD’s report (2013), Greece: Reform of Social Welfare Program, there is a reference to the operation of the Greek social security funds and particularly to its weaknesses in terms of the availability of information about its beneficiaries. In line with the OECD report:

The management of the funds is strikingly ineffective and raises a number of issues including ITC systems, human resources, control of fraud and collection of contributions. … Information systems are not harmonized, or even non-existent, meaning that systems cannot be connected or exchange information. … The systems for controlling abuse and fraud are inadequate and not supported by the appropriate tools. Auditing and control are almost non-existent, and there is a striking lack of information about the beneficiaries. Not all the funds produce annual reports.

(ibid., p. 54)

In the same vein, a similar argument regarding the inadequate operation of the social security funds was made by economist Platon Tinios. Tinios, who has expertise on issues about the development and operation of the

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Greek pension system,\(^56\) claims that there was a lack of information from the social security funds regarding the number of their pensioners, with the IKA\(^57\) the only exception (Tinios, 2010). IKA used to publish information regarding its pensioners—such as pensions types and pensioners’ ages—through its annual *Statistical Summary* (ibid.); however, the IKA stopped publishing its statistics starting in 2007 (Tinios, 2015). Tinios criticizes how the governmental bodies used to refer to the statistical rates of the pensioners since they did not have knowledge about the exact number of their pensioners (ibid., pp. 265–268). He says:

“How many pensioners does the pension system cover and who are they? Who are the people behind the checks? The answer, unfortunately, is that the system does not know about persons since it shares only checks...”

(ibid., p. 265, my translation)

The pensioners’ census as another means to exercise power in society, the state’s admission that it did not know the exact number of pensioners, and the inability of the social security funds to provide accurate data regarding their insured, as described in the OECD report and by Tinios, give room to challenge the credibility and reliability of the rate of disability pensions. As already stated, although the purpose of the census regarded elderly pensioners, all pensioners, instead of specific categories, would be registered. This means that after the end of the census a new *number* or an *object* of pensioners would be enacted as well as a new rate of disability-

\(^56\) In the 1990s, Tinios participated in the team which prepared the Spraos report, which concerned proposals for the reform of the social security system and was published in 1997. According to the Spraos report, in order for the pension system to be sustainable, “radical” reforms should be carried out. For more information regarding Spraos report, see: Committee for the examination of macroeconomics policy. (1997). *Οικονομία και συντάξεις: Συνεισφορά στον κοινωνικό διάλογο* [Economy and pensions: Contribution to the social dialogue].

\(^57\) For instance, in an article that was published in *I Kathimerini*, the journalist discusses the issue of the number of beneficiaries of social benefits by mentioning information by the sources. The first source is the social security fund of IKA, which estimates that the beneficiaries of social benefits are approximately 12%, and the second statement belongs to the Deputy Minister of Health, Markos Mpolaris, who says that there are approximately 12,500 beneficiaries of social benefits. However, according to an anonymous employee at IKA, until early 2012, the IKA did not know the exact number of social beneficiaries (*I Kathimerini*, January 29, 2012).
pension-beneficiaries, a statistical rate different from the rate that the Ministry of Labor and Social Security already announced and built its rhetoric on for the enactment of a new and tighter system for awarding disability benefits. So what is at stake here is that the state, by using the existing statistical rates as fixed and reliable, relied upon the power of numbers to build its rhetoric and to develop its social policy.

On the other hand, the choice of the pensioners’ census and the admission by the representatives of the state that they did not know the exact number of disability pension beneficiaries denote that the existing statistical rates were fictitious, which opens up the opportunity to challenge both the origins and the reliability of the statistical rates as well as to ask, finally, what work disability classification systems do (cf. Bowker & Star, 1999). By that, I mean that, while the systems for assessing and certifying disability are supposed to support the citizens that lack part or all of their work capacity, the above discussion reveals that persons with disabilities, as subjects, are not at the center of these systems; rather, the focus is the rate of disability beneficiaries. Paraphrasing Duchan (2004), the emphasis on the rates of disability beneficiaries instead of on persons with disabilities and their relation to the disability classification system offers room to wonder and problematize Where are the people with disabilities in the disability classification systems? According to Table 6, for example, the governmental authorities announced that after the implementation of the new disability classification system the aim was to decrease the rate of disability beneficiaries from 13.8% (2010) of disability pensioners to 8% (2020).

6.3.3 The “practical politics” in the development of the Single Table for the Disability Percentage Determination (EPPPA)

Bowker and Star (1999, p. 44) claim that before ending up with a standard or a classification scheme, there is a long journey of “negotiations, organizational process, and conflict,” a process they call practical politics. This is the third methodological theme that they propose for deeper analysis of a classification system. Following their argument, this subsection focuses on the specific period before the enactment of the EPPPA, which is the core component of the system for assessing and certifying disability, and seeks to shed light on the political, scientific, and social choices in the development of the disability percentage table.

The second component of the new disability classification system concerns the revision of the disability percentage table. In line with Article 7 of the Law 3863/2010, the new table would replace both the existing
KEVA as well as the disability percentage table that was in use and appeared in the Law 1813/1988 (*Government Gazette*, 2010a). In contrast with the previous system for assessing and certifying disability (the system discussed in Chapter 3), the new table would apply to all social security funds as well as to all employees in the public sector (ibid.).\(^{58}\) A special scientific committee, formed and announced by the Ministry of Labor and Social Security, was responsible for the preparation and publication of the new table within a period of six months after the enactment of the Law 3863/2010 (ibid.). Though the Law 3863 was published in the mid-July 2010, entailing that the EPPPA was supposed to be ready at the beginning of 2011, this did not happen. Instead, it was published with a delay of almost one year, that is, late in 2011.

In July 2011 the minister of labor and social security, through Ministerial Decision, Issue no. 80000/oik.3647/212/4.7.2011, announced both the members of the special scientific committee as well as their duties—namely, the establishment of the EPPPA and the definition of the illnesses that cause permanent disability (*Government Gazette*, 2011c). The composition of this committee was as follows:

**Chairman**
- Athina Dretta – General Secretary of the General Secretariat of Social Security

**Members**
- Ioannis Sarivougikoukas – Deputy Governor of IKA-ETAM, responsible for health care issues
- Athanasios Xenos – Director at the Directorate of Disability and Social Work of IKA-ETAM
- Christodoulos Stefanadis - Professor of Cardiology of the Medical School of the National and Kapodistrian University of Athens (EKPA)
- Athanasios-Meletios Dimopoulos – Professor of Therapeutics of the Medical School of the National and Kapodistrian University of Athens (EKPA)
- Christos Nastas – General Secretary of the National Confederation of Persons with Disabilities (ESAEA). Representatives of

\(^{58}\) For the *fragmentation* of the disability classification systems is Greece, see also the relevant discussions in Chapter 4, pp. 114-119.
the ESAEA, with Ioannis Vardakastanis, Chairman of ESAEA, as an alternate.
- Charalambos Alexopoulos – Occupational Physician at Public Power Corporations S.A. (DEH)
- Michalis Koutras – Physician, Neurologist
- Ioannis Valavanis – Physician, Orthopedic
- Vasileios Koulouris - Head at the Directorate of the Main Insurance of Employees at the General Secretariat of Social Security, with Despoina Patouna, Head of the department at the same Directorate, as an alternate.

(Government Gazette, 2011c)

What is noticed regarding the staffing of the above committee is its heterogeneity. The participants were representatives of the state; the social security fund of the IKA, which had the leading role in the operation of the new system for assessing and certifying disability; and the medical society. As for the representatives of the disability movement, the participation of a representative of the ESAEA was mandatory (Government Gazette, 2010a).

Comparing the members who participated in the enactment of the KEVA (see, e.g., Appendix III) and the EPPPA, what is observed is that, whereas for the KEVA the responsibility for preparing the disability percentage table was on physicians of IKA, in case of the EPPPA it was on physicians from the medical academic society or with other physicians who were not linked to the physicians of IKA. Nastas says that according to the Law 3863/2010, representatives of the medical society, instead of IKA’s physicians, had the responsibility for developing the EPPPA, and, then, in a second stage, because of the ESAEA’s request, representatives from relevant institutions of the Greek state would also have a say in its preparation (C. Nastas, interview, January 14, 2015).

On the other hand, physicians of the IKA, who were members of the health committees for the disability assessment, questioned the staffing of the above committee. Gkiouzelis, who is the chairman of the Hellenic Medical Society of Disability, Social Insurance and Welfare and had

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59 For more information regarding the Hellenic Medical Society of Disability, Social Insurance and Welfare (ELIEAKAP), see footnote 20 of this thesis as well as in the following link: http://hmsofdisability.blogspot.gr/ retrieved February 28, 2017 [in Greek].
been a member of the health committees of IKA since early in the 2000s, challenges the choice of physicians who participated in the aforementioned committee for the development of the disability percentage table, arguing that they lacked knowledge regarding disability in terms of disability assessment (I. Gkiouzelis, interview, May 26, 2015).

A conflict thus emerges here between the IKA physicians and the committee, which prepared Articles 6 and 7 of the Law 3863/2010. The conflict concerns who has the scientific authority, or the expertise, to translate bodily loss, because of an impairment or illness, to a disability percentage. Or, to paraphrase Galis, what is at stake here is who has the authority to determine what disability is and how it is translated into a disability percentage (cf. Galis, 2011, p. 829). For physicians of IKA, in line with Gkiouzelis (2015), they were the IKA physicians because they had the experience of disability assessment; however, for the state and the disability movement, they were physicians who came from the medical and the academic medical society, without involving or inviting physicians who belonged to the Special Physicians’ Body of Health Committees.

Following the controversy regarding who has the authority to establish the disability percentage table, a second point that is brought to the fore refers to the role of the disability movement and especially its position on the choice of the medical society as the main responsible authority for establishing the disability percentage table. Nastas refers to the role of the ESAEA, and he talks particularly about the “prerequisite” that ESAEA set for the development of the new disability percentage table. According to him:

ESAEA had set as a precondition that all the [relevant] institutions of the Greek state be consulted, such as the National Health Council and the medical organizations, which would observe the procedure and [have] knowledge of the progress in each scientific field, and, consequently, [would have knowledge] about the progress of the illness.

(C. Nastas, interview, January 14, 2015)

According to Nastas, the role of the medical society and its scientific knowledge was an essential element for the enactment of the disability percentage table. What emerges here is that the disability movement relied upon the scientific knowledge of the medical society—not on the physicians of the IKA, who had experience regarding disability through their involvement in the health committees, but on physicians who belonged to medical aca-
demic society and medical organizations, which had more scientific status
and prestige than the employees at IKA. Besides, it should be added that, as
we saw in Chapters 3, 4, and 5, the credibility of the physicians who had
participated in the staffing of the health committees for the disability as-
essment has been questioned by stressing their vulnerability to external
factors, such as their vulnerability to political actors who participated in the
local administration of the municipalities and/or prefectures and because of
the physician-patient relationship.

Considering the continuous controversy regarding the alleged disability
fraud, a controversy that has stigmatized persons with disabilities in the
Greek society and has enacted negative stereotypes against persons with
disabilities, to my interpretation, the disability movement’s support of the
committee’s scientific status or prestige could be viewed as a move to gain
the support of public opinion. The disability movement, not only in
Greece but elsewhere, ideologically, approaches disability from a socio-
political perspective. But, here, in the enactment of the system for certify-
ing and assessing disability and particularly the disability percentage table,
what is notable is that the disability movement got involved in the contro-
versy by adopting the medical approach to disability. To my
interpretation, the disability movement “set aside” its ideology and adopt-
ed a scientific-oriented approach to the controversy for the establishment
of the disability percentage table. Following Galis and Anshelm (2013), 60
the reliance on the scientific expertise and prestige of the academic physi-
cians by the disability movement should be viewed as a choice, a political
choice, for changing society’s negative perception of persons with
disabilities as “frauds” and “cheaters.”

Returning to the development of the EPPPA, the Chairman of ESAEA,
Yiannis Vardakastanis, shares his experience as a member of the above
committee as follows:

Early in the summer of 2011, suddenly...the committee [for the
development of disability percentage table] was established...in
order to revise the KEVA according to the Article 7 of the Law

60 Galis and Anshelm (2013), who have studied the involvement of concerned
groups in nuclear waste management in Sweden, claim that when concerned
groups followed a scientific-oriented instead of ideologically-oriented approach to
the controversy regarding nuclear management, there was a shift in the reaction of
the public against nuclear waste, with the citizens less concerned about the conse-
quences of nuclear power.
3863/2010. Nastas [the general secretary of the ESAEA] was a regular member and I an alternate, but we participated together. Our point of view [disability movement] was that [the health committees of] the KEPA should continue attributing a disability percentage based on the old KEVA, and the Committee, without rush or sloppiness, should deal carefully with the preparation of the new regulation so that the update, renewal, and replacement of the [previous] table would be the outcome of a detailed...study regarding what happened in other EU countries of similar size and with similar policies, and so on. In other words, to learn from what has happened [outside of Greece].

(Y. Vardakastanis, interview, September 4, 2015)

However, as Vardakastanis further claims, this proposal by the representatives of the disability movement, was ignored (ibid.). Early in November 2011, the EPPPA was published through Ministerial Decision, Issue no. 11321/oik.26012/1718 (Government Gazette, 2011e). In line with the Ministry of Labor and Social Security, the EPPPA should be used by the health committees of the KEPA after the 1st of January 2012, replacing the KEVA (ibid.).

Summarizing, in this subsection what is presented and discussed is that the development of the disability percentage table was not a process in which entities such as physicians, stakeholders, and representatives of the disability movement simply participated in the design process. Instead, it was a process in which conflicts and political and ethical choices were taken into account. As we saw, physicians with experience in disability assessment challenged the choice of other physicians inexperienced in disability assessment (for developing the disability percentage table) by invoking the concept of expertise. Additionally, we saw how the disability movement, by relying upon the scientific authority of the physicians who came from the academic medical context and/or physicians who did not have a relationship with the disability assessment, made a political choice for reversing the negative stereotypes against persons with disabilities in the Greek society.

6.3.3.1 Reconstructing the EPPPA or the disability percentage table
Browsing Ministerial Decision, Issue no. 11321/oik.26012/1718, the new disability percentage table consists of sixteen chapters, in contrast to the KEVA, which contains eight chapters and two annexes (Government Gazette, 2011e). These chapters are the following:
Chapter 1. Blood disorders
Chapter 2. Respiratory disorders
Chapter 3. Circulatory system disorders
Chapter 4. Digestive disorders
Chapter 5. Female genital organs disorders and sex disorders
Chapter 6. Metabolic disorders
Chapter 7. Dermatological disorders
Chapter 8. Mental disorders
Chapter 9. Nervous systems disorders
Chapter 10. Orthopedic disorders
Chapter 11. Ears, nose and throat disorders
Chapter 12. Surgical disorders
Chapter 13. Eye disorders
Chapter 14. Rheumatic disorders
Chapter 15. Nephrology disorders
Chapter 16. Occupational disorders

(ibt., my translation)

As observed, this version of the disability percentage table has more chapters than the KEVA (see also Chapter 3, p. 99). Comparing the names of the chapters of the EPPPA and KEVA, we see that new chapters were added. For instance, there are chapters on the respiratory disorders, digestive disorders, metabolic disorders, and so on, which did not appear in the KEVA, at least not as separate chapters. Also, regarding the structure, no specific scheme is followed throughout the EPPPA, and sometimes this heterogeneity is observed even in the same sections of the same chapter.

In chapter 1 of the EPPPA, for example, which talks about blood disorders, the structure is as follows: first, there is the name of the blood disorder, e.g., thalassemia; then there is a subsection with a short description of the “pathogenesis” of the disease; then the next subsection offers a presentation regarding the “prognosis” and the “socio-medical aspects”; and at the end there is the disability percentage (see also the analysis in my Chapter 3, p. 103-104). To give an illustration of how the illnesses appeared in the EPPPA, I will use the example of AIDS. The reason that I chose AIDS lies in the fact that it is the same example that I chose in Chapter 3 when I discussed the content of the KEVA (see also pp. 100-101). By using the same example, will be useful for observing whether any changes were made. In the EPPPA, AIDS is described as follows:
Acquired immune deficiency syndrome (AIDS)

A. Pathogenesis
A. Caused by the human retrovirus HIV. After the initial infection and the acute retroviral syndrome, the natural course of the infection is characterized by a progressive reduction of the CD4 T-lymphocytes and an increase in the HIV RNA in blood. Depending on the number of the CD4 cells, the disease is marked as early (CD4>500/μl), mid (CD4: 200-500/μl), advanced (CD4<200/μl) and final stage (CD4<50/μl). The clinical manifestation and evolution of the HIV infection are correlated with the total number of CD4 T-lymphocytes.

The chronic use of antiretroviral medicine has been associated with the appearance of several long-term complications such as coronary artery disease, dyslipidemia, lipodystrophy syndrome, diabetes, hepatotoxicity, nephrotoxicity, osteopenia and osteoporosis.

B. Severity levels

1st-level – Early stage (asymptomatic patients with CD4>500/μl)
It is possible that some patients might experience chronic generalized lymphadenopathy or skin rashes, onychomycosis, recurrent herpes labialis, vaginal mycosis

Prognosis and socio-medical aspects:
Intervention in regard to symptoms. Continuous assessment of chronic psychic stress management. Prognosis is good.
Disability percentage: 10-20%

2nd level – Mid-stage (CD4: 200-500/μl)
Asymptomatic patients or patients with general symptoms (fever, sweat, weight loss, diarrhea syndrome), recurrent episodes of herpes zoster, oropharyngeal or recurrent vaginal mycosis, dysplasia or in situ cervical cancer, idiopathic thrombocytopenic purpura, peripheral neuropathy, neurocognitive disorders, etc. The reduction of the CD4<350/μl and/or the emergence of symptoms necessitate starting antiretroviral therapy.

Prognosis and socio-medical aspects:
The start of antiretroviral therapy and the individual treatment of the above-mentioned symptoms-diseases is usually associated with good prognosis.

Disability percentage of the asymptomatic patients: 40-50%
Disability percentage to patients with the symptoms mentioned above: 67% for one year and, then, as long as they receive antiretroviral therapy and they are symptomatic, 50%

3rd level advanced/final stage (CD4<200/μl)
Manifestation of the disorders that define AIDS: pneumonia P. jiroveci, brain toxoplasmosis, fungal esophagitis, cryptosporidiosis, microsporidiosis tuberculosis, invasive cervical cancer, Kaposi’s sarcoma, lymphomas, and neuropathy. At the final stage CD4<50/μl, there is development of disorders such as diffuse disorder by cytomegalovirus/retinitis, invasive fungal infections, diffuse disorder by Mycobacterium avium complex, cryptococcal meningitis, progressive multifocal leukoencephalopathy, wasting syndrome, dementia.

Prognosis and socio-medical aspects:
Particularly severe situation with questionable course. Patients might exhibit irreversible organ damages, which are to be tested individually, (e.g. blindness by CMV retinitis, lymphoma, neurological/mental disorders).

Disability percentage:
During the emergence of these disorders and their duration: 80% - and above 80%.
Upon developing cancer: above the 80%.
Upon partial immune recovery because of antiretroviral therapy and treatment of the opportunistic infection: 80%
In the case of irreversible organ damages, disability percentages are examined/attributed individually according to organ damages.

(Government Gazette, 2011e, pp. 38078-38079, my translation)

The presentation of AIDS is almost the same, in terms of structure, as in the KEVA. Differences are observed both in the content of illness “pathogenesis” as well as in the subsection with the severity levels. In the EPPPA, for example, in the subsection about severity levels, the reference to laboratory and clinical findings has been removed. As for the values of the disability percentages, which are linked to illness severity, they have been revised. For instance, in the early stage of AIDS (level 1), according to the EPPPA, the disability percentage ranges between 10% and 20%, whereas in the KEVA, for the same severity level (level 1) the disability percentage ranges between 20 % and 25%. Obviously, in this case, the difference between the disability percentages is not huge, but there is a reduction.
Chapter 2 of the EPPPA, which deals with the disorders of the respiratory system, has the same structure as chapter 1. Similarly, chapters 3, 4, 5, 6, and 7 of the EPPPA have almost the same structure; that is, the name of the disease, a short prognosis of the disease, and finally, the severity levels accompanied with the disability percentage.

Chapters 8 and 9 of the EPPPA, on the other hand, which treat of mental disorders (chapter 8) and nervous systems disorders (chapter 9), have adopted different elements. By this I mean that in both chapters there is a reference to the ICD-10 classification system. According to the authors of chapter 8, the use of the ICD-10, as a benchmark will help the physicians of health committees better evaluate the health condition of persons with disabilities and, consequently, be able to attribute a disability percentage that is as close as possible to an applicant’s health condition for claiming their rights, e.g., disability allowances (Government Gazette, 2011e, p. 38165). Also, in chapter 8 there is a reference to the calculation of the disability percentage. Instead of referring to the specific mental disorder and how this disorder is translated into a disability percentage, the authors of this chapter put the emphasis on two concepts: the “frequency” of the symptoms and the “severity” of the disorder. Additionally, an algorithm is introduced for the calculation of the disability percentage. Specifically:

Symptoms frequency could be rated on a scale from 0 to 4, where 0 means complete absence of symptoms, and 4 means daily presence of symptoms during the last 1-2 months before the diagnostic evaluation:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>absence</td>
</tr>
<tr>
<td>1</td>
<td>occasional appearance</td>
</tr>
<tr>
<td>2</td>
<td>periodic appearance</td>
</tr>
<tr>
<td>3</td>
<td>recurrent appearance</td>
</tr>
<tr>
<td>4</td>
<td>systematic appearance</td>
</tr>
</tbody>
</table>

Disorder severity could be rated on a scale from 0 to 4, where 0 signifies the complete functionality in a person’s daily activities, according to the Global Assessment of Functioning (GAF), while 4 signifies a marked reduction in a person’s functionality during the last 1-2 months before the diagnostic evaluation:

Below there is an illustrative way for rating the severity [of the disorder], according to GAF:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>complete functionality (GAF 81–100)</td>
</tr>
<tr>
<td>1</td>
<td>mild reduction (GAF 61–80)</td>
</tr>
</tbody>
</table>
2 – moderate reduction (GAF 51–60)
3 – severe reduction (GAF 31–50)
4 – complete reduction (GAF 1–30)

As for the algorithm, it is formulated as:

\[ D(\text{prognosis})\% = \frac{[(\text{frequency} \times \text{severity})_I - (\text{frequency} \times \text{severity})_II] \times 100}{(\text{frequency} \times \text{severity})_I} \]

Where,

- \( D \) = change/variation
- \( I \) = patient’s history
- \( II \) = current diagnostic evaluation

\((\text{Government Gazette}, 2011\text{e, p. 38165, my translation})\)

What we can see in the above extract is that for a first time there is an emphasis on a person’s functionality instead of disability. I will return to this observation after finishing the description of the remaining chapters of the EPPPA.

For the classification of mental disorders, ten basic diagnostic categories have been introduced in line with the ICD-10. For example, the first diagnostic category refers to the “organic and secondary mental disorders.” In this category, there are four subcategories where there is a reference to a specific syndrome or disorder and its translation (or not) into a disability percentage. Following is a short extract from the aforementioned category.

**Organic and secondary mental disorders**

**Subcategories**

- Types of dementia (Alzheimer, Pick, vascular dementia, mix dementia, Creutzfeldt-Jakob disease, Huntington disease, AIDS, etc.)
  - Prognosis: Potential bad
  - Disability Percentage: 50-80%
- Acute confusion syndromes (deliria)
  - No disability percentage.

\((\text{ibid., p. 38166, my translation})\)

Chapter 9 of the EPPPA, which deals with nervous system disorders, also has a different structure compared to the other chapters of the EPPPA. The reader will not find the name of a disease, its pathogenesis, prognosis, and severity levels; instead, there is an emphasis on the abilities of the person with disabilities. According to the first sentence of chapter 9, for the assessment of neurological disorders, the emphasis is on the “remaining functional
ability” of the claimant in order to attribute him/her a disability percentage. In contrast with the other chapters of the EPPPA, chapter 9 puts at the center of disability assessment the “consequences” of the neurological disorder to the person with disabilities and not the disability assessment of the neurological disorder as such. Similar to chapter 8, another procedure is proposed for the assessment of the remaining functional abilities of the claimants. Specifically, the Activities of Daily Living (ADL) classification scheme\(^\text{61}\) is the scheme proposed for the assessment of the remaining functional abilities of the claimant. The ADL contains fourteen daily activities divided into two categories, basic and advanced, and two severity levels, difficult and impossible. The following table, Table 7, is a copy of the table as it appears in chapter 9 of the EPPPA.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Normal</th>
<th>Difficult</th>
<th>Impossible</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Urination, defecation</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. Body hygiene</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. Bodily cleanliness</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4. Feeding</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. Clothing</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>6. Moving within the house with or without aid</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Sub-total I</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Meal preparation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>8. Washing clothes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9. Housekeeping or minor household work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10. Proper management and taking medication</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11. Managing everyday financial issues</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12. Using telephone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13. Mild exercise, shopping</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14. Moving as a guide or passenger</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sub-total II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7. Fourteen activities of the daily living (ADL)

\[(Government\ Gazette\,\ 2011e,\ pp.\ 38172–38173,\ my\ translation)\]

\(61\) For more information regarding the ADL classification scheme, see the discussion in (my) Chapter 1, pp. 45-46.
In accordance with the above table, the emphasis is on self-assessment of the abilities of a person with disabilities to perform/accomplish specific tasks. Further, the ability to complete the above activities is translated into three more categories:

**A. Mild reduction.** Total score up to 12, but with the subtotal for basic activities less than 8; otherwise, the reduction is considered as moderate.

**B. Moderate reduction.** Total score up to 24, but with the subtotal for basic activities less than 12; otherwise, the reduction is considered as severe.

**C. Severe reduction.** Total score of more than 24 or a score for basic daily activities greater than or equal to 12

(ibid., p. 38173, my translation)

As for the calculation of the disability percentage, another algorithm is proposed,

\[ A + B(1-A) \]

where \(A\) is the highest disability percentage (expressed as a decimal number) and \(B\) the lowest. For example, if a claimant has 35% percentage of disability for condition \(A\) and 20% for condition \(B\), then the total disability percentage is calculated as follows:

\[ 0.35 + 0.20(1-0.35) = 0.48 \text{ or } 48\% \text{ total disability percentage.} \]

The same procedure is followed when a claimant has more than two conditions. In this case, the \(A\) is the decimal number of the first two sums and \(B\) is the decimal number of the condition \(C\).

As in chapter 8, the authors of chapter 9 have adopted parts of the ICD-10 to describe or present a list of the diseases of the nervous system. After taking a quick look at this part, the diseases list looks like a straight copy-and-paste from the ICD-10, but in the Greek language. Specifically:

**Inflammatory diseases of the central nervous system**

(G00-G09)

Bacterial meningitis, not elsewhere classified

*Included*  
Arachnoiditis  
Leptomeningitis  
Meningitis

*Excluded*  
Pachymeningitis

}{

220  ANTONIA PAVLI  *Creative disability classification systems*
Bacterial:
Meningoencephalitis (G14.2)
Meningomyelitis (G14.2)

G00.0 Hemophilus meningitis
\textit{Meningitis due to Hemophilus influenza}

G00.1 Pneumococcal meningitis

G00.2 Streptococcal meningitis

G00.3 Staphylococcal meningitis

G00.8 Other bacterial meningitis

\begin{itemize}
\item Meningitis due to Escherichia coli
\item Friedländer’s bacillus
\item Klebsiella
\end{itemize}

G00.9 Bacterial meningitis, unspecified

\begin{itemize}
\item Meningitis
\item Purulent, NOS
\item Pyogenic, NOS
\item Suppurative, NOS.
\end{itemize}


Regarding the size of chapter 9, it is perhaps one of the most extensive chapters of the EPPPA. I will further comment on chapter 9 together with chapter 8 when I complete the remaining presentation of the EPPPA.

Chapter 10 of the EPPPA, which deals with the orthopedic disorders, is very concentrated in relation to the same chapter in the KEVA. In the EPPPA, there is no detailed description of each orthopedic disorder; rather, there is a two-column table, wherein the first column contains a description of the disorder and the second column contains the relative disability percentage. Lastly, chapters 11, 12, 14, 15, and 16 of the EPPPA follow the same structure as chapters 1 to 7; whereas chapter 13, concerning eye disorders, has similarities with chapter 10, since it is also very concentrated, with the emphasis on visual acuity and the visual fields, or the “eyes’ functional state,” instead of a detailed reference to each eye disorder \textit{(Government Gazette, 2011e, p. 38258)}.

To summarize, the reconstruction of the EPPPA shows that chapters 8 and 9 are the only chapters which followed a different structure and different approach to disability. While the majority of the EPPPA chapters center on the quantification of the disorder or impairment by translating the latter into
a disability percentage, in chapters 8 and 9 we saw that the quantification of an individual’s “functions” and “abilities” is at the center. To be more specific, both in chapters 8 and 9 of the EPPPA, two new methods for the disability assessment are introduced: the GAF and the ADL. In both these classification schemes, the emphasis is on the functions (GAF) and the abilities (ADL) of the persons with disabilities. Regarding the ADL, as we saw in (my) Chapter 1 (see, e.g., pp. 45-46), it is a classification scheme wherein the focus is on claimants’ abilities rather than on their disabilities. Both the GAF and ADL classification schemes have been developed by adopting elements of the individual/medical approach to disability, since the emphasis is on the individual and his/her abilities and functions and since they are self-assessment tools wherein the claimant his/herself assesses the level of his/her abilities to perform specific daily tasks.

This variation, however, brings to the fore a conflict regarding the structure of the EPPPA. On the one hand, we saw that the main approach for the determination of a disability percentage was the assessment of a disorder or impairment; while, on the other hand, in chapters 8 and 9 the assessment focuses on the “functions” and “abilities.” The emphasis on “functions” and “abilities” of persons with disabilities is not a new “trend” that comes out of nowhere. On the contrary, it is linked with the “paradigm shift,” as Marin (2003) calls it, which refers to the transition from a compensation scheme for awarding disability benefits to persons with disabilities to an occupational-oriented scheme, where the emphasis is on the “functions” and “abilities” of persons with disabilities, aiming at their social inclusion and their reintegration into the labor market.

Starting in the 1990s and mostly in the 2000s, several countries around the world have adopted a neoliberal-oriented policy to reform access to the welfare state in order to meet the “challenge” of the continuous increase in the number of disability beneficiaries (e.g., van Oorschot & Boos, 2000; Østerås et al., 2007; Parker Harris et al., 2012, 2014; Grover & Soldatic, 2013; OECD, 2003, 2009). That is, they have implemented occupational-oriented schemes for the award of disability benefits, aiming to assess the remaining abilities and functions of persons with disabilities instead of assessing their disabilities. For instance, in Australia as well as in the United Kingdom, a person with disabilities is eligible for receiving disability benefits only if they can prove that they can work, or, in other words, the access to disability allowances is linked to the labor market (Grover & Soldatic, 2013). While the occupational-oriented scheme for the award of disability benefits refers to all kinds of disabilities, in the Greek case, we saw that the
assessment of the abilities and functions concerns only those claimants that have a mental or a neurological disorder. Furthermore, a second issue that it is also essential to highlight here concerns the content of chapters 8 and 9, as both discuss “mental health problems” and propose a different algorithm and method for the assessment of functions and abilities. The reason that I am focusing on the content of chapters 8 and 9 has to do with the OECD report that was published in 2009. Anyone who browses the OECD report *Sickness, disability and work: Breaking the barriers. A synthesis of findings across OECD countries* will notice that there is a specific reference to *mental health problems*, describing the category as “an unresolved challenge” (2009, p. 10). According to the OECD report, “mental health problems are now the biggest single cause for a disability benefit claim in most countries...and disability policies are not well suited to deal with the mental health problems” (ibid., p. 11).

The discussion in the previous section regarding the need to decrease the rate of disability beneficiaries and the observation by the OECD that the frequency of mental health related problems has increased offer the opportunity to ask *what work classifications do, what happens to the cases that do not fit* (Bowker & Star 1999, p. 9), and *who creates the classifications and standards*. My purpose in raising these questions here for further problematization concerns the politics that were involved in the enactment of the disability percentage table. For example, as already stated, the assessment of the abilities and functions of the persons with disabilities concerns only the claimants who have related mental disorders and no other kinds of impairments or disorders. But why does someone with a

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psychological disorder need to be assessed based on his/her abilities and functions, while someone with a blood disorder is assessed based on his/her disorder? I will return on this issue in the following chapter.

Late in 2011, the two components of the new classification scheme were enacted and ready to be implemented. Comparing the previous attempts, as discussed earlier in this thesis, the “KEPA” system for assessing and certifying disability, as it used to be called, was ready in a period of two years from the time it was first announced early in 2010. Among other things, this reveals the need for quick and radical changes to the system for awarding disability benefits. Nevertheless, since the first day of the operation of the KEPA, several problems emerged, with persons with disabilities complaining about the insufficient operation of the KEPA—from problems with accessibility to the creation of long waiting lists, which caused persons with disabilities to temporarily lose their disability pensions and benefits. Similarly, the publication of the EPPPA, was almost immediately accompanied by negative reactions from both the disability movement and the media. Both the adverse reactions against the EPPPA and the insufficient operation of the KEPA will be discussed in Chapter 7, which deals with the initial implementation stage of the KEPA system for awarding disability benefits.

6.4 Conclusion
Chapter 6 discussed the enactment of the disability classification system, which developed in parallel with the outbreak of the economic crisis in Greece late in 2009. The purpose of this chapter, as with the Chapters 3, 4, and 5 of this thesis, was to shed light on how a disability classification system or a system of awarding disability allowances came into being. In order to do this, I adopted the theoretical/methodological themes of: indeterminacy of the Past, material and texture, and practical politics, as proposed by Star and Bowker (2010), to shed light on the “political, ethical, and social choices” that had been taken into consideration during the development of the disability classification scheme and before the scheme became a black box. In what follows, I will discuss, through the contribution of the above theoretical/methodological themes, some points that emerged during the analysis of the aforementioned system.

Starting with the indeterminacy of the Past methodological theme and the presentation of the ways different social groups expressed their point of view in evaluating the existing disability classification system, we saw that because of the economic crisis a neoliberal agenda was adopted that, among other
things, has led to the reduction of the welfare state spending, for example through the pension system reform. In regard to disability assessment, we saw that the Ad Hoc Committee, which was defined by the state and had an emphasis on the scientific expertise of its members, proposed an employment-oriented approach to disability assessment by putting the emphasis on the rehabilitation of disability beneficiaries and their inclusion in society and the labor market. Thus, the Ad Hoc Committee proposal is in line with the transformation, which has taken place internationally since the 1990s, from a welfare state to a “workfare state.”

An essential point that emerged using the aforementioned theoretical/methodological themes concerns the involvement of the disability movement in the policy-making. As we saw, the disability movement, upon its own initiative, opened the dialogue and had a primary role in the enactment of the legislation of the new system of assessing and certifying disability, and it had a say in the development of the disability percentage table. Recall Marx and McAdam’s (1994) position that in order for a social movement to be evaluated as successful or not, it should be assessed, among other things, as to whether “any new political or economic changes have resulted from their activities” or “any specific legislation has resulted” (as cited in Oliver, 1997, p. 248). Based on the above criteria, the Greek disability movement should be evaluated as a successful social movement, since the political initiative that led to the enactment of the legislation for the new disability classification system belongs to them.

But, as discussed earlier in this Chapter, the disability movement’s initiative found an ally in the political leadership of the Ministry of Labor and Social Security, which proceeded with the procedures for the reform of the disability classification system. Recalling what I claimed earlier in this Chapter, as well as in Chapter 4, the empowerment of the disability movement and its active involvement in the policy-making should also be explained by the political economic theory of corporatism, and in the case of the disability movement, societal corporatism. In this chapter, for example, we saw how the political leadership of the Ministry of Labor and Social Security established a synergy with the disability movement and its request to put an end to the continuing debate in Greek society about the alleged disability fraud through the revision of the system for awarding disability benefits.

The reconstruction of the disability classification system through the help of the above theoretical/methodological themes reveals the dominance of the medical approach to disability. When the analysis was about the negotiations for the development of the new disability classification system or
about the *material components* of that system, there was an emphasis on the scientific status of the participants during the development process—for example, on their expertise or on the academic status of the physicians who would enact the disability percentage table—and there was an approach to disability as a medical condition, since it was medical knowledge and interventions that could lead a claimant to the welfare state.

Thus, focusing on the material components of the aforementioned disability classification system, they were a combination of the *physical entities* and *conventional arrangements*, and both of them denote a relation to the medical approach to disability. For example, the KEPA was and is a *physical entity* in that it is the place where the disability assessment should be done, but simultaneously, considering that KEPA is located in the local branches of IKA hospitals, it is a *conventional arrangement* in that it entails that disability is to be assessed in the hospital. Similarly, the body of physicians who have the responsibility for certifying disability is a *physical entity* in that the physicians work as “certifying agents” (Stone, 1979), but simultaneously, there is an indirect reference to the authority of the medical society. Last, the disability percentage table is another *physical entity* of the system, but the translation of specific characteristics of a disorder and/or impairment and its levels of severity into a specific disability percentage constitute another *conventional arrangement* that system developers made.

The role of statistics, and particularly the disability pension rates, as emerged after the examination of the *practical politics* behind the enactment of the KEPA, was a crucial tool for the governmental bodies to build their argument for the need for a tighter system for awarding disability pensions and allowances. Disability scholars Abberley (1992) and Kirchner (1993) state that the use of *disability statistics* is a tool that used to be used by policy makers for designing disability/social policies. In the case of Greece, however, we saw that, while the system developers imitate what other policy makers used to do with disability statistics, the origins and the credibility of the Greek disability statistics is under question.

Nevertheless, it is essential to mention here the dominant role of quantification in politics and the *power of numbers* to enact objects of governing by setting aside, in this case, persons with disabilities as subjects. As we already saw in this chapter, the whole discussion about the purpose of the new disability classification had to do with the disability pension rates and how the operation of the KEPA should decrease that percentage. There is never any reference to disability beneficiaries as subjects. But the disability classification system concerns persons with disabilities, since it is a means of receiving sup-
port from the welfare state, either temporarily or permanently, because of a lack of appropriate work capacity to be fully included in the labor market.

Considering the lack of a census on persons with disabilities that would provide relevant information about the population and the needs of persons with disabilities in Greece, the decrease of the existing rate of the disability pensioners gives room to challenge the role of the disability classification and to ask What work do classifications and standards do (Bowker & Star, 1999). For example, as stated earlier, the aim of the political leadership of the Ministry of Labor and Social Security was to decrease the rate of disability pensioners from 13.8% of all pensioners to 10% in 2015. This “expected reduction” by the governmental bodies offers room to problematize what this reduction means for persons with disabilities when there is no clear picture of the population of persons with disabilities in Greece, as well as to problematize what the real purpose of the system for awarding disability benefits is.

The discussion about the practical politics that took place during the revision of the disability percentage table offered the opportunity to explore the “invisible work” that was done for the revision of the existing standards. The reconstruction of the disability percentage table, or the EPPPA, shows that there were changes to how an impairment or disorder is translated into a disability percentage as well as new ways to assess disability. In other words, there was a change to the standards for someone to be classified as able or disabled. Because of the new classification scheme, persons with disabilities would have to be reassessed and reclassified as able or disabled in order to fit to the new standards as well as to the new figure or statistical rate or estimate that the state wished to have.

Bowker and Star (1999, p. 6) claim that classification systems “give advantage or they give suffering” to the entities that the classification is about. In the disability classification system discussed in this chapter, the revised classification scheme indeed gives suffering for a number of disability beneficiaries because of the changes to the disability standards, as disability beneficiaries who were classified as disabled under the previous system might suddenly be classified as not fitting (i.e., not meeting) the new classification system requirements and could consequently be excluded from the support of the welfare state. Or, following Star (1991), a number of disability beneficiaries would be transformed to the Others, since the changes to the system’s standards have the power to suddenly reclassify them as non-disabled—not because their health status improved but because the standards were tighter.
Chapter 6 opened the black box of the disability classification system that was developed from 2009 to 2011, after the outbreak of the economic crisis in Greece. While the relevant actors’ views differ regarding the roots to the revision of the system for assessing and certifying disability the consequences of the economic crisis affected its enactment. At the end of Chapter 6, we saw that the two core components of the system for awarding disability allowances were ready to be put into play. Specifically, the first component, the Centers for Certifying Disability (KEPA), started to work on September 1, 2011, while the Single Table for the Disability Percentage Determination (EPPPA) was supposed to be used in the disability assessment as of January 1, 2012. Both of the aforementioned components, however, almost right after their release, came across a storm of negative reactions by the disability movement and the media, to name but a few.

Following Bowker and Star’s (1999) claim that before the enactment of a classification scheme a long journey of conflicts and negotiations has already taken place, Chapter 7 follows a different structure compared to the previous empirical Chapters (Chapters 3 to 6). Chapter 7 thus focuses on the period after the release of the components of the “KEPA” classification system and just before the KEPA components transformed to a black box. Comparing with the previous systems that were discussed in this thesis and mainly the system that was discussed in Chapter 3 (since the systems discussed in Chapters 4 and 5 were not implemented), it was the first time that there was a strong reaction against the new disability classification system after the enactment of the system’s components.

Chapter 7 seeks to shed light on the reactions against the system components that emerged after their development by examining what the points of conflict regarding the “KEPA” classification system components were, what the role of the disability movement in these conflicts was, which social groups were involved in the conflicts against the components of the KEPA classification system, and what the role of the economic crisis was in the reactions against the KEPA classification system.

Chapter 7 consists of three sections. The first and the second sections discuss the conflicts that emerged after the development of the two components, when they were ready to be implemented. Relying on the
theoretical/methodological theme of practical politics (Bowker & Star, 1999), the purpose of the first and second section is to explore the reasons behind the negative reactions to the components of the new system for assessing and certifying disability. Thus, the first section focuses on the conflict between the system developers and the state after the release of the EPPPA, and the second section talks about the conflict that emerged in the initial period after the establishment of the KEPA as the only authority responsible for certifying disability in Greece. Lastly, since the implementation of the KEPA system for awarding disability allowances is beyond the scope of this thesis, the third section offers a short description of the period after the conflicts regarding the two components of the KEPA system by briefly presenting a few improvements that have been made to the KEPA system in order for it to work properly.

7.1 Conflicts and negotiations after the release of the Single Table for the Disability Percentage Determination (EPPPA)

The release of the EPPPA was almost immediately accompanied by negative reactions, both from the disability movement and by the media. The negative reactions to the EPPPA can be divided into two categories. In the first category, the emphasis is on the changes to disability percentages, and particularly, to the reductions in disability percentages for specific disorders such as diabetes, autism, transplant recipients, and so on. In the second category, the point of conflict concerns the content of chapter 8 of the EPPPA, which focuses on mental disorders, and specifically regarding the subsection that talks about “personality disorders and adult behavior,” which caused a storm of reactions both by the disability movement and by the media.

Following Bowker and Star (1999), the aforementioned reactions, and consequently the conflicts between the disability movement and the system developers or the state, is part of the practical politics in the process of the development of a classification scheme. For this section I employ the theoretical/methodological theme of practical politics, seeking to explore the conflicts and negotiations after the release of the EPPPA and just before it transformed into a black box. In what follows, the above reactions will be discussed more analytically by focusing on the political, scientific, and social choices in the process of the EPPPA’s enactment (Star & Bowker, 2010).
7.1.1 The reduction in disability percentages
The release of the EPPPA was accompanied by negative reactions to its content, with one of them concerning the reduction in disability percentages compared to the disability percentages that appeared in the KEVA. In addition, apart from the reduction in disability percentages, the introduction of the concept of *functionality* caused concern to persons with disabilities because, as we saw in Chapter 5 (see, for example, pp. 168-174), the emphasis on *functionality* and abilities, instead of disability, has generated a fear in persons with disabilities that they might lose their vested rights. Below, I will start my narrative with the conflict about the “reduction in disability percentages,” and then I will continue with the issue that emerges with the concept of *functionality*.

More specifically, the publication of the EPPPA met strong resistance by the disability movement. Either by sending letters to the Ministry of Labour and Social Security pinpointing the areas where that the revised version of the regulation (EPPPA) raised questions or by protesting against the application of the EPPPA, the disability movement reacted. At this point, someone will ask why the representatives of the disability movement reacted negatively to the EPPPA after its publication since, as we saw in Chapter 6, both the general secretary and the chairman of ESAEA were members of the special scientific committee for the preparation of the new disability percentage table. A letter from ESAEA to the general secretary of social security, Athina Dretta, who was also the chairman of the aforementioned committee, offers an explanation for this reaction. In this letter, ESAEA demanded that the general secretary of social security explain why the EPPPA was released without first being given for consultation to the members of the special scientific committee (*ESAEA*, March 31, 2011). According to ESAEA’s letter:

On Thursday, October 27, 2011, we were informed about the text with committee’s proceedings regarding the revision of specific chapters of the KEVA. Though the revised version of the KEVA was not sent, as initially agreed upon, for consultation to ESAEA and its bodies, we were informed that it was being sent, marked as urgent for publication by the National Printing House.

(ibid., my translation)
A few days after the EPPPA’s release, ESAEA, with a new letter to the Minister of Labor and Social Security expressed its dissatisfaction regarding the aforementioned event, among other things, noting that:

the attempt for updating the chapters of the KEVA has not been sent for consultation to the ESAEA and to other members of the committee as well, despite the fact that this procedure has been argued during the committee’s meeting, which was established according to the Article 7 of the Law 3868/2010, and a representative of ESAEA is also a member.

(EESA, November 16, 2011a, my translation)

Said otherwise, the disability movement challenges the whole procedure for updating the KEVA, questioning both the exclusion of committee’s participants to discuss the content of the new disability percentage table before its release, as well as the preparation time before its publication, since the “updated” version was ready in a period of three months (ibid.).

Despite the initial exclusion of the representatives of the disability movement in the preparation of the EPPPA, the representatives of the disability movement were determined to defend the rights of persons with disabilities. The disability movement, after considering the reductions in the disability percentages, describes the EPPPA as “a cold fiscal tool for the horizontal cuts to the fiscal expenditure” (EESA, November 16, 2011b; see also Eleftherotypia, November 28, 2011). Additionally, after a quick investigation to the changes introduced by the EPPPA, representatives of the ESAEA submitted their comments to the minister of labor and social security, demanding the re-establishment of the special scientific committee to proceed to a revision of the current version of the EPPPA (EESA, November 16, 2011b).

After reviewing the content of the new disability percentage table, ESAEA focused on the reductions to disability percentages in specific disorders such as autism, thalassemia, diabetes, patients with liver and kidney transplant, and so on (ibid.). As mentioned in the letter that ESAEA sent to the minister of labor and social security, the above disorders were only some examples of a quick review ESAEA conducted of the EPPPA’s content (ibid.). For the representatives of ESAEA, the reductions in disability percentages to specific disorders lacked scientific reasoning, and the representatives accused the authors of the EPPPA of, instead of updating the old KEVA by correcting and/or solving its problems, making the new version worse than the old (ibid.).
In other words, the representatives of ESAEA question the initiatives of the Ministry of Labor and Social Security by challenging “who has the authority to determine what disability is” (Galis, 2011, p. 829). However, it is worth noting here that it is not the first time that the representatives of the disability movement relied on the authority and scientificity of medical knowledge and consequently on the medical society to argue on how the disability percentage table should be developed. Rather, as discussed in Chapter 6, the disability movement argued for the involvement of medical society in the process for the enactment of the new disability percentage table since the beginning of the early discussions for the reform of the disability classification system. As I have already claimed, to my interpretation the continuous reliance on the scientific status and prestige of medical society and especially its involvement in the enactment of the disability percentage table, which is the core component in the disability classification system, should be viewed as a “political choice” by the disability movement in their attempt to reverse the negative stereotypes against persons with disabilities in the Greek society. Also, as noted at the beginning of this section, the disability movement challenged, as well, the role of the special scientific committee questioning the choices of the political leadership of the Ministry of Labor and Social Security, especially the general secretary of social security.

The representatives of the ESAEA, for example, refer to diabetes and wonder why the two types of diabetes have been attributed the same disability percentage, that is, 5% to 10%. For the representatives of ESAEA, diabetes type-I (or insulin-dependent diabetes) and diabetes type-II (non-insulin-dependent diabetes) are not the same diseases (ibid.). Further, they stressed that the consequences that diabetes type-I has for those who suffer from it, in terms of health problems or social restrictions, are not reflected by a 5% to 10% disability (ibid.).

In parallel, the disability movement’s negative reactions after the release of the EPPPA drew the attention of the daily newspapers, which from time to time devoted space to talk about the changes to the new disability percentage table. After studying the material from the newspapers, what is noticed is an attempt by the journalists to give room to representatives of persons with disabilities to explain what the aforementioned reductions in disability percentages meant for them in terms of their access to the state’s social (benefit) policy. In an article that was published in Ta Nea, for instance, there is a reference to the disorders for which the attributed disability percentages were decreased (Ta Nea, December 2, 2011).
Disorders such as autism, thalassemia, diabetes, and AIDS, as well as patients who have undergone a kidney or liver transplantation were among the categories that faced reductions in disability percentages. For instance, in the first year after the transplantation, people who had undergone a liver transplant\(^{63}\) would be classified with a disability percentage up to 80%, while after the second year of the transplantation the disability claimants would be reclassified with a disability percentage of up to 10% (ibid.), meaning that the patients will not be able to continue receiving disability allowances.

Similarly, for people who have had a kidney transplant, the disability percentage in the first year after the transplantation would be 80%, while after the second year, this percentage would be reduced to 50% or up to 67%, according to the decision of the health committees. Considering that the base of the disability benefits policy in Greece starts when a disability claimant is classified with more than 67% of disability\(^{64}\), this reduction, also, means that kidney transplant patients would not be able to receive disability allowances.

Patients who suffer from thalassemia\(^{65}\) also noticed reductions in the disability percentages (\textit{Rizospastis}, November 11, 2011; \textit{Ta Nea}, December 2, 2011). Specifically, in thalassemia, the base was reduced from 67% to 50%, a decrease that, according to Vasilis Dimos, who is the chairman of the Greek Thalassemia Federation, would have crucial consequences for patients with thalassemia (ibid.). According to his interview in the newspaper \textit{Rizospastis}, Dimos describes what the reductions in disability percentages means for a person who has thalassemia (ibid.). As he states:

\begin{quote}
if someone received 50% of disability and s/he is unemployed, then s/he would be uninsured....Every eight to ten days, we are going to the hospital for blood transfusion. If you do not have insurance, they do not accept you [at the hospital]. Every night
\end{quote}

\begin{itemize}
\item \(^{63}\) According to the journalist that reported the case with the patient with liver transplantation, there are approximately 350 patients throughout Greece (\textit{Ta Nea}, December 2, 2011).
\item \(^{64}\) Regarding the 67% of disability and the access to the welfare state, see, p. 150 in this thesis.
\item \(^{65}\) Thalassemia is a blood disease that is common in the countries around the Mediterranean Sea, with Greece having the highest concentration among the European countries.
\end{itemize}
we do an iron-chelation therapy with expensive medication—they cost, more or less, 2000 euros per month. Until today, the social insurance funds covered the cost. If they reduced the disability percentage to 50% of disability, then all these benefits are abolished. …Unemployed with thalassemia are the main affected, that is, 80% of the 4,000 to 5,000 [thalassemia] patients in the country.

(As quoted in Rizospastis, November 11, 2011, my translation)

AIDS is another disease for which there were cuts to disability percentages (To Vima, December 1, 2011; Ta Nea, December 2, 2011). In line with a newspaper article published in To Vima, the journalist quotes the statements by the representatives of the two nongovernmental organizations, Praksis and Kentro Zois, after the release of the EPPPA; particularly, she mentions the consequences of the reduction in disability percentages for HIV-infected patients, since the new regulation would prevent them from claiming disability pensions and allowances (To Vima, December 1, 2011). According to Praksis and Kentro Zois, the revised version of the KEVA would support only those patients in the final stage of the disease.

Additionally, the representatives of Praksis and Kentro Zois expressed their worries that it might be possible for HIV-infected patients to stop taking their medication in order for their health condition to get worse so they could be (re)classified at the final stage of the disease and start receiving disability allowances again (ibid.). By the same token, the Club of HIV-positive of Greece – Positive Voice challenges the politics behind the reduction of disability percentages and the access to the state’s benefits policy (ibid.). Specifically, representatives of the Club of HIV-positive of Greece claimed that there was also a “defamation attempt” by governmental and administrative authorities regarding the rights of HIV-patients for receiving disability benefits in those authorities’ denoting that AIDS patients have been infected on purpose (ibid.).

The mental disorder of autism is another disorder for which the disability percentages were reduced. Foteini Zafeiropoulou, a coordinator of the autism committee at the National Federation of Associations of Parents and Guardians of Persons with Disabilities (POSGAMEA), states in the newspaper Ta Nea that the new disability percentage for autism ranges from 30% to 67% (ibid.). But, as she further stressed, the disability allowances that the parents and guardians receive—e.g., the welfare benefits, early retirement for
the parents of children with autism, and so on—are available only when the
disability percentage is more than 67% (ibid.).

In the prior paragraphs, the representatives of persons with disabilities
described how the changes, and specifically the reductions, in the disability
percentage table had consequences for them in terms of entitlements to
disability allowances. Following Porter (1993, p. 93) and his claim that a
“statistical estimate has the potential to become a new thing,” the changes
to the disability percentages have the power to redefine what disability is.
By this I mean that, after the reductions in disability percentages, some
disorders and impairments that have been classified in the past as
disabilities and, consequently, some disability claimants who suffer from
these disorders and who have been classified as disabled suddenly are not
considered as such, or at least not at the same level of severity. Simultaneously, because of the reductions in disability percentages, many
disability claimants could not be classified in the same disability category
as in the past or as persons with disabilities.

The changes to disability percentages, and specifically the reductions in
disability percentages, have the power to redefine what disability is. What is at
stake here is that the health condition of persons with disabilities did not
change; instead, what changed was the numerical value of the translation of a
bodily condition into a numerical figure. Consequently, a question that arises
here is What happens to the cases that do not fit? (Bowker & Star, 1999). By
that I mean that all of a sudden, persons with disabilities have been
transformed from the subject “disability claimants” to the subject “Others,”
since because of the new standards, the already existing disability claimants
might not fit to the new standards. Following Drabek (2014), who examines
the power of classification schemes to label social groups based on their
activities, and Star (1991), who discusses the power of classification schemes
to transform entities and/or social groups to Others, the changes to the
classification scheme criteria, such as the decrease in disability percentages,
offers room to problematize the power of disability classification systems and
how they classify and label persons with disabilities.

Beyond the reductions in disability percentages, the introduction of the
concept of functionality in the new disability percentage table was another
point of conflict between the representatives of the disability movement
and the governmental authorities. The introduction of the concept of
functionality, however, into the Greek socio-political scene goes back to
2004 and the attempt at the adaptation of the ICF (see Chapter 5). Even
though the ICF classification system was not implemented, the disability
movement had reacted negatively to the concept of *functionality*, and through its involvement in the negotiations with the political leadership of the Ministry of Health and Social Solidarity and the coordinators of the ICF attempt, representatives of the disability movement shared their reflections and concerns. In addition, the outbreak of the financial crisis in 2007–2008 and, after a while, the outbreak of the economic crisis in Greece late in 2009 have opened new discussions both in the international and the national context regarding the systems for awarding disability allowances. Though the discussion for the shift from the welfare state to the workfare state goes back the late 1990s, the financial and economic crisis offer a fertile ground for a new round of discussions for a shift to *employment-oriented policies* and the integration of persons with disabilities into the labor market, rather than compensation policies (OECD, 2009).

Considering the above-mentioned political economic developments, as well as the discussion in Chapter 6, and specifically the presentation of chapters 8 and 9 of the EPPPA (see, for example, pp. 217-224), we saw that the concept of *functionality* and an emphasis on the abilities rather than disabilities was introduced again in the socio-political context of the country, but this time as part of the disability assessment for mental and neurological disorders. The reintroduction of the concept of *functionality* and its association with disability, however, was questioned by persons with disabilities. The reason behind this reaction was the fear of persons with disabilities that the emphasis on abilities would work as a barrier for them to be eligible for disability allowances (*Rizospastis*, November 3, 2011; see also the discussion in Chapter 5, pp. 168-174).

Following the actions of the disability movement against the application of the new disability percentage table, it should be underlined here that the representatives of the disability movement, such as the umbrella organization for persons with disabilities in Greece, made a shift in the way that they were involved in the policy-making; instead of continuing to deal with the political leadership of the Ministry of Labour and Social Security directly, it employed other political tactics, such as demonstrations and protests for defending persons with disabilities’ rights. For instance, on December 13, 2011, the members of the ESAEA organized a protest from Omonoia Square to the Ministry of Finance and Maximus Megaron, which is the official seat of the Prime Minister of
Greece, in order to meet then–prime minister, Lukas Papademos\(^{66}\), to ask him to protect the rights of persons with disabilities because they were affected by the release of the new disability percentage table (*To Vima*, December 13, 2011).

If the reactions by the disability movement were a logical consequence of the radical (austere) cuts to persons with disabilities’ economic allowances, the political leadership of the Ministry of Labor and Social Solidarity also had to deal with the critical voices of the political party of PASOK. For instance, the parliamentary representative of PASOK, Christos Protopapas, with an intervention in the parliament, stressed that although the rationalization to the system for awarding disability benefits was necessary, the reductions in disability percentages as introduced by the EPPPA had serious consequences for disability claimants who were in need of the state’s support\(^{67}\) (*To Vima*, December 2, 2011; *Ta Nea*, December 3, 2011). The deputy minister of labor and social security, Yannis Koutsoukos, in his answer to the intervention, announced the intention of the Ministry to update the EPPPA so as to make the necessary revisions (ibid.).

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\(^{66}\) Because of the political instability in the country after its inclusion to the financial stabilization mechanism by the EC-IMF-ECB, and specifically after the events that took place early in November 2011 (see, for example: *Eleftherotypia*, November 1, 2011; November 2, 2011; *I Kathimerini*, November 1, 2011a; November 1, 2011b; *Ta Nea*, November 1, 2011a; November 1, 2011b; November 3, 2011; *To Vima*, October 31, 2011b; November 1, 2011; November 2, 2011), the political party of PASOK neither was in power nor Giorgos Papandreou was the Prime Minister. Instead, since the middle of November 2011, an interim coalition government replaced PASOK in power with Lucas Papademos, an economist, to be the Prime Minister (*Eleftherotypia*, November 10, 2011; November 20, 2011; *I Kathimerini*, November 11, 2011; *Ta Nea*, November 11, 2011a; November 11, 2011b; *To Vima*, November 12, 2011). As for the political parties that participated in the new interim coalition government were: PASOK, ND, and the political party of Popular Orthodox Rally (LAOS), a radical right-wing populist political party (*Eleftherotypia*, November 13, 2011; November 14, 2011; November 16, 2011; *I Kathimerini*, November 8, 2011a; November 11, 2011b).

\(^{67}\) Considering that PASOK was not in power anymore, the critique by the parliamentary representative of PASOK could be seen as a critical voice from inside the government, since PASOK participated in Papademos’s interim coalition government.
7.1.2 The “personality disorders and adult behavior” debate

The second point of conflict between the representatives of the disability movement and the political leadership of the Ministry of Labor and Social Security was a specific subsection in chapter 8 of the EPPPA, which deals with mental disorders, particularly concerning “personality disorders and adult behaviour.” In this subsection, there is a reference to the personality disorders shown in below.

Habits and impulse disorders
- Pathological gambling – Disability percentage: 20-35%
- Pyromania – Disability percentage: 20-35%
- Kleptomania – Disability percentage: 20-35%
- Trichotillomania – Disability percentage: 20-35%

Prognosis - Potentially good

Sexual Disorders
- Fetishism – Disability percentage: 20-30%
- Fetishistic transvestism – Disability percentage: 20-30%
- Exhibitionism – Disability percentage: 20-30%
- Voyeur – Disability percentage: 20-30%
- Pedophilia – Disability percentage: 20-30%
- Sadomasochism – Disability percentage: 20-30%

Prognosis - Potentially good.”

[Source: Government Gazette 2011b,p.38170, (in Greek, my translation)]

According to the general secretary of the ESAEA, Christos Nastas, when the disability movement came across the above subsection of the EPPPA, it reacted negatively (C. Nastas, interview, January 14, 2015). As he claims:

The [regulation] that was published in 2011 had many gaps. …We, as a disability movement, we would say that these [above] categories, which were considered as a disability, were included in an artful [way], since, in fact, neither a pyromaniac nor a pedophile could be regarded as a person with disabilities. A perversion that someone might have can in no case be regarded as a disability. And a pyromaniac cannot be attributed a disability percentage up to 30% when a person with diabetes with his/her complications can be evaluated by a health committee with less than 30%.

(ibid.)
The chairman of ESZAE, Vardakastanis, offers a similar account: “As it is known, we fought against it [the released version of the EPPPA]. We fought it, because we considered, among other things, that it [the EPPPA] came to include pyromaniacs, pedohiles, voyeurs, and so on” (Y. Vardakastanis, interview, September 4, 2015).

As highlighted in the reconstruction of the EPPPA in Chapter 6, the development of the disability percentage table followed a medical-oriented approach, with chapter 8 (which refers to the psychiatric disorders) to be designed in line with the relevant chapter of the ICD-10 classification system. Because of the “personality disorders and adult behavior” debate after a comparison between the section for psychiatric disorders in the ICD-10 classification system and chapter 8 of the EPPPA, what is noticed is that chapter 8 contains the psychiatric disorders as they appear in the ICD-10. Obviously, in chapter 8 of the EPPPA the disorders were translated into the Greek language and its disorder is accompanied by a disability percentage, which did not exist in the ICD-10 (see, also, Chapter 6).

On the other hand, the disability movement reacted against the existence of the “personality disorders and adult behavior” subsection, and specifically against the subcategories of “habits and impulse disorders” and “sexual disorders” of the EPPPA, relying on social and ethical reasons because of the negatively loaded meanings that have been associated with them, such as with pedophilia. It should be noted here that the discussion about the personality disorders is enacted as a critical (and sensitive) issue which has problematized psychiatrists and psychologists in regard to the criteria for classifying them as mental disorders. For instance, Manning (2006) states that while there are personality disorders that have been added to the ICD-10 under the section of mental disorders, perhaps the same disorders have not been added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III or DSM-IV) and vice versa.

Nevertheless, in the Greek case, the “personality disorders and adult behaviour” debate did not concern whether the aforementioned disorders should be classified as mental disorders or not; instead, the point of conflict was why “habits and impulse disorders” and “sexual disorders” should be accompanied by disability percentages. A differentiation appears regarding how the system developers and (consequently) the state and the disability movement interpret or define what disability is. Considering the discussion in Chapter 6 about the enactment of the disability percentage table, as well as here, in Chapter 7, and the presentation of the conflicts
that came to the surface after the release of the EPPPA, the definition of what disability is as offered by different social groups is a matter of political choices rather than scientific choices.

7.1.2.1 The involvement of the disability movement in the “personality disorders and adult behaviour” debate

Even though the representatives of the Ministry of Labor and Social Security announced their intention to revise the EPPPA, nothing had happened almost two months after its release. The chairman of ESAEA, Vardakastanis, recalls an initial discussion that he had with the minister of labor and social security of the interim coalition government regarding the subsection in chapter 8 discussed in the previous section: “I informed Koutroumanis [the minister of labour and social security] to take measures [about the subsection with personality and sexual disorders] because we are risking our reputation internationally” (ibid.). As Vardakastanis further claims, he attempted to warn the representatives of the Ministry of Labour and Social Security for taking measures and revising the EPPPA, but none from the Ministry heard him. When he realized that he was not heard, and nothing had happened for the revision of the EPPPA, he decided to act and put pressure on the ministry another way. He explains:

I noticed that they did not hear me. In January 2012, now I reveal something that no one knows about, through a friend, who was a foreign press correspondent; I persuaded him, and he published the issue abroad [regarding the subsection in chapter 8]. Within forty-eight hours, we identified 349...publications for this issue.

(ibid.)

13, 2012), and “Greece Disability List Sparks Welfare Benefits Row” (BBC, March 12, 2012) question the initiatives of the government to classify pedophiles and pyromaniacs as disabled. For example, in one of the above weblog posts, the author challenges the government’s decisions by underlining that, while the governmental authorities had to enact austere measures for persons with disabilities and their access to the welfare state they simultaneously classified pedophiles as eligible for receiving disability allowances (Frontpage Mag, January 12, 2012).

The local newspapers also reported on the above issue. For instance, in an article published in Ta Nea under the headline “They Change the Regulation for Persons with Disabilities after the Blunder,” the journalist refers to the issue that was raised with the subsection that classified pedophiles, pyromaniacs, and so on, as disabled by attributing to them disability percentages (Ta Nea, January 9, 2012). As the journalist points out, although the disability percentage that was attributed to the aforementioned mental disorders was not enough to lead to disability pensions and allowances, it would be possible, if it was combined with another disability (e.g. in case of multiple disabilities), that the claimants might be awarded benefits in kind, such as a reduction in the price of tickets of public transport (ibid.). The same article reported the intention of the political leadership of the Ministry of Labor and Social Security to proceed with the readjustments to the EPPPA by establishing a new special scientific committee responsible for revising the EPPPA after considering the issues that had been raised because of its earlier version (ibid.).

Recalling the discussions up until now, we saw that the involvement of the disability movement in the policy-making has gone through several stages, from noninvolvement (Chapter 3) to full involvement (Chapter 4) to involvement upon its own initiative (Chapter 5). In the attempt discussed both in Chapters 6 and 7, while the disability movement was involved, similarly with Chapter 5, after its own initiative, there is a differentiation in terms of involvement. By that I mean that the disability movement actions were not only limited to the direct communication with the governmental authorities that announced the revision of the systems for assessing disability (Chapter 5). Instead, the disability movement was involved by employing new “political tactics.” Through protests and mobilizations as well as the use of news media, including the international news media, the representatives of the disability movement aimed to both inform and influence public opinion about the government’s intentions
regarding the classification and definition of disability based on the content of the new disability percentage table.

The employment of news media to spread the issue with the disability percentage table and inform the public opinion shows as well how the disability movement attempted to put pressure on the government to revise the EPPPA. Following Mavrogordatos, this type of action suits the definition of pressure groups, since disability movement is a group that, in order to defend its rights, puts pressure on the power (Mavrogordatos, 2001, p. 21). Further, having in mind that one of the characteristics of pressure groups is that each member aims to be involved in politics, e.g., to enact specific legislation, ESAEA’s utilization of the international news media not only aimed to influence public opinion regarding the political choices in the definition of disability but also aimed to further involve the disability movement in politics as it aimed to achieve the abolishment and revision of the EPPPA.

Summarizing the disability movement’s involvement in the conflict related to the EPPPA, we see that there was a shift in terms of the movement’s initiatives to demand the revision of the EPPPA. Instead of dealing with the governmental authorities directly, the disability movement employed other political tactics to influence public opinion as well as to put pressure on the governmental authorities. Therefore, the disability movement, for the defense of persons with disabilities’ rights, employed tactics both from the theoretical frame of new social movements and pressure groups. To be more specific, as already described, the disability movement proceeded with “direct action” initiatives, such as demonstrations and protests, with the objective of attracting as much publicity as possible (Barnes & Mercer, 2010), and it leaned on the power of news media, particularly the international news media, to put pressure on the government to remove the “habits and impulse disorders” and “sexual disorders” subcategories in the EPPPA.

Additionally, in the aforementioned wave of negative reactions to the release of the EPPPA, other social groups also participated. For example, nongovernmental organizations such as Praksis and Kentro Zois were also involved in the conflict regarding the new disability percentage table, explaining, for instance, to the public how the new EPPPA would affect HIV patients. Having in mind the discussions of the prior empirical chapters that have already been studied and analyzed so far, from Chapter 3 to Chapter 6, this was the first time that other social groups, or social groups less obviously relevant to disability issues, joined the disability movement in their attempt to prevent the use of EPPPA.
7.1.3 Revising the Single Table for the Disability Percentage Determination (EPPPA)

After the reactions against the EPPPA on both the local and international levels, the revision of the EPPPA was a foregone conclusion. Hence, through the Ministerial Decision, Issue no. 80000/oik.9488/760/23.4.2012, the Minister of Labor and Social Security announced the reestablishment of the scientific committee to revise the EPPPA (Government Gazette, 2012a). The composition of the new committee was almost the same as the committee that was responsible for developing the first version of the EPPPA (see, pp. 209-210), with the exception of three changes. Specifically, the members of the special scientific committee who were responsible for revising the EPPPA were the following:

**Chairman**
- Ioannis Sarivougioukas – Deputy Governor of IKA-ETAM, responsible for health care issues

**Members**
- Vasileios Paterakis – Director at the Directorate of Disability and Social Work of IKA-ETAM (Paterakis replaced Athanasio Xeno, who retired)
- Christodoulos Stefanadis – Professor of Cardiology of the Medical School of the National and Kapodistrian University of Athens (EKPA)
- Athanasios-Meletios Dimopoulos – Professor of Therapeutics of the Medical School of the National and Kapodistrian University of Athens (EKPA)
- Christos Nastas – General Secretary of the National Confederation of Disabled People (ESAEA). Representative of the ESAEA, with Ioannis Vardakastanis, Chairman of ESAEA as an alternate
- Charalambos Alexopoulos – Occupational physician at DEH A.E.
- Michalis Koutras – Physician – Neurologist
- Ioannis Valavanis – Physician – Orthopedic
- Vasileios Koulouris – Head at the Directorate of the Main Insurance of Employees at the General Secretariat of Social Security, with Ilias Vavetsis, Head of the department at the same Directorate as an alternate

(Government Gazette, 2012a)
The updated version of the EPPPA released early in May 2012 through the Ministerial Decision, Issue no. 11321/oik.10219/68. As for its structure, it is almost the same as the version that was published in November 2011. The second version of the EPPPA also consists of 16 chapters with the same structure and content as in the first version of the EPPPA. Changes are observed only to some of the chapters regarding the disability percentages, e.g., chapters 1, 3, 4, 6, and so on. To give an example of the changes that appeared in the second version of the EPPPA, I will describe the case of diabetes. First I will describe how diabetes appeared in the first version of the EPPPA, and, then in the second version. In the first version of EPPPA, diabetes appeared in chapter 6, a chapter that deals with the metabolic disorders, and was described as follows:

**Diabetes**
Disability percentage is defined by the existence or not of complications and their severity.

B. Severity level
1st level
Diabetes (type-1 or type-2) without complications
Disability percentage: 5-10%

2nd level
Diabetes (type-1 or 2) with mild microvascular complications (non-proliferative retinopathy, microalbuminuria)
Disability percentage: 10-20%

3rd level
Diabetes (type-1 or 2) with severe complications (myocardial infarction, kidney failure, stroke, amputation of body parts, blindness, etc.)

Disability percentage is defined according to the severity of complications (see: relevant chapters)

*(Government Gazette, 2011b, p. 3815, my translation)*

As we can see in the above presentation, patients with diabetes type-1 or type-2 would receive the same disability percentages, based on their symptoms and complications. But, as stated earlier, the disability movement had argued against that decision on the grounds that the
severity of symptoms and complications between those who have diabetes type-1 and those who have type-2 are not similar. In the second version of EPPPA, the section on diabetes, located again in chapter 6, was rewritten both in terms of its content and in terms of disability percentages. In the updated version of the EPPPA, diabetes is described as below:

**Diabetes**
Diabetes type-I, insulin-dependent: with the confirmation of the disease: [disability] percentage 50%

The percentage increases according to the presence of the following complications:

**Diabetes type-I**
a) Proliferative diabetic retinopathy which requires laser treatment.
Decrease of visual acuity below 5/10 Maculopathy Disability percentage: 67% and above

In the case of visual acuity below 1/20, see: eye disorders.
Peripheral diabetic neuropathy resulting from electrophysiological check-up
Diabetic ulcers, partial or complete amputation
Kidney failure, incipient or complete (clearance creatinine <40, nephrotic syndrome)
Disability percentage: 67% and above

In case of end-stage kidney disease, see: nephrotic syndrome, end-stage kidney disease (hemodialysis).

b) Coronary heart disease. Myocardial or confirmed coronary stenosis after coronary angiography
Stenosis of >60% of the arteries, carotid or peripheral arteries

**Diabetes type 2 (treatment with tablets):**
1st-level, without complications Disability percentage: 20%
2nd-level, upon the presence of serious complications.

**Diabetes type-2 (Insulin-treated):**
In the case that diabetes is not possible to adjust with antidiabetic tablets and is solely regulated by administering insulin injections, all that applies to type-1 also applies here.

*(Government Gazette, 2012b, p. 23397, my translation)*
Also, in the same chapter, chapter 6, a new section on “Familial hypercholesterolemia” was added.

If in the chapters of the second version of the EPPPA, there were only slight changes from the first version to chapters’ content, particularly to disability percentages, in chapters 8 and 9 the revisions were more extensive. First, in chapter 8 of the EPPPA, the algorithm mentioned in (my) Chapter 6 (p. 217-218) for the calculation of disability percentages does not appear. Also, there are changes to disability percentages, either decreases or increases, for almost all severity levels. The subsections of “habits and impulse disorders” and “sexual disorders”, which had appeared in the section “personality disorders and adult behaviour” and, as we already saw, caused a storm of reactions, was deleted. On the other hand, the Down syndrome disorder, which was not included in the first version of EPPPA because, according to the Ministry, they forgot to include it (To Vima, December 1, 2011), was added in this chapter as well.

Like chapter 8, chapter 9 of the EPPPA is a totally a new chapter. As discussed in Chapter 6 of this thesis, the structure of chapter 9 in the first version of EPPPA was “innovative” compared to the rest of the chapters. In the first version, the emphasis was on the assessment of the tasks that a disability claimant was able to accomplish through the application of ADL classification scheme,68 and its content was also influenced by the ICD-10 classification scheme. In the second version of the EPPPA, however, all this information disappeared. The structure of the “new” chapter 9 follows a structure similar to chapters 1, 2, and so on: that is, a description of the disease and then the disability percentage according to the severity of the disease. In the second version of the EPPPA, chapter 9 is shorter than in the first version.

Considering the points of conflict after the release of the first version of the EPPPA, a comment worth adding here concerns the changes that were done in the new EPPPA. As we saw, representatives of the disability movement had pinpointed specific disorders from the first version of the EPPPA, which they demanded be revised. In the second version of the EPPPA, all those disorders, such as autism, Beta-thalassemia, AIDS, and patients with kidney or liver transplants have been revised, with an

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68 For more information about ADL classification scheme, see for example, Chapter 1, pp. 45-46 and Chapter 6, pp. 219-220.
increase in the disability percentages. For instance, according to the first version of the EPPPA, a patient with liver transplant would be classified with 80% of disability in the first year after the transplantation, while after the second year, the disability percentage would be 10%. In the second version of the EPPPA, however, patients with liver transplant would receive 80% of disability, and if the transplantation is successful, then the disability percentage would be permanent.

The second comment is not relevant to the content of the EPPPA; rather, it refers to the ministries that were responsible for developing and publishing the new disability percentage table. While the Ministry of Labor and Social Security was responsible for publishing the first version of EPPPA, and the minister of labor and social security, through the Ministerial Decisions, Issue no. 80000/oik.3647/212/4.7.2011 and Issue no. 80000/oik.9488/760/23.4.2012, defined the members of the special scientific committees for the enactment of the EPPPA, for the second version of the EPPPA, the ministerial decision through which it was enacted was signed both by the Minister of Labor and Social Security and by the Minister of Finance (Government Gazette, 2012b).

To summarize, the reconstruction of the second version of the EPPPA reveals how the conflicts between the disability movement and the political leadership of the Ministry of Labor and Social Security forced the ministry to proceed with a revision to the disability percentage table, which resulted in the enactment of a new ministerial decision that contained the revised version of the disability percentage table. As shown, the changes to the EPPPA almost followed the disability movements’ comments as they were submitted to the Ministry of Labor and Social Security after the release of the first version of the EPPPA.

Taking together the reconstruction of the EPPPA as well as the conflicts after the release of the first version of the EPPPA, what emerges is that the whole discussion around disability or around the disability experience was transformed into a policy-making issue. The conflicts and negotiations between the governmental authorities and the disability movement were enacted into a new disability percentage table. Moreover, as it turns out, the disability movement’s initiatives and actions were successful in that several of the disability movement’s recommended points were followed in the second version of the EPPPA.

In the revised version of the EPPPA, all chapters follow the same structure, centering on the quantification of disorders or impairments into disability percentages, and setting aside all the innovative characteristics that
were included in the first version of the EPPPA. The concepts of *functionality* and *abilities*, as well as the references to the self-assessment classification schemes of ADL and IADL, have been removed and replaced by a list of disorders and their attributed disability percentages. As for the disorders that had been underlined by the representative’s movement, they were updated. While the revision of the EPPPA shows how the involvement of the disability movement succeeded in protecting persons with disabilities from the consequences of the first version of the EPPPA, the comparison of the first and the second version of the EPPPA leaves room to problematize *what work classification systems do*, as well as the politics that are embedded in the quantification of disability. In what follows I will explain what I mean with the problematization regarding the quantification of disability and *what work disability classification systems do*.

Comparing the first and second versions of the EPPPA, several issues come to the fore concerning the *political choices* in the enactment of the disability percentage table. As already mentioned (p. 234), in the first version of the EPPPA, disability claimants who had undergone a liver transplant would be reclassified from 80% of disability in the first year after the transplantation to 10% of disability beginning in the second year. According to the second version of the EPPPA, however, the same disability claimant would be reclassified in the second year with more than 80% of disability, which is clearly a remarkable deviation between the two disability percentages.

The question that arises here is why the author had translated the same bodily condition with 10% of disability in the first version of the EPPPA but with more than 80% in the second version—a striking deviation, as it is one thing to be classified with 10% of disability, which means almost no loss, and quite another thing to be classified with more than 80%, which means almost total loss. Following Porter (1991), the numbers or disability percentages have the *power* to translate disability from a bodily condition to a numerical figure or to create disability as a numerical object, which can be an easier object to treat for administrative reasons. However, it should be noted that numbers have the power not only to “create objects,” as Porter (1993, p. 97) argues, but also to destroy already existing objects. By that is meant that the above example shows how a bodily condition that had been classified in the past as a disability would not be considered a disability anymore for no other reason than the decrease in the disability percentage attributed to it.
Lastly, based on the examples that I described above, the huge deviations between the disability percentages for the same disorder and, consequently, how disorders are translated into numerical figures, are enough to raise questions about what work classification systems do (Bowker & Star, 1999) as well as who creates disability classification systems. As we saw, in a period of less than 6 months, someone with a liver transplant can be reclassified from 80% of disability, or almost total loss, in the first year of his/her successful transplantation to 10% of disability, or almost no loss, after the second year.

7.2. Conflicts and negotiations after KEPA is put into play
As discussed in Chapter 6 (pp. 199-203), on September 1, 2011, the institution of the KEPA was established as the only authority in Greece responsible for assessing and certifying disability. The implementation of the KEPA, similarly with the EPPPA, was accompanied by negative reactions by the disability movement, which stressed the consequences of the implementation of the KEPA for persons with disabilities. Like the prior section, this section draws on the theoretical/methodological theme of practical politics, as proposed by Bowker and Star (1999), seeking to shed light on the conflict that emerged after the KEPA was put into play as well as on the political and social choices in the negotiations for solving or revising the issues that the establishment of the KEPA created.

7.2.1 The KEPA conflict through the disability movement’s voices
The first complaints against the operation of the KEPA was reported to the newspapers a few weeks after the KEPA was put into play. For example, in two Eleftherotypia articles, the journalists referred to the lack of KEPA in the regional units of Trikala, Aetolia-Acarnania, and Ilia. Disability claimants who lived in the those regional units would have to travel to the closest regional unit to submit their applications and to be assessed and certified by the local health committees, denoting, indirectly, the lack of planning for the implementation of the KEPA (Eleftherotypia, September 8, 2011; September 30, 2011).

The representatives of ESAEA, in parallel with the reactions against the release of the EPPPA (as discussed in the previous section), reacted against the implementation of the KEPA. After collecting and summarizing the initial problems with the operation of the KEPA, as they had already been registered by local disability organizations, ESAEA sent a letter to the minister of labor and social security, submitting both its findings regarding
the operation of the KEPA and a number of proposals for the improvement of KEPA’s operation (ESAEA, November 16, 2011c). According to ESAEA’s letter, the main findings regarding the operation of the KEPA were as follows:

- the lack of establishment of KEPA in all the large regional units of the country, and
- a lack of proper introduction, presentation, and explanation regarding the role of KEPA as the new authority for certifying disability.

(ibid., my translation)

As for its proposals, some of them were the following:

- the release of specific circulars by the minister of labor and social security about the certificates that persons with disabilities had already received from the previous authority that was responsible for certifying disability that showed that their disability was permanent,
- acceptance by other institutions of the already temporary disability certificates until those certificates expired,
- the fee of 46.16 euros to be covered by the National Organization for the Provision of Healthcare Services69 (EOPYY) instead of by persons with disabilities, and
- interpreters of Greek sign language for helping deaf people during the disability assessment procedure.

(ibid., my translation)

Despite ESAEA’s initiative to submit some proposals for the better operation of the KEPA late in 2011, the problems with the KEPA continued. ESAEA, in a new letter to the minister of labor and social security—after changing its rhetoric to a more “demanding rhetoric” rather than the “advisory rhetoric” used in the previous letter—shared again its findings regarding the problems with the operation of the KEPA and resubmitted its pro-

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69 The National Organization for the Provision of Healthcare Services (EOPYY) was established in 2011 after the enactment of the Law 3918/2011 for the purpose of offering healthcare services to its insured (Government Gazzette, 2011a). At the beginning it was under the supervision of both the Ministry of Health and the Ministry of Labour and Social Security, but since April 1, 2012, it is only under the supervision on Ministry of Health.
posals on how the several issues enacted because of the implementation of the KEPA would be solved (ESAEA, February 8, 2012).

Considering the efforts by the representatives of the disability movement to deal with the Ministry of Labor and Social Security directly for solving the insufficiencies of the KEPA, the political leadership of the ministry did not establish a synergy with the disability movement for solving the issues with the KEPA. Thus, in summer 2012, the issues with the improper operation of the KEPA still remained (Ta Nea, July 2, 2012; To Vima, July 4, 2012; Rizospastis, July 5, 2012). In a Ta Nea article, for example, the journalist refers to the long waiting period for disability claimants to be assessed by the KEPA health committees, with the delays often exceeding nine months (Ta Nea, July 2, 2012). Also, as the journalist highlights, there were 53,000 disability claimants on hold, waiting to be assessed (ibid.).

In another To Vima article the journalist stresses the consequences of the delays for disability claimants, specifically concerning their eligibility for receiving disability allowances (To Vima, July 4, 2012). By quoting the ESAEA’s view, the journalist stresses how the delays had led to several disability claimants’ not being eligible to continue to receive their disability pensions and allowances (ibid.)—an issue which, according to the disability movement, was critical because the financial situation of disability claimants was weak and they were totally dependent on disability allowances for covering their needs (ibid.).

In spite of the wave of negative reactions to the KEPA, nothing changed until late in the fall of 2012, with the conflict between the representatives of the disability movement and the political leadership of the Ministry of Labor and Social Security still existing. For this reason, the disability movement, rather than continuing with the official communication that it had established with the governmental authorities through letters, made a shift by employing other political tactics. By demonstrating and protesting, persons with disabilities aimed to influence public opinion regarding the insufficient operation of the KEPA and its consequences for persons with disabilities. Through a press release, ESAEA asked all persons with disabilities and their families to protest the KEPA (ESAEA, October 22, 2012). According to the press release, the disability claimants’ situation was “close to being transformed into a humanitarian crisis [my translation],” since the insufficient operation of the KEPA had prevented disability claimants from receiving disability pensions and allowances because they lacked the disability certificate to be issued by KEPA (ibid.). For instance,
in fall 2012, almost one year after the establishment of the KEPA, 70,000 disability claimants were still waiting to be assessed by the health committees of the KEPA (ibid.).

Persons with disabilities thus protested the KEPA. By using banners such as “No to the social euthanasia of persons with disabilities,” “Person with disabilities and poor,” and “No to the social exclusion of persons with disabilities,” they demanded a solution to their problem of not receiving disability pensions (I Kathimerini, October 23, 2012; Rizospastis, October 24, 2012; I Avgi, October 28, 2012). As the chairman of the Panhellenic Union of Paraplegic and Physically Challenged, Grigoris Mousios, complains to the newspaper I Avgi:

[Our] healthcare stops. How will we live? Must we die? We live by borrowing [money], otherwise we will become beggars. They force us again to do what we fight to stop [begging]. We see persons with disabilities being forced to return to the streets and beg. I know several cases.

(as quoted in the newspaper I Avgi, October 28, 2012, my translation)

The issue of the long waiting period continued, and at the beginning of 2013, representatives of ESAEA, in a new letter to the minister of labor and social security, Yiannis Vroutsis, complained about the difficult position of disability claimants (ESAEA, January 24, 2013). Specifically, representatives of ESAEA describe the KEPA classification system as a system that “produces poverty, neediness, and misery” for disability claimants (ibid.). Bowker and Star (1999, p. 6) claim that “for any individual, group or situation, classification and standards give advantage or they give suffering”; in the case of the transition to the KEPA disability classification system, persons with disabilities, instead of receiving the state’s support because of their disabilities, were stuck on the long waiting lists of the KEPA, waiting for their disability assessment, and many of them they did not receive their disability allowances and were not able to renew their health insurance because of the lack of a disability certificate.

7.2.2 The KEPA conflict through the administrative authorities’ voices
The prior section discussed the conflict that emerged in Greek society after the establishment of the KEPA. Here, in this subsection, I will discuss the KEPA conflict through the accounts of the representatives of the administrative authorities and how they explained the poor infrastructure of the
KEPA as pinpointed and questioned by the disability movement, especially the long waiting period for the disability assessment.

Starting with the perspective of the Directorate of Disability and Occupational Medicine of IKA, which is the institution that has KEPA under its supervision, the problems that emerged after KEPA was put into play had their roots in the poor infrastructure planning when the system was being developed between 2010 and 2011. The head of the Directorate of Disability and Occupational Medicine, Eleni Niarhakou, describes the initial period of the operation of the KEPA as follows:

In 2010, with the Law 3863/2010, the KEPA was established and put into play on September 1, 2011. When the KEPA operation started, there was no...transition stage. That is, the institution of the KEPA started to be implemented, and, in parallel, IKA services, which were asked to undertake this attempt, also to take care of all the pending cases from the other social security funds [and] welfare services. As a result, [it has taken] until today [2015] to examine cases from the system(s) that existed before KEPA. ...On September 1, 2011, the physicians employed at the services of IKA were 200, maximum 300, since until then IKA had its own healthcare sector for its insured. Consequently, [the IKA] tried to operate based on its own structures, both in terms of healthcare and administrative staff...In other words, when the KEPA started, IKA was asked to undertake a large number of pending cases. We estimate [that the number of pending cases] was about 180,000 to 200,000 before September 2011.

(E. Niarhakou, interview, June 6, 2015)

Thus, the problems with the new institution of the KEPA began almost immediately upon its implementation because the services of IKA were expected to assess and certify disability for a larger number of disability claimants in relation to the already existing number of IKA insured, with the same number of staff, both in terms of administration and the staffing of the health committees. To Niarhakou, the IKA staff were too few to cover the new demands of the KEPA system (ibid.). As she further adds, because of the economic crisis and the changes to the pension scheme, several employees retired; consequently, administrative issues emerged because of the lack of employees to staff the IKA services, much less the services that were related to the KEPA (ibid.)\textsuperscript{70}. For example, because of

\textsuperscript{70} IKA had around 9000 employees in 2010 and 2011, but that number had decreased to approximately 4500 in 2015 (E. Niarhakou, interview, June 6, 2015).
the lack of administrative staff at the local centers of KEPA, as well as the insufficient information system, requests that were submitted by persons with disabilities to the KEPA in January 2012 were added to the information system six months later, which meant that the delays in the disability assessment could exceed one year (ibid.).

Another obstacle to the operation of the KEPA concerns the staffing of the health committees. From the beginning of 2012, all the healthcare services would be provided by a new institution, the EOPYY, which meant that IKA no longer had a healthcare branch, as in the past. Thus an issue was created concerning the physicians who would participate in the KEPA health committees (ibid.). While Niarhakou states that the employment contract that IKA had with the former physicians and members of the Special Physicians Body of Health Committees of IKA continued to exist, their inclusion under the new institution of EOPYY meant that the IKA did not have the authority to control them anymore, since they belonged to another authority (ibid.). As Niarhakou claims:

I can say that an objective and realistic evaluation of what we were going to face [after the transmission to KEPA] did not exist. Perhaps there was insufficient information to the IKA’s executives from the other institutions [social insurance funds] regarding what was going to come in [to the KEPA].

(ibid.)

Stratis Hatziharalabous, who is the head of the Department of Health Education and Prevention at the Ministry of Health and a former employee of the Department of Disability at the Ministry of Health, also focuses on the issue of the long waiting period for a person with disabilities to be assessed by the KEPA health committees (S. Hatziharalabous, interview, June 14, 2015). He argues that the issue emerged because of the structural and deep changes to the social security system (ibid.). Also, Hatziharalabous describes the KEPA system as a further development of the IKA system (the system discussed in Chapter 3). Like Niarhakou, he stresses that the issue with KEPA was the staffing of the health committees.

As discussed in Chapter 3, the health committees that operated the system for assessing and certifying disability at IKA was staffed by physicians who had an employment contract with IKA, since the social security fund of IKA offered its insured healthcare services. IKA used to have its own medical staff, and because of this medical staff, it was possible to move its staff to other services such as the Special Physicians’ Body of Health Committees of IKA,
since it was a body that operated within the social security fund of IKA.\textsuperscript{71} However, after the economic crisis and the need for structural reforms in the social security system, all the healthcare services were placed under a new organisation, that is, the EOPYY, which was a new institution responsible for offering healthcare services to all insured. Hence, after this change to the social security system, IKA did not have medical staff because they had been transferred to EOPYY.

According to Hatziharalabous, the changes in the operation of IKA had consequences in the staffing of the new Special Physicians’ Body of Health Committees, since the KEPA, as an institution, belongs to IKA and is under the responsibility of the Minister of Labor and Social Security. While the KEPA was under the supervision of IKA, the physicians that were supposed to staff the health committees belonged to the Ministry of Health and Social Solidarity. Though, at the beginning, KEPA was under the supervision of both the Ministry of Labor and Social Security and the Ministry of Health and Social Solidarity, later it was only under the supervision of the Ministry of Health (S. Hatziharalabous, interview, June 14, 2015). To Hatziharalabous, there was an administrative and legislative gap concerning the staffing of the health committees because the physicians belonged to a different ministry than the Ministry under which KEPA operates. Therefore, there were delays in the staffing of the health committees.

Beyond the administrative and legislative issues, however, Hatziharalabous adds one more factor to explain why the KEPA did not operate properly. The term that he uses is the word “pressure.” As he states, during the development stage, there was no time and/or room for flexible movements; rather, there was “pressure” to proceed with:

“cuts to disability allowances, and mainly, to disability pensions, because there were many disability pensions...and because it was predicted that in order to continue receiving disability allowances you should only have the disability certificate of KEPA; if someone did not have it, then his/her allowances would be cut off. So it was like...forcing them to [be quickly assessed] by the KEPA.”

(ibid.)

\textsuperscript{71} See Chapter 4, pp. 119-124, for more information about the fragmentation of the Greek social security system.
In the same vein, Maro Pikramenou, who works at the Ministry of Labor and Social Security, uses the term “demands” to describe the politics and semantics in the process of developing and implementing the KEPA (M. Pikramenou, interview, September 1, 2015). Specifically, Pikramenou describes the story regarding the development of the KEPA as the new system for assessing and certifying disability as follows:

First of all, the Law [concerning the KEPA] was enacted very quickly. It was done very quickly. There was not [the relevant] infrastructure in order for the [the KEPA] to be implemented. It was done, and there were demands, let’s say, from abroad, and you know [the consequences of the economic crisis] and everything was done very quickly. … Normally, we would check the differences between the legislation, the provisions, how it was operated by the physicians. … It was enacted in a Law, but in the background, nothing existed. Neither what benefits or provisions the welfare services offered, nor what provisions the Ministry of Finance had. … Everything was done very quickly. There should have been some teams established to identify the problems and then to develop the KEPA. [In fact], the exact opposite happened. The KEPA was established…and from then on, many issues emerged.

(ibid.)

Taking together the accounts of Niarhakou, Hatziharalabous, and Pikramenou, the lack of planning for the infrastructure necessary to properly operate the system was the main argument that the informants stressed. While the necessary infrastructure did not exist, persons with disabilities needed a KEPA disability certificate after the establishment of the KEPA to be eligible for receiving or continuing to receive disability allowances. But that was nearly impossible. Despite the attempts of IKA to solve the issues that emerged (E. Niarhakou, interview, June 6, 2015), the long waiting period because of the insufficient infrastructure had negative consequences for persons with disabilities.

Although the legislation that established the KEPA was enacted in less than two years from the announcement of its upcoming revision, the necessary infrastructure was almost totally absent. While, as mentioned earlier, there was “pressure” and “demand” for the revision of the system of assessing and certifying disability, there was not any concern for how this system would be implemented. But the fulfillment of the rights of persons with disabilities regarding their access to disability pensions and benefits
was totally dependent on the new KEPA classification system, which did not operate properly, creating adverse consequences for persons with disabilities.

Having in mind the voices of persons with disabilities and the voices of the administrative authorities, what is noticed is that their accounts lean on their experiences, or their disability experiences. However, following Diedrich (2005), Moser (2006), and Galis (2011), the accounts of the abovementioned actors are not just descriptions; rather, their accounts are also of different types of disability experience, which extend from personal experiences to policy-making issues. For instance, persons with disabilities share their personal experiences of the insufficient operation of the KEPA, while administrative authorities share their disability experiences of being involved in the policy-making practices.

7.2.3 The involvement of the Greek Ombudsman

In the conflict regarding the problems that emerged after the KEPA was put into play, one more actor was involved. This new actor was the *Greek Ombudsman*, which is an independent authority with the mission to act as a mediator between citizens and the public administration regarding the problems that the citizens have and especially to protect vulnerable social groups. While the Greek Ombudsman had received complaints from persons with disabilities before the establishment of the KEPA (*The Greek Ombudsman*, 2013), in 2013, after the study and investigation of 350 reports submitted to the Greek Ombudsman by persons with disabilities from September 1, 2011, through February 11, 2013, the Greek Ombudsman published the special report, “Remarks by the Greek Ombudsman Regarding the Operation of the Centers for Certifying Disability (KEPA).” The purpose of this report by the Greek Ombudsman was—after collecting, studying, investigating, and mediating the persons with disabilities’ complaints—to “highlight the structural weaknesses of the new system,” aiming “to bring to the attention to the relevant Minister the need for taking legislative and organizational improvement initiatives in order to achieve the smooth operation of the KEPA health committees” (*The Greek Ombudsman*, 2013, p. 3).

72 The Greek Ombudsman is an independent authority established in 1998. Its aim is to act as a mediator between the public administration and the citizens who lived in Greece for helping them to defend their rights and to be equal treated. A special interest is in vulnerable social groups and in the protection of their rights.
While the content of the report offers an analytical and technically detailed presentation of the problems that had emerged since the transition to the KEPA, I will present the main issues only briefly for the purpose of this thesis. According to the Greek Ombudsman, some of the main weaknesses of the KEPA system for awarding disability benefits were:

- serious delays in the disability assessment and the factors that lead to these delays;
- medical certificates taken into consideration in the disability assessment procedure;
- issues regarding the referral procedure and the existence of the fee;
- occupational disability assessment; and
- the composition of the health committees and the wording of the technical decision.

(ibid., my translation)

Following the special report findings, despite the fact that the establishment of the KEPA as the main authority for assessing and certifying disability was a huge innovation in that there was a shift from the fragmented ways of assessing and certifying disability (see, e.g., Chapter 4) to a more coherent and centralize way, the consequences to persons with disabilities because of the long waiting period were essential. The need for better planning was a crucial factor for the improvement of the KEPA operation. Also, another issue came to the surface in the above report in reference to the different legislative frameworks that existed from social insurance fund to social insurance fund. For instance, as mentioned in the report, at first the physicians who participated in the new Special Physicians Body of Health Committees of the KEPA came from the prior Special Physicians Body of Health Committees of IKA, so the physicians who participated in the health committees were familiar with the legislative framework of IKA but lacked legislative knowledge of the other social security funds, an issue which affected the disability assessment process and enacted issues and delays for the disability claimants who were insured under other social security funds (ibid.).

Below are some of the recommendations that the Greek Ombudsman submitted to the administrative and governmental authorities for the elimination of the problems that emerged:

- Better collaboration between the Directorate of Disability and Occupational Medicine of IKA-ETAM and the EOPPY for the
establishment and monitoring of the Special Physicians Body of KEPA Health Committees

- Better collaboration between the Directorate of Disability and Occupational Medicine of IKA-ETAM and the social security funds as well as the welfare services
- Participation of physicians who belong to the National Healthcare System (ESY) in the KEPA health committees
- Reexamination of the physician specializations that allowed a physician to be eligible for participating in the health committees, e.g., pediatrician
- Simplification of the legislation that concerns persons with disabilities
- Increase in the disorders and impairments for which disability is classified as permanent
- Continuation of the disability pensions and benefits for as long as it takes for the reassessment by the KEPA health committees. *(The Greek Ombudsman, 2013, pp. 24–26, my translation)*

### 7.3 A short description of the current state of the KEPA classification system

After three years of intense conflicts and negotiations regarding the components of the new system for assessing and certifying disability, several of the issues that emerged were close to being resolved after the involvement and collaboration of the disability movement, the political leadership of the Ministry of Labor and Social Security, the social security fund of IKA, and the medical society. Also, following the negotiations with the aforementioned actors, a few revisions were made to improve the implementation of the KEPA.

One of the improvements to the KEPA classification system concerns the enactment of a table containing the disorders whose conditions are permanent and irreversible. The purpose of this table was twofold: on the one hand, to protect disability claimants with permanent and irreversible disorders from the burden of frequent disability assessments, and on the other hand, to improve the operation of the KEPA by reducing the number of applicants and thus the long waiting period for the reassessment *(To Vima, October 31, 2013)*.

The Minister of Labor and Social Security, in accordance with Article 7 of the Law 3863/2101, announced in February 2013 the establishment of a
new special scientific committee\textsuperscript{73} assigned to decide which disorders should be classified as permanent and irreversible.\textsuperscript{74} Late in October 2013, the scientific committee released a list entitled of \textit{43 Permanent and Irreversible Disorders} \textit{(Eleftherotypia, October 31, 2013; see also, Government Gazette, 2013).} According to this list, disability claimants who met the criteria of the list would receive a permanent disability certificate and would not have to be assessed again by the health committees \textit{(I Kathimerini, October 31, 2013; To Vima, October 31, 2013).}

The minister of labor and social security, Yiannis Vroutsis, states that the release of the \textit{43 Permanent and Irreversible Disorders} constituted a relief for disability claimants since it put an end to the need for continuous disability assessments of persons with disabilities \textit{(Eleftherotypia, October 31, 2013; To Vima, October 31, 2013).} The general secretary of social security, Panagiotis Kokkoris, says that the purpose of the list was to protect disability claimants from continuous disability assessment and to decrease the number of applicants at the KEPA by 20\% \textit{(I Kathimerini, October 31, 2013).} What is worth adding here is the emphasis, one more time, by the Minister of Labor and Social Security, on the scientific-orientated nature of the committee that was responsible for preparing the above list—an emphasis that calls to mind the continuous reliance on the power of scientific knowledge by the governmental authorities, regardless of the political parties involved, as discussed earlier in this thesis.

Additionally, in 2015, four years after the establishment of the KEPA, the political leadership of the Ministry of Labor and Social Security, which belonged to the SYRIZA government,\textsuperscript{75} proceeded with updates to the legislation regarding the improvement of the KEPA implementation. According to the Law 4331/2015, the disability certificate issued by the KEPA would be recognized by all the services of the public sector, and the fee of 46,14 euros that disability claimants were to pay when they wanted to be granted disability allowances from welfare services would be abolished (ibid.). Additionally, the Law 4331/2010 proceeds with changes to the establishment of the special scientific committee for the revision of the

\textsuperscript{73} Regarding the staffing of the special committee for deciding which disorders and impairments would be classified as permanent and irreversible, see Appendix VI.

\textsuperscript{74} Regarding the emphasis on the scientific role of the special committees, see pp. 210-212.

\textsuperscript{75} On January 25, 2015, the left political party of SYRIZA won the parliamentary elections and replaced the ND political party in power.
EPPPA. Appendix VII presents the new staffing of the special committee for the updating of the EPPPA.

Comparing the participants of the aforementioned committee (Appendix VII) with the participants in the committees that established the first and second versions of the EPPPA (see, Chapter 6, pp. 209-210, and, 244) as well as the list of the permanent and irreversible disorders (Appendix VI), one can note an increase in the number of representatives from the medical society. Considering the conflict discussed in Chapter 6 (pp. 210-212) regarding the participants in the special scientific committee, as noted above, physicians from various medical specializations have been added as well as physicians who are members of the Special Physicians’ Body of Health Committees and the ELIEAKAP who have an expertise in disability assessment.

Vardakastanis, in an interview that I conducted with him on September 6, 2016, describes the current state of the implementation of the KEPA as a “period of tranquillity.” As he says there are obviously still issues with the operation of the KEPA, but not as many as in the first years of its establishment (ibid.). Also, Niarhakou, in the interview that I conducted with her on June 6, 2015, describes the effort on behalf of the IKA to solve as quickly as possible the problems that emerged since the KEPA started to be implemented.

Here, I would like to close by using two points from the interviews that I conducted with the head of the Directorate of Disability and Occupational Health at IKA-ETAM, Niarhakou, and the chairman of ESAEA, Vardakastanis. To begin with the head of the Directorate of Disability and Occupational Health of IKA-ETAM, which KEPA falls under, she offers the following description of what the KEPA has done since its establishment on September 1, 2011:

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76 Physicians who are specialists in pediatrics were added to the new Scientific Committee for revising the EPPPA. It is worth adding here that in the Greek Ombudsman’s special report regarding the operation of the KEPA, there is a reference to the absence of pediatricians on health committees for disability assessment. While the special report refers to the participation of pediatricians in health committees, here we can see that pediatricians were included in the committee responsible for developing and updating the EPPPA.

77 Following footnote 20, the members of ELIEAKAP are also physicians who belonged to the Special Physicians Body of the Health Committees and have participated in the health committees for assessing and certifying disability.
Today there is a history, so to speak, from 2011 and after. What exists? Where does it exist? How many of them [persons with disabilities]? What kind of differences exists between the primary and secondary health committees? What references? What kind of disorders do the Greeks have?

(E. Niarhakou, interview, June 6, 2015)

To my understanding, the above quote by the head of the Directorate of Disability and Occupational Medicine has something to say regarding the objectives that have been embedded in the enactment of the disability classification system. The above description brings to the fore a “big brother” feature in the operation of the KEPA, since the new disability classification system is not just a system that is supposed to support persons with disabilities; on the contrary, it is a system that has as its main objective to control the citizens who apply for being eligible to receive disability allowances. Keeping in mind what was discussed in Chapter 6 regarding the alleged “fake disabled” as well as the alleged “high rate of disability beneficiaries,” what is revealed here about the objective of the new system for assessing and certifying disability is that the main principle behind the enactment of the new disability classification system is that a “good” citizen with disabilities is a citizen who can be well counted and/or classified (cf. Bowker & Star, 2001, p. 423).

On the other hand, the chairman of ESAEA, Vardakastanis, refers to the number of disability applicants and the disability certificates that were issued by the KEPA by challenging the way that disability assessment has been treated by the Greek state since the establishment of the KEPA (ibid). By referring to the high number of disability certificates, which from September 2011 until November 2015 was 552,930, he compares the disability assessment procedure to “an assembly line” (ibid.). He means that that the number of disability certificates issued by the KEPA was more important for the governmental and administrative authorities than the persons with disabilities as subjects. Following Porter, the number of disa-

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78 In a personal communication that I had in fall 2015 with the Directorate of Disability and Occupational Medicine at IKA-ETAM regarding the number of disability certificates that have been issued since KEPA was put into play, I was informed that from September 2011 to November 2015, 552,930 disability disclosure results were issued. Appendix VIII contains the response by the Directorate of Disability and Occupational Medicine to my request about the number of disability disclosure results that were issued by the KEPA from September 1, 2011, to the middle of November, 2015.
bility claimants has the “potential to become a new thing”; indeed, through the number of disability certificates that have been issued by the KEPA, disability has been enacted as “a new thing,” and persons with disabilities “have been made governable” (cf. Porter, 1999, p. 96).

What I want to argue here is that both the statements by Niarhakou and Vardakastanis offer the opportunity to problematize the purposes of the disability classification system. For instance, the head of Directorate of Disability and Occupational Medicine of IKA stressed the new feature of the KEPA classification system to control the disability claimants, whereas the chairman of ESAEA criticized the emphasis by the system developers on treating disability claimants as an object (e.g., the number of disability claimants that have been assessed within the new system) and not treating disability claimants as subjects.

7.4 Conclusion
Chapter 7 discussed the initial period after the KEPA system for assessing and certifying disability started to be implemented. Though the study of the implementation of the disability classification system is beyond the scope of this thesis, in the case of the KEPA, it was the first time that (after the EPPPA was released and the KEPA was put into play) a wave of negative reactions to the system components emerged into the Greek society. Chapter 7 thus examined the EPPPA and the KEPA conflicts that were enacted between the system developers and the society and how the conflicts translated to changes to the KEPA system components. Because of the content of this chapter, I relied on the theoretical/methodological theme of practical politics to explore the “political, ethical, and social choices” that had been taken into consideration during the development of the disability classification scheme and before the disability classification system transformed into a black box (Star & Bowker, 2010, p. 233).

One of the first points that came to the surface after shedding light on the EPPPA and KEPA conflicts concerns the crucial role of the disability movement. Having in mind the role and involvement of the disability movement in policy-making in the earlier chapters of this thesis, what has been noticed in this chapter is a shift in the disability movement’s strategy. By this shift I mean that the disability movement employed new political tactics, such as protests and demonstrations and the power of the news media, particularly the international news media, to influence public opinion regarding the KEPA classification system and its negative consequences for persons with disabilities. Following Barnes and Mercer (2010), the
disability movement employed “direct action” tactics, with the objective to gain as much publicity as possible and to influence public opinion regarding the political choices behind the establishment of the new system. Recalling the earlier discussions in Chapters 3, 4, and 5, it was when the systems were being developed in times of austerity that the disability movement employed direct action tactics such as demonstrations to defend the rights of persons with disabilities in the context of the system for awarding disability allowances.

While earlier in this thesis I claim a corporatist synergy between the disability movement and the governmental authorities, especially when the socialist party of PASOK was in office, for explaining the involvement of the disability movement in policy-making, here, in this chapter, what is noticed is that the disability movement did not lean on the corporatist bonds with the governmental authorities. Instead, it adopted tactics from the pressure groups theory: for example, the use of the media, both to put pressure on the governmental authorities by publicizing the “questionable” political choices behind the enactment of the disability percentage table and to be involved in politics and in policy-making, such as in the revision of the existing legislation for the determination of disability percentages.

The second point that I would like to further discuss and that emerges with the help of the theoretical/methodological theme of practical politics concerns the content of the two components of the new classification system that enacted conflicts in Greek society. By “content” I refer to the issues that emerged after the release of the EPPPA and the implementation of KEPA. The presentation and discussion of the conflict that arose after the release of the EPPPA as well as the reconstruction of the second version of EPPPA reveal a “gap” regarding the translation of the bodily condition into a disability percentage.

Even though, as already discussed in this thesis, all the politicians underlined the scientificity and objectivity that accompanies the disability percentage table, which is the core component of the system for assessing disability, the issues that came to the surface after the release of the first version of the EPPPA bring into doubt the reliability and credibility of the disability percentage table. For instance, the revision and the release of the second version of the EPPPA, and especially its upward revisions to disability percentages, after the storm of intense reactions by society against it offer room to challenge the credibility of the disability percentage table as well as to problematize the political choices for its enactment.
Following Porter (1991) and his argument on how rates or numbers are transformed into a political instrument in the hands of governmental authorities, the development of the disability percentage table should also be viewed as a political instrument in the hands of the governmental authorities. By that I mean that, although the governmental authorities stressed the objective nature of the disability percentage table because of the trust in numbers, the debate with the first and the second version of the EPPPA challenge their argument, since the objectivity behind the translation of a disorder or an impairment into a percentage is questioned.

One more point that I would like to add here concerns the economic crisis and the development of the disability classification system. Recalling the discussions in Chapters 4 and 5—specifically, the lack of determination by the political parties in office to complete and implement the systems that they developed—we saw that the opposite happened in the system discussed in Chapters 6 and 7. Friedman claims that “only a crisis—actual or perceived—produces real change” (as quoted in Klein, 2008, p. 140); in the case of Greece, it was because of the economic crisis that the KEPA system was developed and implemented quickly. Klein (2008, p.140) argues that:

if an economic crisis hits and is severe enough...it blows everything else out of the water, and leaders are liberated to do whatever is necessary (or said to be necessary) in the name of responding to a national emergency. Crises are, in a way, democracy-free zones—gaps in politics as usual when the need for consent and consensus do not seem to apply.

The economic crisis that “hit” Greece was “severe enough” for the politicians, as discussed in Chapter 6, to argue for the need for radical structural reforms to the operation of the state as a response to the “national emergency,” with the revision of the new system for assessing disability to be one of these reforms. With regard to politicians’ lack of a “need for consent and consensus” during times of economic crises, the presentation and discussion of the conflicts in this chapter highlight how, in the name of responding to the bad economic situation of the country, the Greek governmental authorities proceeded (among other reforms) with cuts to disability pensions and allowances by redefining disability through the adoption of a neoliberal vocabulary and by attacking the vulnerable social group of persons with disabilities. For example, the lack of infrastructure planning in the KEPA classification system had negative consequences for
persons with disabilities because persons with disabilities were stuck on long waiting lists without receiving their disability pensions and allowances (after some time)—not because they did not meet the new standards but because of the system’s insufficiency.
8. Conclusion

In the first empirical chapters of this thesis, I examined why the development of a system for assessing and certifying disability emerged as a controversy in Greek society from 1990 to 2015. In order to do this, I described the process of the development of each of the four disability classification systems that were proposed in this 25-year period. My main concern was not to treat a disability classification system as “a given infrastructure”; on the contrary, following Bowker and Star (1999), my aim was to examine how we end up at classification schemes by exploring: the political, ethical, and social choices and the negotiations and conflicts between the relevant actors in each attempt, as well as the practices behind their enactment.

Building my theoretical/methodological strategy for the analysis and presentation of the empirical material, I chose concepts and theories from the scientific fields of the science and technology studies, disability studies, sociology, and political science. More specifically, I relied on the theoretical/methodological themes of indeterminacy of the Past, material and texture, and practical politics as guides for the reconstruction of each of the disability classification systems that Greece attempted to develop in its social security system. My purpose was to explore how the development of a system for assessing and certifying disability developed as a controversy in Greek society, a controversy that lasted almost twenty years.

In the first empirical chapters, Chapters 3 to 7, I opened the black box of each of the four candidate systems—both completed and uncompleted—for assessing and certifying disability. In each system, I described the process through which the system for assessing and certifying disability was designed. Recalling what has already been presented and discussed, while there were similarities in the processes for the enactment of each system, there were also unique characteristics in terms of the conceptualization of disability as well as in the choices behind each enactment. Also, by taking together all four attempts, essential key findings emerge and further contribute to the understanding of the systems for assessing and certifying disability. The questions that arise here are What do we learn in the previous 200 pages or so about the debate on the enactment of disability classification systems in Greece? and What is the contribution of the findings of this study in the area of the study of disability classification systems? In what follows, I will discuss the main empirical findings of this
project in connection with the theoretical framework that I built and presented at the beginning of this thesis.

8.1 The involvement of the disability movement in policy-making

One of the first findings after the reconstruction of the four systems for assessing and certifying disability is that one of the social groups that had an essential role in the conflicts and the negotiations for their enactment was the disability movement. While the disability movement was not involved in the development of the first system, it had a say in the following three attempts through the development of the disability classification systems.

To be more specific, in the first attempt, when the conservative party New Democracy (ND) was in office, the disability movement, as discussed in Chapter 3, did not participate in the negotiations for the enactment of the disability classification system. Conversely, in the system that was developed when the socialist party of PASOK had replaced ND in office (described in Chapter 4), the disability movement had a strong voice in the whole attempt, including from different subject positions. As I claimed in the analysis of Chapter 4, the key actors had a hybrid identity: they were politicians or policy makers as well as persons with disabilities themselves and/or members of the disability movement. In Chapter 5, on the other hand, we saw that when ND was again in office, the involvement of the disability movement was not considered necessary in the initial negotiation period; however, after an initiative by the members of the umbrella organization of persons with disabilities, the disability movement had a voice in this attempt.

In Chapter 6, which was a period when PASOK returned to power and the economic crisis started in Greece, the disability movement—again, after its own initiative—was involved in the development of the system for assessing and certifying disability, and, as shown from the analysis of this attempt, there was an agreement on behalf of the governmental authorities to proceed with the revision of the system for assessing and certifying disability. The difference between the involvement of the disability movement in Chapters 5 and 6 is that in Chapter 5 the role of disability movement was limited to the national conference held for discussing issues relevant to the adaptation of the ICF at which the movement presented the perspective of persons with disabilities, whereas in Chapter 6, the disability movement was involved in the enactment of the legislation that established the system for assessing and certifying disability.

On the other hand, in Chapter 7 we saw that as long as the economic crisis deepened, the political instability in the country affected the synergy
between the disability movement and the governmental authorities. By that I mean that, even though the representatives of the disability movement used to maintain direct communication with the governmental authorities by sending letters or by communicating directly, late in 2011, as this study shows, the representatives of the disability movement employed new forms of political tactics to defend the rights of persons with disabilities.

Following Barnes and Mercer (2010), the disability movement made a shift in its involvement in the process of the development of the disability classification system in the period of economic crisis by employing “direct action” tactics such as protests and demonstrations for gaining, among other things, as much publicity as possible. “Direct action” tactics belong to the new social movements’ theoretical framework (Habermas, 1981; Touraine, 1985; D’Anieri et al., 1990). Keeping in mind that the main characteristics of the new social movement theoretical framework concern quality of life and human rights issues (Habermas, 1981), to my interpretation this choice by the disability movement has something to say about the consequences of the economic crisis on persons with disabilities in terms of access to the welfare state.  

The disability movement did not limit its action to protests and demonstrations; on the contrary, it relied upon the power of the media, and specifically the international news media, to inform and gain the support of public opinion about the political choices behind the establishment of the new system. However, this last tactic or action of putting pressure on governmental authorities is a characteristic of the pressure groups theory (Mavrogordatos, 2001), under which the disability movement was not only aiming to influence public opinion but was also aiming to be involved in politics.

Echoing Klein (2008) and her statement on how an economic crisis brings the upside-down in terms of actions and initiatives by the governmental authorities to solve or put an end to the crisis by downgrading the role of consent between the interested parties, to my interpretation the aforementioned degradation does not only limit the consensus between the interested parties; rather, the degradation concerns the synergy between the govern-

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79 I would like to underline here that in this thesis I am focusing only on the tactics that the disability movement employed in relation to the development of disability classification systems. By that I mean that I did not cover the full history of the disability movement and its actions to defend persons with disabilities. For instance, in Parergon, there is reference to direct actions that the members of the disability movement have carried out since the mid-1970s.
mental authorities and the interested parties. For example, when representatives of the disability movement were involved in the initial stage for the enactment of the disability classification system at the beginning of the economic crisis, there was a sense of a synergy between the state and the disability movement; however, as the economic crisis became more severe, the sense of synergy between the state and the disability movement started to fade. It was that moment that the disability movement made a shift, setting aside its usual tactics of being involved in policy-making and employing other political tactics to get as much publicity as possible and to influence the public opinion as well as being involved in politics.

8.2 The involvement of political parties in the enactment of the disability classification systems

A second finding of this thesis, already touched on in the above section, concerns the role of the political parties in the enactment of each disability classification system discussed in Chapters 3 through 7. By that I mean that every new announcement for the reform of the system for assessing and certifying disability happened shortly after a change in the political landscape of the country. Back in the early 1990s, the conservative political party of New Democracy (ND) replaced the socialist party of PASOK in power, determined to proceed with radical structural reforms to the operation of the state. Inspired by the neoliberal trends occurring since the 1980s in the United Kingdom and in the United States, ND proceeded with reforms to the operation of the state by significantly cutting the expenses of the welfare state. As for disability issues, the reconstruction of the disability classification system which was developed in that period (see Chapter 3) and concerned the general scheme for social security revealed a medical approach to disability issues and underlined the dominance of medical knowledge.

The win of the socialist party of PASOK in the parliamentary elections of 1993 marked a change in the operation of the state. Also, a new system for assessing and certifying disability was proposed. What is essential in this attempt is the synergy between the PASOK government and the disability movement, with the latter to be fully involved in the enactment of the disability classification system. In other words, what we learn from this attempt is that the PASOK government gave room to persons with disabilities to be key actors in the attempt to develop the disability classification system.
After nine years in office, PASOK lost the parliamentary elections in spring 2004 and was succeeded by the ND. Shortly thereafter, the political leadership of the Ministry of Health and Social Solidarity announced the government’s intention to change the system for assessing disability by adopting the ICF classification system. The choice to adapt the ICF followed the current international trend of transferring the focus from disability to functionality and abilities of persons with disabilities. Though the adaptation was not completed, the preference of the political party of ND for the enactment of neoliberal policies (e.g., Chapter 3) for the disability assessment is revealed.

In fall of 2009, ND was replaced by PASOK in power after PASOK won the 2009 parliamentary elections. The return of PASOK to power coincided with the start of the economic crisis in Greece, when there was a demand by the EC, the ECB, and the IMF for radical structural reforms in the operation of the state. Despite the efforts that lasted almost fifteen years for the revision of the existing system(s) for assessing and certifying disability, the conditions for the disability assessment were still the same as in 1993.

Following Sotiropoulos (2003), the involvement of the political parties in the enactment of the disability classification systems shows that both the political parties of ND and PASOK treated the development of a disability classification system as a “political problem.” By stressing the issue with the alleged “faked disabled,” both the conservative party of ND and the socialist party of PASOK argued for enacting a new system to decrease the number of alleged “faked disabled.” While readers of this thesis have learned about the interest of the political parties to be involved in the revision of the existing system for assessing and certifying disability, they have not received an answer up until now as to why, in the end, the political parties failed to implement what they were supposed to.

Naomi Klein (2008, p. 140), quoting Milton Friedman, says that when states’ economies run under normal circumstances, “economic decisions are made based on the push and pull of competing interests.” Having in mind the political economic theory of clientelism, which is a crucial characteristic of the operation of the Greek state, together with the above argument by Friedman, an answer to the question of why the political parties did not proceed with the implementation of the systems they developed should be sought in the unwillingness of the politicians to change the already balanced environment among the various social groups that participated in the implementation of the systems of assessing and certifying disability, e.g., physicians, social security funds, administrative staff, and so on.
However, what has already been described to explain the unwillingness of the political parties to proceed with the revision in the existing system for assessing and certifying disability is a feature of the political theory of corporatism. Echoing Mouzelis (1986, p. 75), “corporatism...always implies de jure arrangements between the state and various civil-society associations for the purpose of avoiding ‘social strife.’” But recalling what has been discussed throughout this thesis regarding the enactment of disability classification systems, and the enactment of disability policies in general, the reason, in my understanding, for the nonimplementation of the disability classification system should not be sought in the corporatist relationships between the state and specific social groups. Rather, the nonimplementation of the disability classification system should be approached and explained using the conceptual frame of clientelistic corporatism, as introduced by Tsoukalas (1986), to examine the asymmetrical relationship that the state has established with “selective” social groups in terms of “unequal distribution of rights, opportunities and benefits” (Sotiropoulos, 2003, p. 103). Following Sotiropoulos (2003), the enactment of disability classification systems belongs to the social welfare state; however, the political element is very strong, and there exist in parallel clientelistic relationships between the social groups involved.

For example, in Chapter 4, we saw that while there was an attempt to remedy the fragmentation of the disability classification systems, an issue that was stressed by the disability movement and that has an essential role during the development process, in the end, the proposed solution was not implemented. But the “fragmentation” of the disability classification systems as well as the fragmentation of “disability policies” in terms of providing disability benefits in cash and in kind should be explained as elements that fall under clientelistic corporatism.

### 8.3 Disability fraud: Persons with disabilities as a threat to the society

This study also focuses on the debate of the alleged disability fraud, which was a recurrent issue in the political debates after a change in the political party that was in office and before the announcement of an upcoming revision to the existing system for assessing and certifying disability and/or of cuts to disability benefits. This study shows that the construction of the concept of disability fraud has its roots in the political context of the country. Following Tsoukalas (1986) and his argument regarding the use of clientelistic corporatism to describe the relationship between the state
and social groups, an asymmetrical relationship was created between those who had the power and specific social groups. By taking advantage of the selective policies for persons with disabilities, politicians aimed to enlarge their network of supporters by “exchanging” benefits for votes. As I already claimed, however, in the name of their political ambitions they stigmatized and enacted negative stereotypes against the vulnerable social group of persons with disabilities by creating fear in the society.

The reconstruction of the four disability classification systems shows, as well, that the system’s revision through the adoption of stricter eligibility criteria for disability allowances is also a reason to further problematize the origins of the concept of disability fraud. As discussed in Chapter 6, the system that was developed after the outbreak of the economic crisis did not leave any option to persons with disabilities other than to be reassessed by the new institution of the KEPA and by the new disability percentage table. This study shows that the aforementioned system for assessing and certifying disability introduces stricter eligibility criteria (in order for someone to be classified as able or disabled), such as changes to the already existing disability percentages in the disability percentage table. But the changes to the disability percentages simultaneously meant that persons with disabilities who had been classified as disabled under the previous scheme were suddenly enacted as entities that they do not fit the new standards, or as Susan Leigh Star (1991) would claim, persons with disabilities were suddenly enacted as Others.

Following Bowker and Star (1999, p. 9) and their questions Work do classification and standards do? and What happens to the cases that do not fit?, this study shows that the politicians’ argument about the alleged “fake disabled” as threats to the state and society or as “folk devils,” as described by Briant et al. (2013), is questionable. To summarize what I have already claimed and what I will claim again in this concluding discussion of this thesis, the following are all issues that offer room to problematize the origins of the concept of “disability fraud”: i) the “use” of disability statistics in the governmental authorities’ rhetoric concerning the need to revise the systems for assessing and certifying disability, ii) the introduction of stricter eligibility criteria in order for someone to be classified as able or disabled, and iii) the clientelistic relationships between those in power and specific social groups in order to exchange benefits for votes.
8.4 Statistics as a political instrument
The use of statistics by the politicians as a means to build their rhetoric and persuade the public of the need for reform to the system for assessing and certifying disability was also one of the main areas on which this study focused. Following Kirchner (1993), governmental authorities and policy makers rely on disability statistics or the rates of disability beneficiaries to design their disability/social policies, such as the systems for awarding disability benefits. The Greek politicians, by imitating the international trends, often referred to the rates of disability beneficiaries to build their rhetoric to explain why there was a need for a stricter system for awarding disability benefits. Since early in the 1990s, in almost every discussion for the revision to the system for awarding disability benefits or cuts to disability benefits, the reference to the rates, and specifically to the high rates, of disability beneficiaries was continuous. No one can challenge the power of numbers or statistics. On the contrary, the correlation of numbers with concepts such as validity and trust was a strong instrument in the hands of politicians to persuade the public.

While disability scholars such as Abberley (1992) and Briant et al. (2013) imply a possible “manipulation” of the use of disability statistics by the politicians and/or policy makers, this study has shown that the reference to the rates of disability beneficiaries that Greek politicians have repeatedly used as early as in the 1990s lacks credibility and reliability. One might argue here that the lack of reliability of the statistics that the Greek authorities referred to is a special case. Certainly, that is an option. But keeping in mind the problematization already expressed by scholars such as Abberley (1992), Briant et al. (2013), and Best (2001) regarding the nature of statistics, the Greek case offers a good example for further challenging and problematizing the use of statistics or disability statistics in the enactment of social/disability policies in the enactment of disability classification systems.

As this study shows, as early as the 1990s the Greek politicians referred to the rate of disability pensioners of the social security funds without giving room to question the origins of these rates. They presented specific rates that came from the largest social security funds of the Greek state. The outbreak of the economic crisis and the need for deep structural reforms to the operation of the state as demanded by the troika, a tripartite committee consisting of representatives from the EC, the ECB, and the IMF, brought to the fore that the use of the rates that the Greek politicians had repeatedly referred to in arguing for the enactment of a new system for awarding disability benefits lacked reliability and credibility, since the social security funds
were unable to provide this kind of information. Nevertheless, despite the questionable nature of the rates of the disability beneficiaries, the governmental authorities announced reforms to the systems for awarding disability benefits for decreasing those rates.

8.5 From multiple voices to the multiplicity of disability experience

One of the theoretical/methodological strategies that I followed in this study for the reconstruction of each disability classification system that was developed in Greece from early in the 1990s to early in the 2010s was to give voice to relevant actors and social groups in an attempt to shed light on the reasons why there was a need for revising the existing disability classification systems. Through this strategy, each social group or actor evaluated or retold the story of the already existing disability classification system by giving a different account. But keeping in mind that each of the systems that was described in Chapters 4, 5, and 6 aimed to replace the system that was described in Chapter 3 and concerns the system that was implemented in the context of the general social security system, all the stories that were retold by the relevant actors concerned the same system or condition for assessing disability.

Recalling what was already discussed in this thesis, we saw that the voices of the relevant actors evaluated the existing disability classification system by using different *vocabularies* and by referring to different *practices, personal experiences, policy-making issues*, and so on. For instance, we saw that in Chapter 4 the main argument in the evaluations of the relevant actors was around the system fragmentation, with persons with disabilities evaluating the system fragmentation based on their personal experiences, and with policy makers and politicians referring to administrative practices. In Chapter 5, the evaluation of the existing disability classification system was not oriented toward personal experiences or administrative-related experiences; rather, the evaluation was done by referring to scientific practices on how disability is assessed. Last, in Chapter 6, the evaluations ranged from practices related to policy-making issues (e.g., adoption of neoliberal policies for reducing the welfare state and enacting cost-cutting measures in terms of welfare allowances) to politico-scientific practices (e.g., emphasis on rehabilitation and the inclusion of persons with disabilities into society) to personal experiences issues (e.g., the negative stereotypes enacted in Greek society because of the concept of disability fraud and the consequences of those stereotypes on persons with disabilities).
Echoing Bowker and Star (1999), indeed differences between the “social worlds” of the relevant actors resulted in different evaluations about the weaknesses of the existing system for assessing disability, as the different actors were surely influenced by the trends that dominated in their “social worlds.” But the study of the “voices” of the relevant actors and social groups did not yield only simple descriptions of the disability classification system; rather, the descriptions by the actors and social groups were the outcome of their own disability experiences—which extend from the personal experiences of persons with disabilities to the “material context of realities” (Diedrich, 2005; Moser, 2006; Galis, 2011). Based on the voices of the relevant actors and how they evaluated the disability classification system based on their experience or disability experience, this study shows that the disability experience is not only limited to the experiences that are related to impairment; rather, the disability experience extends to multiple fields—scientific fields, policy-making fields, administrative fields, and so on.
While the topic of this thesis is the study of the disability classification system that has been developed in Greece from 1990 to 2015, there are also some essential stories that, even though they do not fit with what has been presented in the main body of the thesis, are worth including in the manuscript to assist readers in comprehending the case. For this reason, I added at the end of this thesis one more part that I call Parergon. In what follows I will explain what Parergon is in general and what constitutes Parergon for this thesis.

Parergon (πάρεργον) is a Greek word. It is a complex word that derives from the word para- (πάρα), which in Greek means additional, and -ergon (έργον) which means work. Hence, Parergon means additional work. Unlike a supplement, which is a supportive material to the main body of a work, Parergon exists independently because it is an additional work that is not limited to the specific context of the main work but, despite its remote relationship to the main body of work, is helpful material for a further understanding of the topic under study. Thus, in the case of this project, the history of the formation of the Greek disability movement is an essential story that—though somewhat unrelated to the reconstruction of the disability classification systems—needs to be part of this project for a better understanding of the role of persons with disabilities in the society and particularly in the policy-making.

A short history of the Greek disability movement

1930s–1940s: Initial attempts for the formation of the Greek disability movement

The initial attempts for the formation of the disability movement in Greece go back to the 1930s and to the intense interest of blind people in politicizing and demanding their rights. In 1932, thus, the Panhellenic Association of the Blind, the first disability organization of persons with disabilities in Greece, was established (Kouroumblis, 2000). A few years later in 1934, blind people, under the guidance of the Panhellenic Association of the Blind, organized their first mobilization by demanding the enactment of social measures for them.
A second essential moment in the course of the formation of the disability movement is linked to the disabled veterans of WWII and their demand for better hospital care. Specifically, early in the 1940s, disabled veterans, who were hospitalized at the Athenian hospitals until recovering from their wounds, were disappointed about their insufficient hospital care; for that reason, they began to organize in groups and committees to demand better conditions for their hospitalization (Fyka, 2010; Rizospastis, February 12, 2006). As Kouroumblis (2000) points out, the politicization of disabled veterans, both during and after the war years, should be explained by the fact that disabled veterans belonged to a generation that was educated, compared to previous generations, and determined to claim its rights.

Even though there was an intense interest by disabled veterans to mobilize, there was a lack of coordination between their actions (Fyka, 2010; Rizospastis, February 12, 2006). Therefore, there was a need for support and guidance by an external entity, guidance that was found in the National Liberation Front (EAM). Founded on September 27, 1941, after the collaboration between four left-wing political parties—namely, the Communist Party of Greece (KKE), the Socialist Party of Greece (SKE), the Union for People’s Democracy (ELD), and the Agricultural Party of Greece (AKE)—EAM was the main movement for the Greek resistance during the occupation of Greece by the Axis Powers. Disabled veterans gradually integrated into the EAM and, by following its guidance, started to act more organized. For example, they participated in small groups of five members, and they were forbidden to communicate with members of other similar groups (except with just one representative, using nicknames), and they participated in demonstrations organized by the EAM (Rizospastis, February 12, 2006). Either on wheelchairs or with their crutches, they were on the first lines, while on the other side were the invader’s tanks (ibid.).

The first mobilization of the disabled veterans was at the Ministry of the Army, demanding better conditions in terms of their treatment and care at the hospitals. In a tribute by the newspaper Rizospastis, there was a reference to the events that happened that day. As mentioned in this tribute, disabled veterans did not hesitate to participate in this demonstra-

80 The Axis Powers were the nations of German and Italy that they fought together during the WWII against those nations that belonged to Allies of WWII, with Greece to be part of the Allies of WWII.
tion because of their health conditions; instead, they went to the demonstration using their wheelchairs and crutches and demanded better conditions for their “cure” (*Rizospastis*, February 12, 2006). The outcome of this mobilization was to take under their control the administration of medications by defeating the German-friendly administrators who had been responsible for it (ibid.).

**1950s–1970s: The politicization of persons with disabilities and the formation of disability organizations**

The year 1951 constitutes an important landmark for persons with disabilities in Greece. That year the Greek state enacted the first legislation about the rights of persons with disabilities, specifically for the blind, and concerning the responsibilities of the Greek state towards persons with disabilities. The Law 904/1951 made the Greek state responsible for educating and offering disability allowances to the blind (*Government Gazette*, 1951). As Galis (2006) underlines, the enactment of the Law 904/1951 signifies the first time in the history of the Greek state that a disability issue had its place on the government’s political agenda.

The politicization and mobilization of persons with disabilities further continued in the 1950s with the establishment of the second disability organization in 1955, after an initiative of the graduates of the Rehabilitation Center for the Physically Challenged (Galis, 2006). Until the end of the 1950s, a number of disability organizations emerged, such as The Association for the Deaf, the Panhellenic Association of Paraplegics, and the Panhellenic Disability Movement, to name but a few (Kouroumblis, 2000).

In 1960, the National Association of Parents and Guardians of Misfit Children (PEGKAAP) was founded. To Kouroumblis (2000, p. 326), the foundation of PEGKAAP constitutes a critical moment for parents and families of children with disabilities, since the birth of children with disabilities was loaded with negative meanings for the families such that the parents, because of the stigmatization, usually preferred to leave the children in institutions.

In the 1960s and 1970s people with disabilities both in Europe and the United States participated in the establishment of disability organizations for claiming their “rights,” instead of their “needs” (Oliver, 1990). As Oliver argues, this shift from the “needs” of persons with disabilities to their “rights” as equal members of the society would happen only through associations of persons with disabilities and not through associations for persons with disabilities (ibid.). UPIAS in the United Kingdom, the Self-Advocacy...
Movement in Sweden, and the Independent Living movement in the United States are representative examples of this attempt. By developing and participating in their own associations, persons with disabilities gained the voice to express and share their experiences—something that was not taken into consideration in the past. Galis (2011), inspired by Foucault, argues that the concept of the insurrection of subjugated knowledge describes this initiative by persons with disabilities. As he claims:

This sort of knowledge, which has been previously disqualified as non-conceptual, insufficient, and hierarchically inferior by the gatekeepers of “scientifi city,” appeared from below, based on what people know/experience at a local level and contributed to open up for a critique of the modernist “hierarchy of erudition and sciences.

(ibid., p. 833)

The establishment of disability organizations of persons with disabilities signifies a shift regarding the conceptualization of disability by persons with disabilities. Through the politicization, persons with disabilities were no longer the sinners who should live under the oppression and dependence of charity, institutionalization, and/or the Church. Rather, they were able to judge and demand what was better for them, for example, education, economic allowances, access to the welfare state, and so on.

Late in the 1970s: The occupation of the “House of the Blind” and the mobilization of paraplegics

An essential moment for the further establishment of the disability movement in Greece consists in the occupation of the House of the Blind in 1976, since it marks a change in how persons with disabilities, and particularly the blind, through their politicization, started to demand changes to their quality of life according to their rights and not to their needs. Specifically, it was in 1976 when blind pupils and their parents complained about the living conditions in the House of the Blind. In two articles that were published in the daily newspapers To Vima (March 3, 1976) and I

81 The House of the Blind was a private charitable institution that was founded in 1906 by private charity initiatives aiming to protect the blind from begging. In 1912, the institution’s administration passed to the Greek Orthodox Church, with the Archbishop of the Greek Orthodox Church to be the chairman of the board. The Greek Orthodox Church kept the administration until the middle of the 1970s.
Avgi (April 29, 1976), there was a reference to the Parents Association complaints. Specifically, blind pupils and their parents complained about the awful conditions under which the House inmates lived.

On May 2, 1976, the blind occupied their House by demanding a change in the ownership of the House. According to the blind, the administration should be transferred to the state instead of the Church (Galis, 2006). Under the slogan “bread, work, and not begging,” the blind also demanded to be treated as equal members of society, to be pensioned, to have social and professional rehabilitation, and to manage their own affairs (Ta Nea, May 12, 1976; I Kathimerini, May 21, 1976, May 25, 1976). The reaction from the board was to close the food storages to leave the children without food, to disconnect the telephone lines to isolate them, and to call their parents to take care of their children.

In parallel, the events that were happening in the House of the Blind grabbed the attention of the director and film producer, Maria Hatzimichali-Papaliou. Hatzimichali-Papaliou’s documentary, The Struggle of the Blind (1976–1977), depicts the terrible conditions as well as the oppression that blind students faced in the House. Based on the narratives of the personal experiences of blind pupils as well as their parents about the events that took place from April 1976 to October 1977, this documentary is an essential source for understanding the insurrection that the blind undertook in the House. Even though the purpose of the House was to educate and protect the blind and to offer support and food to those who were unable to work, the House operated more as a place of discipline and punishment and as an institution that aimed to create blind people as “machines of pity” (The Struggle of the Blind, 1977).

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After a five-month period of negotiations, on October 2, 1976, the board of the House agreed that the school should be reopened, and a few days later, on October 8, the ownership of the House transferred to the state (Galis, 2006). This “struggle” of the blind marks a new period regarding the conceptualization of disability issues in Greece. Additionally, it was the beginning of a new era regarding discussions on disability issues as well as a source of inspiration for other categories of persons with disabilities to form disability organizations in Greece for demanding their rights. The mobilization of the Greek Paraplegics Association in the late 1970s constitutes a relevant example regarding the realization of persons with disabilities that it was crucial for them to establish disability organizations for having a voice and demanding their rights (ibid.).

1980s: The change on the country’s political landscape and its consequences for persons with disabilities

In 1981, the victory of the socialist party of PASOK in the parliamentary elections brought a new philosophy regarding the policies that were going to be enacted. In contrast to ND, which was not interested in the development of a social welfare policy, one of the main priorities of PASOK’s political program was the development of a welfare state and a “social wage” (Katrougalos, 1996). The socialist party of PASOK wished to differentiate its type of politics from that of the prior conservative governments. By calling its political program *Allaghi* (Change), PASOK designed its political strategy focusing on citizens, particularly on those citizens who did not belong to privileged groups. According to Lyrantzis (2005, p. 247), PASOK adopted a populist strategy, aiming, on the one hand, to appeal to the masses, and on the other hand, as a new political party, to create a body of supporters.

In the 1980s, social groups that were marginalized or did not participate in any discussions or negotiations with governmental bodies started to have a voice. As Sotiropoulos (1995) points out, during the 1980s there was an emergence of social movements, such as the feminist movement, the environmentalist movement, and so on, whose members were looking for participation, at some level, in the political system. Regarding the social group of persons with disabilities, Galis (2006, p. 76) argues that the win of PASOK in the elections of 1981 constituted an es-
sential moment for persons with disabilities: “Disability issues began to become objects of concern for state policies and politicians.”

For example, Vardakastanis, the chairman and one of the founding members of the ESAEA, who also participated in the occupation of the House of the Blind, states:

The decade of the 1980s was crucial for the Greek society, for the political and social constitution of the country. ... For persons with disabilities, there was a significant change, since suddenly, while we were looking for our self-organization, our self-motivation, our self-representation, after the regime change, in the decade of 1970s, we met on the opposite side a “wall” by the political and social power. After the rise of the socialist government of Andreas Papandreou, this [ignorance was] destroyed. Suddenly, in 1982, persons with disabilities, who had a major role in the 1976 movement [the occupation of the House of the Blind], were placed in positions of responsibility, [such as] advisors to ministers, members of boards [relevant] for persons with disabilities [issues], [so] the organizations started to gain ground on the consultation.

(Y. Vardakastanis, interview, September 6, 2016 my emphases)

In a similar vein, the former chairman of the Greek Paraplegics Association, Athanasios Viglas, in his interview with Vasilis Galis, notes that the PASOK government gave room to persons with disabilities for negotiating and claiming their rights, both for their quality of life and for their inclusion in society (ibid., p. 76). To put it differently, PASOK’s political program was an ally of the demands of persons with disabilities and their associations.

Also, the shift on the political stage was also translated into the enactment of several social measures and benefits, in cash and/or in-kind, for persons with disabilities by the Greek state. Some of these social measures and benefits are listed below:

- The right to work in the public sector (Law 1320/1983)
- The right to study in higher education

83 Galis (2006), in his PhD dissertation regarding the development of Metro in Athens during the 1990s, examines thoroughly the development of disability movement in Greece. Particularly, he pays attention to their role during the designing process of it.
• Provision of social housing
• Tax-free car import for persons with disabilities
• Disabled parking permit
• Free mobility with public transportation.

(A Citizen with Disabilities’ Guide, 2007)

Also, in 1986, the Law 1648/1986 was enacted for offering special care to persons with disabilities aged 15 to 65 who were not able to work, with the Department of Welfare Services at the Ministry of Health, Welfare and Social Security to be responsible for those services.

The formation of the National Confederation of Persons with Disabilities (ESAEA) in Greece

According to Vardakastanis, the point of departure for the formation of the “umbrella organization” of persons with disabilities in Greece, that is, the National Confederation of Persons with Disabilities (ESAEA) goes back to the events that happened in the House of the Blind (Y. Vardakastanis, interview, September 6, 2016). As he states:

The establishment of the ESAEA in Greece was not an automatic procedure. One would say that the “spring” for persons with disabilities in Greece started after the regime change [in 1974]. The big boost towards the empowerment of persons with disabilities [in Greece] was the uprising of the blind on May 2, 1976, in Kallithea. …[That] gave a big boost to persons with disabilities to look for their self-organization. What must be explicit here is that what we have is a clear self-organization. A clear self-motivation. A clear emancipation and self-representation. In other words, there has never been an organized effort by the state, in any degree or form, for the organization of persons with disabilities.

(ibid., my emphases)

However, the change in the political landscape in the 1980s motivated persons with disabilities to further politicize and claim their own rights. According to Barnartt et al. (2001, p. 436), it was around the 1980s when there was an international general wave by disability organizations to form “umbrella organizations” to “coordinate political activity and speak with one voice on behalf of the disability community.” The British Council of Organizations of Disabled People (BCODP) in the United Kingdom,
the American Coalitions of Citizens with Disabilities in the United States, and the Coalition of Provincial Organizations of the Handicapped (COPOH) in Canada constitute some examples of these “umbrella organizations” (ibid.).

Following the international paradigm, the members of the disability organizations in Greece realized that, in order to be heard in the sociopolitical context, it was essential to come together and unite their voices for claiming their rights. Representatives of a number of disability organizations started initial discussions for the establishment of an “umbrella organization” to coordinate disability organizations and to represent the Greek disability movement in the political context of the country. To Vardakastanis, the International Year of Disabled Persons by the United Nations in 1981 and, as already stated, the change of the political landscape of the country since the socialist party of PASOK replaced the conservative party of ND in power, were the two events that played an essential role in the formation of the ESAEA. Regarding the International Year of Disabled Persons, Vardakastanis states that “it had a decisive role [for the establishment of the ESAEA] because, objectively, it created a mobility in Greece; together with the socio-political developments of the time...they started to create a greater maturation, let’s say, of the “spring” (Y. Vardakastanis, interview, September 6, 2016).

In the same vein, Anastasios Lagopoulos, a former chairman of the National Federation of Associations of Parents and Guardians of Persons with Disabilities (POSGAMEA), in his interview in the documentary Nothing About Us Without Us,84 in the episode regarding the history of the ESAEA, talks about the formation of the ESAEA by stressing the difficulties that the existing disability organizations faced when they acted individually until the 1980s. Specifically, he says:

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84 Nothing About Us Without Us is a documentary produced by the ERT Neumedia that presents the history of the disability movement in Greece. Each episode describes the establishment of a specific disability organization together with relevant events and rights that persons with disabilities have won in Greek society. In episodes 25 and 26, the tv-program presents the formation of the National Confederation of Persons with Disabilities in Greece. Both episodes are available at the digital archive of Hellenic Broadcasting Corporation (ERT) and they can be retrieved in the following links: episode 25: http://archive.ert.gr/78688/, and episode 26: http://archive.ert.gr/78665/.
In 1988, all the secondary associations of persons with disabilities had a meeting where they decided that it was necessary to establish a tertiary association to help with the coordination of the actions of all disability organizations. ... In the past we did not have it...Everyone [disability organizations] was claiming whatever they wanted, but [acting] individually, they could not accomplish their purposes.


In the same documentary, Manolis Karaiskos, a founding member of the ESAEA, refers to the reasons the establishment of the ESAEA was necessary. Karaiskos claims that it was a period when persons with disabilities depended on charity organizations, a situation that had adverse consequences for a person with disabilities (ibid.). Specifically, he says:

*It was very annoying for us...because no one cared about us. So, we started eight [disability] associations, from all the disability categories, meeting each other, repeated meetings, to organize the area [of disability], because, without organization, we were not able to do anything.*

*(ibid., 5:34–5:54)*

Nonetheless, the whole process was not easy because there was a lack of communication between the different disability organizations that participated in the scheme for the formation of the ESAEA. Yiannis Triantafyllou, a founding member of the ESAEA, refers to the early difficulties that the representatives of disability organization faced because of the multiplicity of what disability is as well as the inability of the different disability categories to understand the multiple problems that each disability category faces (ibid.). Despite the difficulties, disability organizations decided to set aside their differences and proceed with the foundation of the ESAEA in 1989 for representing the disability movement in the discussions with governmental authorities.

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Thomas Kleisiotis, who was a former vice-chairman of the ESAEA, describes the moments during the preparation of the founding act of the ESAEA by referring to an event that happened concerning the choice of the ESAEA’s logo. According to him, during the writing of the founding act at the offices of the Paraplegics’ Association of Greece, four people were there who joined hands at one point to express their enthusiasm (ibid.). This gesture inspired them to choose four united hands as the logo of the ESAEA for expressing the united role of the ESAEA (ibid.).

Summarizing, the ESAEA was founded in 1989 after the collaboration between disability organizations of persons with disabilities and their families. The aim of the Confederation is to represent persons with disabilities in the political and social discussions in the country (Disability Issues, 2005, p. 11). Also, ESAEA is responsible for defending the rights of persons with disabilities, eliminating the discrimination and marginalization towards persons with disabilities, and demanding the equal treatment of persons with disabilities in society (ibid.). Last, the national conference, which takes place every three years, is the most important component in the operation of the Confederation, since through its proceedings the representatives of the federations and associations decide about the issues of concern for the following period (ibid.).

86 The federations and associations of persons with disabilities that participate in the ESAEA are: i) the Panhellenic Association of the Blind, representing the blind or persons with visual impairments, ii) the National Federation of Physically Disabled, representing people with paraplegia and other physical impairments, iii) the Hellenic Federation of the Deaf, representing deaf and people with hearing impairments, iv) the Panhellenic Federation of Societies of Parents and Guardians of Disabled People, representing the parents and guardians of children with disabilities, v) the Greek Federation of Thalassaemia, representing persons with thalassaemia, sickle-cell and micro sickle-cell anaemia, vi) the Panhellenic Federation of People with Kidney Conditions, representing the persons with kidney conditions, vii) the Panhellenic Federation of Associations - Organizations of People with Diabetes Mellitus, representing persons with diabetes, viii) the Association for the Protection of Greek Haemophiliac’s, representing persons with haemophilia, ix) the Panhellenic Federation of Families for Mental Health, representing the families of persons with mental disorders, and x) The Panhellenic Hansen’s Contact, representing person Hansen illness (Disability Issues, 2005, p. 11).
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Institute of Social Protection and Solidarity

Ministry of Health (and Welfare)


Ministry of Labor and Social Security


Ministry of the Interior, Public Administration and Decentralization

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**Ta Nea**

Οι τυφλοί επιμένουν: Θα συνεχίσουμε τον αγώνα μας [The blind insist: We will continue our struggle]. (1976, May 12). *Ta Nea*, p.5.


Ζητούν πρότασεις... μετά τα μέτρα! 110 δις χάνουν ασφαλισμένοι-
συνταξιούχοι [Proposals asked for... after the measures! 110 billion lost


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[More than 3000 healthy... disabled]. Ta Nea, p. 41.

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Έκθετος ο Κουβέλας: Προχώρησε ερήμην της κυβέρνησης αναιρώντας και
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Nea, p. 8.

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Κομπίνα 1 δις με ανάπηρους-μαϊμού [Jobbery of 1 billion with fake disa-

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«μαϊμού» [Crosscheck for ‘fraud’ disability pensions]. Ta Nea, p. 11.

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αυστηρό έλεγχο [Disability card in ’99, after austere control]. Ta Nea,
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To Vima


Δύσκολη περίοδος: Και τώρα σε αυστηρή επιτήρηση από τις Βρυξέλλες [Hard times: And now under strict surveillance from Brussels]. To Vima, (on-line version).


Στο 12,5% του ΑΕΠ θα ανέλθει το έλλειμμα το 2009, υποστηρίζει ο κ. Γ. Παπακωνσταντίνου [Deficit will reach 12,5% of GDP in 2009, says Mr.G. Papakonstantinou]. (2009, October 20). To Vima, (on-line version).

Βαλειρία ισορροπίας. Οι προεκλογικές δεσμέυσεις της κυβέρνησης και οι απαιτήσεις της ΕΕ [“Balancing operation”. Government pre-election commitments and EU requirements]. To Vima, (on-line version).

Αφόρητες πιέσεις από την ΕΕ για την λήψη μέτρων. Σε κλίμα γενικότερης απαξίωσης της Ελληνικής οικονομίας η υποδοχή του Υπουργού Οικονομικών στο ECO/FIN [Unbearable pressure from the EU to take measures: Reception of the Minister of Finance at ECO / FIN to take place in a climate of depreciation for the Greek economy]. To Vima, (on-line version).

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ERT AE (Producer), & Chatzimparmpas, C. (Director). (2009). Τίποτα για εμάς χωρίς εμάς: επεισόδιο 25, ΕΣΑμεΑ, μέρος 1ο [Nothing for us with-
Creative disability classification systems

VI. Webpages/Blogs/Weblogs


greece-recognizes-pedophilia-as-%E2%80%9Cdisability%E2%80%9D.

Appendix I. Timeline with the most important events from 1990 to 2015

87 For the designing of the timeline as appears in pages 339, 340, 341, and 342, I used the Keynote™ software.
Creative disability classification systems

KEPA (2009-2015)

1st Component:
September 2011:
Establishment of the Centers for Certifying Disability (KEPA)

2nd Component:
November 2011:
Enactment of the Single Table for the Disability Percentage Determination (EPPPA)

Enactment of the table with 43 Permanent and Irreversible Disorders

Enactment of the Law 4331/2015:
Updates to the legislation for improving the implementation of the KEPA

2011

Persons with disabilities
reverted to KEPA and EPPPA

2012

personality disorders
and adult behaviour
debate

June 2012
ND won the parliamentary elections

2013

2nd Component:
May 2015: Revision of the Single Table for the Disability Percentage Determination

2014

2015

PASOK
Coalition Government
ND (with PASOK &)
Syriza
Appendix II. List of interviewed informants

1. Representatives of ministries and public administration organizations

- **Ministry of Health**
  
  *Panagiotis Kouroumblis* – Lawyer, Politician. Minister of Interior. Former Minister of Health (January 2015 – September 2015). Former chairman of the Greek National Confederation of Persons with Disabilities. Interviewed June 10, 2015 (when I conducted the interview Kouroumblis was Minister of Health).


- **Ministry of Labour and Social Solidarity**
  

- **Ministry of Culture, Education, and Religious Affairs**
  

- **Social Security Insurance (IKA)**
  

- **Institute of Social Protection and Solidarity, IKPA** *(Since 2010 IKPA was merged with the National Centre for Social Security-EKKA)*

- University of Ioannina

- Directorate of Welfare at Kalamata municipality

2. Representatives of disability organizations

- Greek National Confederation of Disabled People

- National Federation of the blind
Paraskevi (Vivi) Tsavalia – General Secretary of the National Federation of the Blind. Interviewed May 22, 2015.

- Piraeus Association of Physically Challenged
Vasilis Dimitriadis – PhD in quality assurance systems in health and welfare services, from the medical school of the University of Crete. Chairman of the Piraeus Association of Physically Challenged. Retired employee of the Hellenic Railways Organization. Interviewed January 21, 2014.
3. Representatives of medical organizations

- Special Physicians’ Body of Health Committees of IKA


- Panhellenic Medical Association

- Hellenic Medical Society of Disability, Social Insurance and Welfare
Appendix III. Committee for compiling the regulation for disability assessment degree

Chairman
Georgios Hrisanthopoulos  Special General Secretary of Ministry of Health, Welfare and Social Security

Members
Ioannis Kavaratzis  Deputy governor of IKA - Pathologist
Michalis Kossivas  General director of Health Services of IKA – Orthopedic
Charilaos Kipraios  Director at the Directorate of Disability and Social Work of IKA - Cardiologist
Ioannis Papadopoulos  Assistant Professor, University of Athens. Orthopedic at IKA
Athanasios Karakatsanis  Neurologist at IKA
Georgios Karantanas  Pathologist at IKA
Evaggelos Zimalis  Director at the diagnostic center “Aghia Marina”. Occupational physician at IKA
Constantinos Iliopoulos  Representative of PanHellenic Medical Association. Orthopedic
Charalampos Tsakas  Representative of National Federation of Scientific Health Staff of IKA. Pathologist
Faidon Trifonidis  Pathologist – Gastroenterologist at IKA

Secretary
Constantinos Kotsilinis  Director at the General Secretary of Social Security

[Source: Social Insurance Institute, 1995, p. 3]
Appendix IV. A sample of the disability allowances that the welfare services and the social security funds of IKA, OGA, and OAEE awarded to disability claimants

The welfare services award welfare benefits to the following disability categories:

- Blind
- Deaf
- Severe mental deficiency
- Thalassemia
- AIDS – Hemophilia
- Severe disability (more than 67% of disability). In this category, several kinds of disorders that cause disability are included, e.g. epilepsy, diabetes mellitus, Lupus erythematosus, and so on
- Cerebral palsy
- Persons suffering from Hansen’s Disease
- Paraplegia – Quadriplegia – Amputation
- Transport Allowance
- Persons with kidney failure under dialysis
- Patients who have undergone heart, liver, kidneys, lungs, and bone marrow transplant


Below are the categories of the welfare benefits which are given by the municipalities of the country. In parenthesis, it is the amount of the disability benefit which is awarded every two months,

- Financial assistance for people having received transplants (kidneys, heart, etc.) for better food quality (€362)\(^88\)
- Support disability benefit for deafness (€362),

\(^88\) The amount of the financial assistance for people having received transplants (kidneys, heart, etc.) for better food quality, retrieved July 20, 2017 from: https://psnrenal.gr.
• Support disability benefit for Paraplegia – Quadriplegia – Amputation (Insured and non-insured persons, €771)
• Support disability benefit for Hansen’s disease (€362 or €697 (varying according to subcategory)
• Support disability benefit for severe mental deficiency (€527)
• Support disability benefit for blindness (€362 or €697 - varying according to subcategory)
• Support disability benefit for transport allowance (€165)
• Support disability benefit for thalassemia (€362)
• Support disability benefit for AIDS - Haemophilia (€697)
• Support disability benefit for Cerebral Palsy (€697)
• Support disability benefit for severely disability (€313)


The social security funds also award disability benefits to their insured.

For example, the IKA provides their insured with the following disability benefits:

• Non-institutional care benefit
• Pensioners’ Social Solidarity Benefit (EKAS)
• Total invalidity benefit


While the OGA and the OAEE provides their insured with the following disability benefit.

• Disability benefit for Paraplegia – Quadriplegia

Appendix V. An illustration on how ‘disability card’ should be

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The front view of temporary *Disability Card*.

My illustration based on the Article 12, from the Ministerial Decision Issue No P3a/F80/OIK.907 *(Government Gazette, 2001)*
«Η Κάρτα Αναπηρίας (Κ.Α.) που εκδίδεται σύμφωνα με τις διατάξεις του Π.Δ. 210/98 (ΦΕΚ 169, τ. Α’), χρησιμεύει ως αποδεικτικό της αναπηρίας (Ν. 2430/96, ΦΕΚ 156, τ. Α’, άρθρο 4, παρ. 2). Επικυρωμένο αντίγραφο της Κάρτας Αναπηρίας κατατίθεται στην αρχή ή Υπηρεσία της Ελληνικής Επικράτειας, προκειμένου να χορηγηθούν παροχές ή να παρασχεθούν διευκολύνσεις για τα άτομα με Ειδικές Ανάγκες (Α.μ.Ε.Α.) όπου και αν αυτό προβλέπεται από την εκάστοτε ειδική νομοθεσία.»

The back view of temporary Disability Card.

My illustration based on the Article 12, from the Ministerial Decision Issue No P3a/F80/OIK.907 ((Government Gazette, 2001)
Appendix VI – Special Committee for deciding the permanent and irreversible disorders

Chairman

• Panagiotis Kokkoris - General Secretary of the General Secretariat of Social Security

Members

• Rovertos Spyropoulos - Governor of IKA-ETAM

• Christodoulos Stefanadis - Professor of Cardiology of the Medical School of the National and Kapodistrian University of Athens (EKPA).

• Eleftherios Stamboulis - Professor of Neurology of the Medical School of the National and Kapodistrian University of Athens (EKPA).

• Thalia Spyropoulou – Physician, member of the Special Physicians’ Body of Health Committees of IKA,

• K. Vlachos – Physician, member of the Special Physicians’ Body of Health Committees of IKA,

• I. Zacharos - Physician member of the Special Physicians’ Body of Health Committees of IKA,

• Giorgos Kourouklis – Occupational Physician,

• Christos Nastas - General Secretary of the National Confederation of Persons with Disabilities (ESAEA).

(To Vima, February 12, 2013)
Appendix VII – The staffing of the new special committee for updating the Single Table for the Disability Percentage Determination

According to Article 4 from the 4331/2015, the special scientific committee for updating the KEPA should be consist of,

**Chairman**

- The General Secretary of the General Secretariat of Social Security

**Members**

- The General Director of Social Security, with his/her alternate the Head of the Department of Primary Insurance for Employees and Sicknesses of the Ministry of Labor, Social Security, and Social Solidarity
- Head of Directorate of the Disability and Occupational Medicine of IKA-ETAM, with his/her alternate
- One professor of cardiology from a Greek medical school, with his/her alternate
- One professor of neurology from a Greek medical school, with his/her alternate
- One professor of otorhinolaryngology from a Greek medical school, with his/her alternate
- One professor of ophthalmology from a Greek medical school, with his/her alternate
- One pathologist from the Special Physicians’ Body of Health Committees, with a pneumologist from the Special Physicians’ Body of Health Committees, as an alternate
- One orthopedic from the Special Physicians’ Body of Health Committees, with a rheumatologist from the Special Physicians’ Body of Health Committees, as an alternate
- One surgeon from the Special Physicians’ Body of Health Committees, with an urologist from the Special Physicians’ Body of Health Committees, as an alternate
• One occupational physician, with his/her alternate,

• One child-psychiatrist, who works in disability structures with his/her alternate,

• One representative from the National Confederation of Persons with disabilities (ESAEA), with his/her alternate,

• One physician, member of the Hellenic Medical Society of Disability, Social Insurance, and Welfare (ELIEAKAP), specialized in psychiatry, with his/her alternate,

• One physician, member of the Greek Pediatric Society, specialized in child neurology, with his/her alternate specialized in pediatric

(Government Gazette, 2015, p. 665, my translation)
Appendix VIII. IKA letter with the number of disability claimants

Αθήνα, 18/11/2015

ΑΡ. ΠΡΩΤ. ΒΑΘΜ. ΠΡΩΤ.
Γ05/ 161
Σχέτ.: 1467/19-5-15

ΠΡΟΣ
Την και Αντωνία Πανλή
Antonia.Pavl@oru.se

ΠΛΗΡΟΦΟΡΙΕΣ: Διοίκηση Ε.
Ταχ. Δ/νση: Αγίου Κωνσταντίνου 8
Τ.Κ.: 10241 ΑΘΗΝΑ
Τηλέφωνο: 210 5215388
FAX: 210 5229066
e-mail: diefanap@ika.gr

ΤΗΜΑ: «Απάντηση σε ηλεκτρονική επιστολή σας»
Σχέτ.: Η με αρ.πρωτ.2995/22-9-2015 επιστολή σας

Σε απάντηση της ανωτέρω σχετικής επιστολής, σας γνωστοποιούμε τα εξής:

Σας ενημερώνουμε ότι ούτε μας με τα στοιχεία που ανήλθηκαν από το ΟΠΣ ΙΚΑ ΕΤΑΜ από 1/9/2011 (ημ.εναρξης λειτουργίας του θεσμού των ΚΕΠΑ) εκδόθηκαν 552,930 Αποτελέσματα Γνωστοποίησης Αναπηρίας.

Η ΠΡΟΕΙΣΤΑΜΕΝΗ ΤΗΣ ΔΙΑΣΗΣ ΑΝΑΠΗΡΙΑΣ & Ι.Ε

ΕΛΕΝΗ Μ. ΝΙΑΡΧΙΩΤΗ

ΑΚΡΙΒΕΣ ΑΝΤΙΓΡΑΦΟ
Η προεισταμένη του Τμήματος
ΙΑΤΡΙΚΗΣ ΤΗΣ ΕΡΓΑΣΙΑΣ
Ε ΔΑΒΑΚΗ

ANTONIA PAVLİ  Creative disability classification systems  357
Topic: “Answer to your email request”
About: Regarding your request with Registration Number 22-9-2015

As a response to your above mail request, we hereby disclose the following:

We inform you that according to the data collected from the IIS [Integrated Information System] of IKA-ETAM, (starting date of the operation of the KEPA) 552,930 disability disclosure results have been issued since 1/9/2011.

The Head at the Directorate of Disability and Occupational Medicine

Eleni S. Niarhakou

[my translation]
Studies from the Swedish Institute for Disability Research

1. **Varieties of reading disability**  
   Stefan Gustafson  

2. **Cognitive functions in drivers with brain injury – anticipation and adaptation**  
   Anna Lundqvist  

3. **Cognitive deafness**  
   Ulf Andersson  

4. **Att lära sig leva med förvärvad hörselnedsättning sett ur par-perspektiv**  
   Carin Fredriksson  
   ISBN 91-7373-105-6, 2001

5. **Signs, Symptoms, and Disability Related to the Musculo-Skeletal System**  
   Gunnar Lundberg  

6. **Participation – Ideology and Everyday Life**  
   Anette Kjellberg  

7. **Föräldrar med funktionshinder – om barn, föräldraskap och familjeliv**  
   Marie Gustavsson Holmström  
   ISBN 91-7203-500-5, 2002

8. **Active wheelchair use in daily life**  
   Kersti Samuelsson  

9. **Två kön eller inget alls. Politiska intentioner och vardagslivets realiteter i den arbetslivsinriktade rehabiliteringen**  
   Marie Jansson  
10. **Audiological and cognitive long-term sequelae from closed head injury**
    Per-Olof Bergemalm
    ISBN 91-7668-384-2, 2004

11. **Att vara i särklass – om delaktighet och utanförskap i gymnasiesärskolan**
    Martin Molin
    ISBN 91-85295-46-9, 2004

12. **Rättvis idrottsundervisning för elever med rörelshinder – dilemma kring omfördelning och erkännande**
    Kajsa Jerlinder
    Licentiate Degree, 2005

    Per-Inge Carlsson
    ISBN 91-7668-426-1, 2005

14. **Hearing and cognition in speech comprehension. Methods and applications**
    Mathias Hällgren
    ISBN 91-85297-93-3, 2005

15. **Living with deteriorating and hereditary disease: experiences over ten years of persons with muscular dystrophy and their next of kin**
    Katrin Boström
    ISBN 91-7668-427-x, 2005

16. **Disease and disability in early rheumatoid arthritis**
    Ingrid Thyberg
    ISBN 91-85299-16-2, 2005

17. "**Varför får jag icke följa med dit fram?**" Medborgarskapet och den offentliga debatten om dövästamma och blinda 1860-1914
    Staffan Bengtsson
    ISBN 91-85457-06-X, 2005

18. **Modalities of Mind. Modality-specific and nonmodality-specific aspects of working memory for sign and speech**
    Mary Rudner
    ISBN 91-85457-10-8, 2005
19. **Facing the Illusion Piece by Piece. Face recognition for persons with learning disability**  
Henrik Danielsson  
ISBN 91-85497-09-6, 2006

20. **Vuxna med förvärvad traumatisk hjärnskada – omställningsprocesser och konsekvenser i vardagslivet. En studie av femton personers upplevelser och erfarenheter av att leva med förvärvad traumatisk hjärnskada**  
Thomas Strandberg  

21. **Nycklar till kommunikation. Kommunikation mellan vuxna personer med grav förvärvad hjärnskada och personernas närstående, anhöriga och personal**  
Pia Käcker  

22. **"Aspergern, det är jag". En intervjustudie om att leva med Asperger syndrom**  
Gunvor Larsson Abbad  

23. **Sounds of silence – Phonological awareness and written language in children with and without speech**  
Janna Ferreira  

24. **Postponed Plans: Prospective Memory and Intellectual Disability**  
Anna Levén  

25. **Consequences of brain tumours from the perspective of the patients and of their next of kin**  
Tanja Edvardsson  

26. **Impact on participation and service for persons with deafblindness**  
Kerstin Möller  

27. **Approaches to Audiological Rehabilitation with Hearing Aids: studies on prefitting strategies and assessment of outcomes**  
Marie Öberg  
28. Social Interaction and Participation in Activities of Everyday Life Among Persons with Schizophrenia
   Maria Yilmaz
   Licentiate Degree, 2009

29. Focus on Chronic Disease through Different Lenses of Expertise Towards Implementation of Patient-Focused Decision Support Preventing Disability: The example of Early Rheumatoid Arthritis
   Örjan Dahlström

30. Children with Cochlear Implants: Cognition and Reading Ability
   Malin Wass

31. Restricted participation: Unaccompanied children in interpreter-mediated asylum hearings in Sweden
   Olga Keselman

32. Deaf people and labour market in Sweden. Education – Employment – Economy
   Emelie Rydberg

33. Social rättvisa i inkluderande idrottsundervisning för elever med rörelsehinder – en utopi?
   Kajsa Jerlinder
   ISBN: 978-91-7668-726-0, 2010

34. Erfarenheter av rehabiliteringsprocessen mot ett arbetsliv – brukarens och de professionellas perspektiv
   Helene Hillborg

35. Knowing me, knowing you – Mentalization abilities of children who use augmentative and alternative communication
   Annette Sundqvist
36. Lärare, socialsekreterare och barn som far illa – om sociala representationer och interprofessionell samverkan
Per Germundsson

37. Fats in Mind
Effects of Omega-3 Fatty Acids on Cognition and Behaviour in Childhood
Ulrika Birberg Thornberg

38. "Jobbet är kommunikation"
Om användning av arbetshjälpmedel för personer med hörselnedsättning
Sif Bjarnason

39. Applying the ICF-CY to identify everyday life situations of children and youth with disabilities
Margareta Adolfsson

40. Tinnitus – an acceptance-based approach
Vendela Zetterqvist

41. Applicability of the ICF-CY to describe functioning and environment of children with disabilities
Nina Klang

42. Bringing more to participation
Participation in school activities of persons with Disability within the framework of the International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY)
Gregor Maxwell

43. From Eye to Us.
Prerequisites for and levels of participation in mainstream school of persons with Autism Spectrum Conditions
Marita Falkmer
44. **Otosclerosis, clinical long-term perspectives**  
Ylva Dahlin-Redfors  

45. **Tinnitus in Context - A Contemporary Contextual Behavioral Approach**  
Hugo Hesser  

46. **Hearing and middle ear status in children and young adults with cleft palate**  
Traci Flynn  

47. **Utrymme för deltagande, beslutsprocesser i möten mellan patienter med ospecifica ländryggssbesvär och sjukgymnaster i primär vård**  
Iréne Josephson  

48. **”Man vill ju klara sig själv” Studievardagen för studenter med Asperger syndrom i högre studier**  
Ann Simmeborn Fleischer  

49. **Cognitive erosion and its implications in Alzheimer’s disease**  
Selina Mårdh  

50. **Hörselscreening av en population med utvecklingsstörning**  
Utvädering av psykoakustisk testmetod och av OAE-registrering som komplementär metod  
Eva Andersson  

51. **Skolformens komplexitet – elevers erfarenheter av skolvårdag och tillhörighet i gymnasiesärskolan**  
Thérèse Mineur  

52. **Evaluating the process of change:**  
Studies on patient journey, hearing disability acceptance and stages-of-change  
Vinaya Kumar Channapatna Manchaiah  
53. Cognition in hearing aid users: Memory for everyday speech
Hoi Ning (Elaine) Ng

54. Representing sounds and spellings Phonological decline and compensatory working memory in acquired hearing impairment
Elisabet Classon

55. Assessment of participation in people with a mild intellectual disability
Patrik Arvidsson

56. Barnperspektiv i barnavårdsutredningar – med barns hälsa och barns upplevelser i fokus
Elin Hultman

57. Internet Interventions for Hearing Loss
Examining rehabilitation Self-report measures and Internet use in hearing-aid users
Elisabet Sundewall Thorén

58. Exploring Cognitive Spare Capacity: Executive Processing of Degraded Speech
Sushmit Mishra

59. Supported employment i en svensk kontext – förutsättningar när personer med funktionsnedsättning når, får och behåller ett arbete
Johanna Gustafsson

60. Effects of Specific Cochlear Pathologies on the Auditory Functions: Modelling, Simulations and Clinical Implications
Amin Saremi
61. Children with profound intellectual and multiple disabilities and their participation in family activities
   Anna Karin Axelsson

62. Lexical and Semantic Development in Children With Cochlear Implants
   Ulrika Löfkvist

63. Rethinking sound. Computer-assisted reading intervention with a phonics approach for deaf and hard of hearing children using cochlear implants or hearing aids
   Cecilia Nakeva von Mentzer

64. Assessing cognitive spare capacity as a measure of listening effort using the Auditory Inference Span Test
   Niklas Rönnberg

65. Employees with Aided Hearing Impairment: An Interdisciplinary Perspective
   Håkan Hua

66. Prosthetic and Orthotic Services in Developing Countries
   Lina Magnusson

67. Dealing with digits - Arithmetic, memory and phonology in deaf signers
   Josefine Andin

68. Time is of the essence in speech recognition: Get it fast or think about it
   Shahram Moradi

69. Effects of hearing loss on traffic safety and mobility
   Birgitta Thorslund
70. **Aspekter på lärande vid dövblindhet - möjligheter och begränsningar för personer med Alström syndrom**  
Berit Rönnåsen  

71. **Memory and communication in typically developing infants and children with Autism Spectrum Disorder: Behavioral and electrophysiological indices**  
Emelie Nordqvist  

72. **Cognitive capacities and composite cognitive skills in individuals with Usher syndrome type 1 and 2**  
Cecilia Henricson  

73. **Functioning and Disability in Adults with Hearing Loss Preparatory studies in the ICF Core Sets for Hearing Loss project**  
Sarah Granberg  

74. **Speech recognition and memory processes in native and non-native language perception**  
Lisa Kilman  

75. **To include or not to include: Teachers’ social representations of inclusion of students with Asperger diagnosis**  
Ann-Charlotte Linton  

76. **Health and People with Usher syndrome**  
Moa Wahlqvist  

77. **Children with mild intellectual disability and their families – needs for support, service utilisation and experiences of support**  
Lena Olsson  
78. **Deafblindness**  
Theory-of-mind, cognitive functioning and social network in Alström syndrome  
Hans-Erik Frölander  

79. **Signs for Developing Reading**  
Sign Language and Reading Development in Deaf and Hard-of-Hearing Children  
Emil Holmer  

80. **Speech masking speech in everyday communication**  
The role of inhibitory control and working memory capacity  
Victoria Stenbéck  

81. **Neural and Cognitive Effects of Hearing Loss on Speech Processing**  
Eline Borch Petersen  

82. **A biopsychosocial approach to functioning, oral health and specialist dental health care in children with disabilities – Swedish and international perspectives**  
Johanna Norderyd  

83. **Samverkansprojekt, och sen då? – en uppföljande studie av samverkansprocessen kring barn och unga som far illa eller riskerar att fara illa**  
Ulrika Englund  

84. **Aural rehabilitation programs for hearing aid users**  
Evaluating and clinically applying educational programs, supported via telephone and/or the internet and professionally guided by an audiologist  
Milijana Malmberg  

85. **Tolkning vid förmedlade samtal via Bildtelefoni.net – interaktion och gemensamt meningsskapande**  
Camilla Warnicke  
86. **Vardagsslivets aktiviteter. Handlingen som terapeutiskt redskap för personer med svårare psykiska funktionshinder – Analys av arbetsterapeuters berättelser med utgångspunkt i G H Meads teori om social handling**
   Marianne Boström

87. **Creative disability classification systems: The case of Greece, 1990-2015**
   Antonia Pavli