# the manifesto of social clinics

***inosc – international network of social clinics 2024***


*www.inosc.net*

# contents



# what is a social clinic?

Social Clinics are autonomous community-based healthcare collectives that provide primary healthcare services. We believe that healthcare inequities are intertwined with other forms of social and economic marginalisation and exclusion. As such, they need to be confronted politically. Social Clinics operate autonomously and are self-managed. Our goal is to challenge conventional organisational structures through innovative practices encompassing everyday interactions, processes, and medical procedures. We firmly believe in people's capacity to organise, self-govern, and collectively make fair and egalitarian decisions concerning their work, health, and lives. Social Clinics serve as a radical political model, offering a vision of a more equitable, just, consistent, and anti-authoritarian societal structure that can extend beyond healthcare. If it can be successfully implemented in healthcare, it can be applied anywhere.

The name "Social Clinics" was chosen collectively to encompass a diverse array of experiences striving for a different concept of health and healthcare, including Solidarisches Gesundheitszentrum, Ambulatori Popolari, Centres de Santé Communautaire Autogérés, Κοινωνικό Ιατρείο Αλληλεγγύης.

# basic principles

Social Clinics are **anti-capitalist, anti-fascist, anti-racist and transfeminist.** We are committed to fighting all forms of discrimination based on factors such as geographic origin, sex, gender, social class, sexual orientation, and religious beliefs. We recognize the necessity of uniting these various struggles and hold an intersectional perspective on them.

# what we do

While offering primary healthcare services, our impact extends beyond healthcare provision; it also involves being 'allies' and active participants in social struggles that contrast the processes of marginalisation of communities and groups, thus contributing to making their struggles visible.

# why we exist

Healthcare systems have been systematically dismantled due to cuts in public spending, leading to widespread discrimination and exclusion from essential services. Social Clinics actively fight to overcome barriers such as bureaucratic, economic, and language challenges that people face when accessing healthcare. This form of political action can sometimes take the form of conflict and protest, aiming to guarantee universal access to healthcare and uphold the right to health for all.

We felt the need to create spaces where hierarchies and power dynamics in healthcare and medical practices can be questioned and challenged. We advocate for a radical and collective vision of healthcare, where everyone who enters our clinic is treated equally, regardless of their status or background. Our assemblies and collective structures show our commitment to dismantling all forms of hierarchy and fostering open discussion and critique. In our daily roles and routines, we often lack the time and space to collectively reflect on our health and how we care for ourselves and others. Social clinics provide precisely that time and space. This Manifesto is the product our collective discussions and reflections, our dreams and aspirations.

# what sets us apart

Social clinics are not private clinics, charities, or social enterprises. We are militant collectives with a radical vision of healthcare. Our intention is not merely to fill the gaps left by the dismantling of public healthcare. Through our action, we are committed to advocating for equitable and universally accessible public health systems that guarantee everyone's right to health.
We aspire to develop new healthcare models where community bonds are indispensable, and personal and collective well-being are acknowledged as intrinsically interconnected. We believe that only a robust and cooperative community based on solidarity, encompassing the environment, our living and working conditions, nutrition, and networks of human and non-human relationships, can enable us to live healthy lives and be capable of caring for one another.

# why a network

This Manifesto represents the inaugural outcome of the International Network of Social Clinics (INOSC). Our network wants to connect collectives operating in different contexts but united by a common vision of how to rethink and change healthcare and our communities. We aim to expand our struggles and share our knowledge, experiences, and practices. Our Manifesto is as an open invitation for other collectives and activists to join us in our fight to rethink and reimagine healthcare collectively.

# section 1
# neoliberal policies and relations with public health system

Over the past few decades, neoliberalism has affected global health by acting as a structural determinant of health. It influences health policies both directly and indirectly, at both national and international levels, impacting all the other determinants of health. Neoliberalism's disinvestment in public welfare and the collapse of universal healthcare systems are interdependent processes. This makes it difficult to distinguish the causal relationship between these processes and rising chronic diseases, which are largely driven by declining quality of life for the majority of the population.
At the core of both processes is an ideological belief that markets are more efficient at allocating resources in an individualistic society driven by economic and material interests. In this context, any form of welfare is rejected as an interference with the market and is therefore deemed incompatible. Health reforms over the last three decades have been driven by this neoliberal agenda. Governments have implemented neoliberal principles to all aspects of social and individual life through:

- **privatising and commodifying the public sphere;**
- **deregulating the private sector, with health insurance playing an increasing role;**
- **reducing taxes on capital;**
- **cutting public spending;**
- **restricting union power, leading to lower wages;**
- **applying managerial approaches to healthcare programs and policies.**

This shift has turned health systems into markets and healthcare into a commodity. Today, the patient is treated as a consumer, the disease becomes a commodity, and "treatment" - provision of services – is merely the product being sold. Furthermore, both public and private healthcare workers have seen their working conditions deteriorate dramatically, with lower pay, longer hours, and increased pressure. These mechanisms have also led to the creation of countless 'medical deserts', areas where a severe shortage of healthcare personnel limits access to essential services.
Subjecting healthcare to market forces has had devastating effects on societies. Clinical medicine has deteriorated, and the therapeutic relationship has weakened. Treatment now focuses solely on symptoms, dictated by rigid protocols that prioritise specific procedures and medications, often to the patient's detriment. The very essence of medical science has also been affected by these changes. Medical practice has become increasingly fragmented, with more specializations and a focus on promoting costly therapies (as we will explore in Section 2). Furthermore, due to increased time pressure, doctors now depend more on diagnostic tests than on clinical evaluations.
Prevention is treated as an individual matter and a moral responsibility, such as through regular check-ups or maintaining a healthy lifestyle. Meanwhile, the structural, environmental, and social factors that affect both individual and collective health are overlooked. Poverty, unemployment, and precarious work—direct and indirect results of neoliberalism, capitalism, colonialism, patriarchy, and racism—have been shown to negatively impact public health. Ecological degradation, along with the contamination of food, the natural environment, water and air, has been linked to higher rates of cancer, diabetes, obesity, and other health disorders. Yet, the structural processes driving health inequality remain unaddressed by the dominant healthcare model. Instead, the dominant model perpetuates unhealthy structures rooted in neoliberal biopolitics.

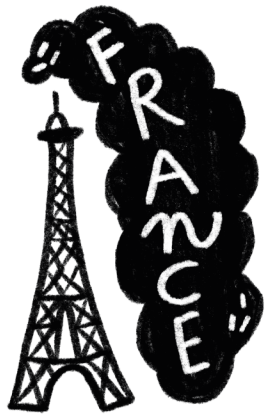
**The SARS-CoV-2 emergency** brought these issues into sharp focus. The environmental crisis in particular has returned to the forefront, with radical transnational ecological movements highlighting its implications from a **political ecology perspective**. This global event accelerated and exacerbated the issues we have described, making the failures of neoliberal policies even more apparent.

COVID-19 also demonstrated that in countries where health services were **privatised**, governments struggled to control the spread and severity of the disease. Similarly, where **public health systems** were dismantled, they failed to protect the population—particularly marginalised and vulnerable groups. Primary care, already severely reduced by neoliberal health reforms, turned out to be a key factor in the health system. Yet, **this recognition has not resulted in** a **reversal** in terms of policy or increased resource allocation in health systems. While there was a significant influx of resources during and after the initial phases of the pandemic, these funds were channelled through vertical support programs. Such programs provided only limited financial or material aid and did not lead to a structural reorganization of welfare services. This "new" phase of neoliberalism still aims to preserve existing power structures and promote further consumerism.

Although Social Clinics operate in different contexts, when analysing health and healthcare under neoliberalism, we see a series of commonalities. In all contexts, the legal right to healthcare does not always translate into actual access to services. Even in countries with universal healthcare coverage, there are often obstacles to health services. For instance, many face numerous barriers when seeking a voluntary termination of pregnancy or attempting to access healthcare services without a residency permit. Similarly, our different national healthcare systems are under constant threat of privatisation. Private sector involvement can be found within state healthcare systems, challenging the idea that state services necessarily equate to public services, particularly in the realm of healthcare. Finally, we noticed that there are specific medical issues which are not normally covered by state healthcare. This phenomenon can be observed in dental care, where systematic exclusion from free public services is evident. Indeed, dental care predominantly relies on private sector provision, leading to high costs and consequently rendering it inaccessible to a significant proportion of the population.


While Germany generally has universal healthcare insurance that also covers mental healthcare, this does not mean that people have equal access to healthcare. First of all, there are statutory and private insurances. People with higher incomes can afford private insurance, which often means faster and better treatment. Some people are excluded from health insurance if they do not have a residence permit. Other people may be able to obtain insurance but have to face other barriers, such as language and mobility, whilst trying to get treatment.

The biggest barrier, however, is the shortage of licenced practices. This is due to outdated regulations based on assessments that no longer reflect current needs. As a result, even insured individuals may struggle to find practitioners with the capacity to accept new patients. Also, waiting times to see specialists can be as long as six months. This issue is particularly severe for those seeking psychotherapy, which involves a complex application process that can be overwhelming for people with mental health conditions. Waiting lists for psychotherapy can be as long as 18 months.




In France, healthcare coverage depends on income. Some people have public universal healthcare insurance, while others only have 70% of the public healthcare insurance and are recommended to also have private insurance for the remaining 30%. Yet, even many of those eligible for universal insurance have no access to it due to excessive bureaucracy.
People without a residency permit can access public healthcare, but they must navigate a complicated process. Public insurance does not provide comprehensive dental and ophthalmology care. In addition, patients often have to pay for services upfront and then get reimbursed by the insurance.

Although fees are regulated, some practitioners charge extra and these additional costs are not reimbursed by the insurance.
As in Germany, one of the main barriers is the shortage of recognised practitioners, a problem caused by outdated regulations. Part of the French population does not have access to a GP, and specialist appointments are also hard to obtain. The ease of accessing a practitioner varies by region. In France there are no regulations concerning where doctors have to work, resulting in some areas becoming “medical deserts”.
Public hospitals face worsening conditions due to inadequate funding. Many healthcare professionals have left the public sector since the COVID-19 pandemic due to challenging working conditions. Other barriers include difficulties in booking appointments through digital platforms, language barriers, and mobility issues.


The Italian healthcare system, Servizio Sanitario Nazionale (SSN), is a universal and comprehensive service designed to provide medical care to all Italian citizens and residents. Established in 1978, it is funded primarily through taxation and falls under the governance of the Ministry of Health.
The SSN offers a wide array of healthcare services, encompassing hospital care, outpatient services, specialist consultations, and prescription medications. It is designed to ensure healthcare access for everyone, regardless of financial status, according to the principles of universal health coverage.

However, the Italian healthcare system faces several challenges. Privatisation is one of them, with an increasing presence of private healthcare providers alongside the public system. This has raised concerns about the potential prioritisation of profit over patient care.
Another issue is the trend towards "corporatisation," where hospitals and healthcare facilities are transformed into semi-autonomous entities with greater administrative independence. While presented as a way to improve efficiency, it has led to variations in the quality of care and resource allocation between regions and a general decline of healthcare services. Also, long waiting lists for elective procedures in some regions pose a significant challenge, impacting the quality of care and patient satisfaction.


In Greece, the National Health System (ΕΣΥ) was established in 1983, significantly later than similar systems in other European countries. Our National Health System is mostly hospital-centred, investing more on hospitals more than on primary healthcare, which has, in turn, been insufficiently developed. While the public system has faced continuous degradation, the private sector has historically maintained a privileged support from all Greek governments, leading to its increased control over various healthcare services.

Funding comes from the state budget, insurance bodies, and private donations. Public health spending as a percentage of GDP has fallen significantly, from 6.8% in 2009 to 4.8% today, according to the latest OECD report.

## Staffing and working conditions

Chronic understaffing is a major issue for the Greek Healthcare System. The number of medical staff positions fell from 52,000 in 2009 to just over 18,000 by 2018, while the average age of permanent staff is 59 years.
Working conditions, particularly for junior doctors, are harsh, with many on-call duties each month and low pay. The system has also increasingly relied on temporary contracts, such as 18-month auxiliary doctor contracts, hourly wages, block contracts, and three-month contracts.

## Access for the citizen

Until around 2000, public health services were free for all. In 2011, uninsured individuals were excluded from all medical services, leaving over 3 million people without access to healthcare facilities. In 2016, uninsured people regained the right to access public health services, but those without legal documents or residency permits (estimated at over 500,000) remain excluded.
Access to public health services is hindered by chronic understaffing and the ongoing weakening of the healthcare system. During the COVID-19 pandemic, it became almost impossible to receive adequate hospital care, and OECD statistics show that life expectancy in Greece fell by six months during the crisis years.

# section 2
# critique of the dominant healthcare model

Social Clinics aim to develop medical practices emerging out of a critique of dominant healthcare practices and models, addressing their specific historical, political and epistemological foundations.

We aim to **challenge the division and disconnects upon which the biomedical model is built**. This dominant model separates the body from the mental/psychological, the individual from their social and ecological environment, and the doctor from the patient. **Biomedicine compartmentalises the unified entity of the human body into separate components,** with each part managed by a medical speciality. As a result, biomedicine loses the ability to observe and recognise all those overall patterns of operation that unify the parts into a whole. It neglects how the human organism functions as an integrated system and its relationship with the surrounding social and ecological environment.
Rather than viewing health as the body-psycho-social process of well-being, biomedicine can be considered as **medicine of the damage and of the emergency**. Medical practice is reduced to a simple relationship between symptoms and drugs or procedures.
The relationship between doctor and patient reflects **the authoritarian and hierarchical regulation of the entire society**. The doctor exerts power over the corporal, mental and social dimensions of human existence, while the patient is relegated to a position of ignorance and passivity. Thus, medicine has developed into a major mechanism that produces and reproduces a specific idea of “normality”, making people “passive” and subject to control.
It constantly supports the **pathologization of natural and social conditions**, framing them as medical problems that require control. A clear example is the medicalization of childhood, where children’s resistance to the over-organization of their lives is pathologized and treated with medication. Similarly, natural experiences like mourning and aging are also pathologized.
The increasing **integration of medicine with market forces** has intensified these processes. Biomedicine is now largely driven by **medical technologies, pharmaceutical corporations, and insurance companies**, aligning directly with their vested interests. Likewise, neoliberal science has become a space of competition between subjects who constantly struggle to acquire and accumulate ”scientific capital” (prestige, fame, recognition, etc.). As a result, any ”truth” in medicine is shaped by this competition.

Social Clinics are spaces where we can pause and reflect to collectively develop a critique of medical practices and experiment with a new vision of healthcare. We aim to reconnect the isolated parts of the fragmented human body, highlighting its connection to its community and its wider ecology. We create the conditions to develop new scientific practices and approaches that treat the body not as a ‘machine’ made up of isolated parts, but as an integrated whole. We believe that **health is a dynamic process**, not a state; it is **a social product, not an individual one**. As such, our health depends on our collective action. Producing health implies **taking care of ourselves and others, whether illness is present or not.**

# section 3
# emerging medical practices

Across the Social Clinics involved in our network, we can identify a range of emerging practices that are inclusive and egalitarian, fostering the creation of communities of care. These practices produce new ways of 'knowing' about healthcare, aligned with our organisational principles and political aspirations towards the creation of more equitable, just, and anti-authoritarian societal structures that can extend beyond the healthcare sector.

## KIA

At KIA, The Other Medicine Team takes an approach that treats individuals as a physical-mental-social whole. Patients are active participants in their treatment. Rather than referring to them as 'patients', with the passive connotation that the term implies, we call them "incomers". The "incomer" attends a joint session with the Health Team, which includes a general practitioner, a psychotherapist and a non-healthcare (non-specialist) member of the Social Clinic.
Information is gathered based on the Health Card, which covers all areas of life: education, work, occupational hazards, career path, insurance, residence, support network, family, relationships, and life events based on the incomer's genogram. It also includes information on diet, sleep, habits, physical hygiene, oral hygiene as well as medical history, heredity and, current symptoms. A physical examination is conducted as part of this comprehensive approach, whose ultimate aim is to produce a transcontextual understanding of the incomer, mapping their relations to the contexts of work, residence, relationships, health, etc.).
This practice connects symptoms with current wider problems, like work precarity, and unemployment, to major life events like illnesses, deaths, separations, or bankruptcy. It also takes into account relationship history, such as patterns of trauma. The Health Card provides a "hologram" of the incomer, offering a preventive dimension by identifying risks related to the body (e.g. heredity), relationships, and social conditions.

## village 2 santé

At Village 2 santé, we believe that care starts the moment you enter the clinic. All professionals—regardless of their specialisations—provide care at an equal level. We aim to demedicalise the process by recognising that doctors are not the only professionals capable of providing care. Depending on the situation, incomers may see a variety of practitioners, including social workers, nurses, medico-social coordinators, or specialists in work rights, etc. Care is also provided through collective activities and community conviviality. We have meetings to discuss the most complex situations, ensuring the best solutions are found through collaboration.

## Ambulatorio Popolare Caracol Olol Jackson

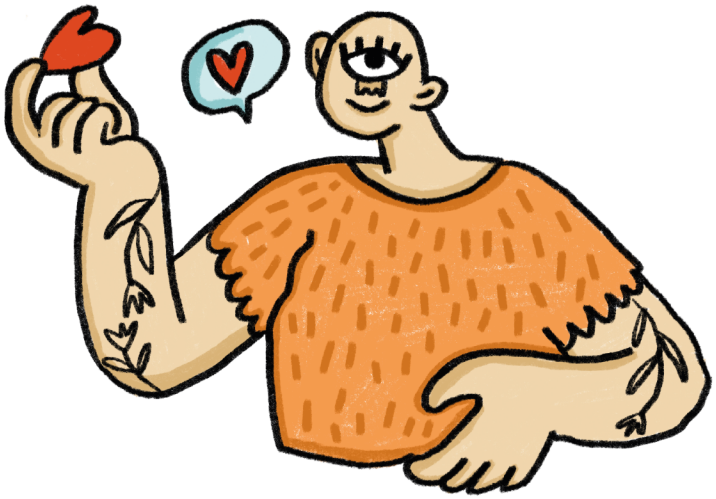
Our attitude towards the incomers who arrive at our clinic goes well beyond the mere medical relation. We take care of the clinic space: we want the place to be beautiful and uplifting in order to restore dignity and self-respect to whoever enters and operates here. Our care focuses on the overall well-being of our incomers, not just their symptoms

response, care, information, or referral to other services.
- Direct access even without an appointment and then programming.
- Focus on communication, which can be professional and empathic, formal and respectful but also friendly and informal. 'We believe that communication time is a time of care".
- Devote the necessary time to both listening and caring.
- Offer specialised services that are not provided by public healthcare: pain therapy and acupuncture; psychological and psychotherapeutic support; primary and prosthetic dental care; financial assistance for prosthetic treatment, low costs, and instalment payments.
- Organisation of health education meetings on the development and care of personal health.
- Psychosocial support in navigating everyday life needs, orientation towards public services, and mediation with other specialists.
- Create cultural, artistic, and musical spaces that weave together broader aspects of health.
- Dealing with gender issues in broad forms, ranging from artistic expression to face-to-face exchanges.
- Taking care of the environment and the territory by promoting meetings and mobilisations.
Health is an individual and collective good. It revolves around a network of balances whose threads depend on the economy, our relationships, information, education, and above all by a community that takes care of itself.

## Laboratorio di Salute Popolare

The Social Clinic "Laboratorio di Salute Popolare"(Bologna, Italy) was established in 2019 by students and care professionals as a space for inter-professional analysis and reflection. It is part of a broader political space that strives to provide employment support, legal aid and document requests and language tuition, as well as to promote community, cultural, and political advocacy actions in Bologna. For us, care is a multidimensional process that takes place through community involvement. Our efforts address both urgent needs and long-term community development, which serves as a preventive tool. The weekly assembly of LSP has produced four different services over the years: a medical outpatient clinic, which deals with general health, identification of needs and orientation to the national health system, a psychological support desk, a dental clinic and a gynaecological clinic. Each service is run by specialised professionals, but care is coordinated by a multiprofessional team and discussed in the assembly. In addition, clinical activity is complemented, whenever possible, by educational activities, usually public. These constitute dedicated spaces for reflection where people are freed from the hierarchical relationship between health service providers and service users, allowing for an equal exchange of health needs and collective construction of new spaces for action.
In each clinic, we use "social triage" to identify the most critical social determinants of health for each incomer, beyond their expressed medical needs. This approach allows us to refer incomers to other services within the centre (employment assistance, legal desk, Italian school) or to other services in town. Everyone is welcome, regardless of their social or legal status. We help those eligible to register with the national health system, and for those without legal documents, we collaborate with the legal aid activists of our centre or with other services to find alternative solutions.

# section 4
# political meaning of care



It may seem obvious what we mean by caring or taking care, whether it is provided by professionals or non-professionals. However, when we look at the definition of caring, it might cover somatic, emotional, mental and psychological well-being, safety, and dignity of ourselves and others. We believe that besides the care we take for ourselves or others individually, there is a **collective care approach,** which includes our families, friends, colleagues, and community. **This approach is deeply political and intertwined with every aspect of our collective present and future.**

The political dimension of care refers to how care is influenced and how it in turn influences political systems and structures. **Care is not only a private or individual matter, but it also has important social and political implications.** The provision of care can be shaped by political decisions and policies, such as funding for healthcare and social services, labour laws, and regulations and immigration policies. **Social clinics fight to remove the bureaucratic, economic, and language barriers that prevent people from accessing the healthcare system.** This form of political action can sometimes take the form of conflict and protest, aiming to guarantee universal access to healthcare and uphold the right to health for all. **We also propose a politicised model of care and health, starting with the common struggle – and ideological premise – for free public healthcare for all.** At the same time, care can also challenge political systems and structures by questioning and subverting dominant power relations and advocating for more equitable systems. Care work—often undervalued and underpaid—is disproportionately carried out by women, racialised individuals, and immigrants. This has led to the rise of **intersectional political and social movements that advocate for better working conditions, higher wages, and greater recognition of care work**. These movements raise critical questions and remind us that care is essential to our social fabric and must be placed at the heart of political discussions. Rather than prioritising profit, we should place collective well-being at the centre of how we organise labour and production.

**The political dimension of caring also extends to broader social and environmental concerns.** Caring for your neighbourhood by addressing long-standing community problems or gathering collective solutions can be seen as acts of care. Tackling climate change and caring for the planet is another example of **the political dimension of care. Overall, the political dimension of care highlights how care is shaped by and shapes social and political structures and emphasises the importance of advocating for more just and equitable systems of care.** For these reasons, we strongly support the convergence of political struggles and directly take part in broader social and political movements which fight the intersectional oppressions of our society.

We believe that social clinics, with our way of thinking, of organising, of being part of our wider communities, are an example of radical change. The values and practices of social clinics contribute to addressing not only healthcare issues but also larger **humanitarian and ecological crises**. By operating as self-managed collectives, social clinics set an example for restructuring society **in a fair, equitable, just, consistent and anti-authoritarian way.**

# microclinica Fatih

The social clinic “Microclinica Fatih” played a key role in activism against the Turin Immigration Detention Center (Centro di Permanenza e Rimpatrio - CPR) in collaboration with other political collectives. Our contribution was to expose the severe inadequacies in medical care and healthcare assistance within the CPR. The clinic raised public awareness on the involvement of the Medical Association of Turin (OMCEO Torino), which had entered into a cooperation project with the private operator of the CPR. This project encouraged volunteer doctors to offer their services but failed to prevent a tragic suicide within the CPR or provide transparency regarding its operations. Through an open letter addressed to the Medical Association and a public protest held outside its offices, the clinic and its allies succeeded in effecting the withdrawal of the cooperation project. The Turin CPR ultimately shut down thanks to persistent protests by detainees who, through acts of defiance, rendered it uninhabitable. Their actions, combined with the relentless advocacy of groups like Microclinica Fatih, brought an end to the facility. Today, the clinic continues to draw attention to the profound injustice in the treatment of migrants in Italy’s immigration detention system.

# section 5
# organisational models, autogestion and decision-making

Our organisational models are based on the principles of **direct democracy and self-management**. These principles demonstrate that **people can organise, manage themselves, and make collaborative and egalitarian decisions about their work, their health and their lives.** We believe that applying horizontal and anti-hierarchical self- organisation in healthcare sets a radical political example for envisioning our society. **If it can succeed in healthcare, it can be applied anywhere**. **Autogestion**, as we practise it, **is a collective and egalitarian organisational practice that employs horizontal decision-making based on consensus.** All organisational decisions are reached through collective discussions in assemblies. Each social clinic has various levels of assemblies. While most clinics have a general assembly involving all members, some clinics also have separate working groups that organise their assemblies. Additionally, some social clinics participate in the general assemblies of the spaces they operate in or are affiliated with, such as social centers or national social clinic networks.

In line with a radical and collective vision of healthcare, we believe **assembly practices emphasise a commitment against any form of hierarchy**. We try to treat all participants equally, regardless of their professional background or qualifications. We also organise different moments of discussion which are open to the incomers who receive support from the social clinic. This is a way of facilitating **discussion and promoting the importance of our care-focused concept**. These moments also serve as a form of self-care for our collective, our activists, and our incomers. They are a means of **transforming healthcare by prioritising care over medicine** and addressing the needs of the community. **The concept of care permeates all aspects of our organisational practices.**

Autogestion is a multiphase process that involves collectively identifying what needs to be decided, formulating a proposal, and determining who makes the decision, who implements it, and when. The decision-making process is based on consensus and requires constant re-evaluation of the agreement and, if necessary, the process itself. Our experience taught us that achieving consensus can be challenging, so some social clinics have developed specific strategies to facilitate the process. When disagreements persist, we sometimes postpone the issue to the next assembly, allowing for continued discussion until a collectively agreed proposal emerges. In some clinics, the elaboration of a new proposal may be delegated to a smaller group before presenting it to the entire group for discussion. Overall, **self- management means placing trust in the power of collective dialogue.**

**Social clinics fight for equitable and universal public health systems that ensure everyone's right to health.** We acknowledge that health systems have been dismantled due to public spending cuts and have played a significant role in perpetuating discriminatory and exclusionary practices. We take political action depending on the changes in context, health system models, public policies, power dynamics, social movements, and strategic choices.

# laboratorio di salute popolare

The social clinic "Laboratorio di Salute Popolare" (Bologna, Italy) is part of a network of social centres in the city, in which activists can freely participate at any level of organisation. Projects may originate from individual assemblies or from the convergence of different areas of work (e.g. from the social clinic and the Italian language school). These projects are discussed collectively, analysed from multiple perspectives, and shaped into a common political line that then informs all activities of the various social centres. The search for convergence, while respecting the individuality of the single projects, is constant and carried out in weekly meetings. There are no structural hierarchies among the activists and the different projects, even if there are different levels of complexity, ranging from the organisation of the specific event to the political line being taken in the city's fabric. Since we use this assembly mode, anyone who accesses the clinics (with few exceptions related to psychological support cases) can access any discussion space: professionals and patients are on the same level as political subjects and influence each other in the policy process.

# KIA

From 2014 onward, Greece saw an unprecedented wave of refugees due to the wars in Syria, Iraq, and Afghanistan. Between 2014 and 2016, an estimated 1.5 million refugees passed through Greece either from the sea (East Aegean islands) or from land (Greek-Turkish border of Thrace). Thousands of refugees were housed in makeshift camps around Thessaloniki, often in empty industrial buildings overseen by the army, where several NGOs operated. Social clinic members formed a reception group in Lesbos, later establishing a clinic and solidarity group in Idomeni. We also entered several camps around Thessaloniki (such as Softex, Fraport, Vasilika, and Diavata) without formal permission, despite entrance being officially prohibited. In these camps, we supported self-organized refugee activities related to accommodation, food, healthcare, and education. We also opened a pathway for visits to the social clinic. In Port camp, we managed to cooperate with a group of refugees to assess their needs, to provide our support to meet these needs and to create a connection with the social clinic (which is just 400 metres from the port) where they could get an appointment with a dentist or other specialist, and obtain medicines if needed.

# microclinica Fatih

Microclinica Fatih recognizes autogestion as a concrete model of horizontal organisation, giving a political meaning to actions that otherwise would be considered useless. Our clinic is part of CSOA GABRIO, an occupied building since 1994. We strongly believe that autogestion can bypass delegation and empower individuals, making it easier for people who come to the Microclinica Fatih to join the collective. This model fosters new relationships between incomers and activists of the clinic, breaking down traditional power dynamics.

# section 6
# anti-hierarchical structures

Our anti-hierarchical structure concerns not only the way we make decisions but also the way different professions interact within the same clinic. We believe that **our non-hierarchical model has a positive impact on how we treat the incomers but also on how we treat each other as a team**.

It is therefore important to highlight that **hierarchy does not only exist between patient and doctor, but also among different professionals**. When hierarchy is maintained over time, it fosters distinct habits and behaviours across all members of the organisation. It supports and reproduces a rigid social order, creating subjects who either take on roles of obedience or command. At the same time, it limits the creativity of their thinking and their practice, as everyone remains confined by their roles.

Our decision to adopt an anti-hierarchical structure aims to create specific forms of knowledge and relationships. **We believe that knowledge is diffused among all care professionals and even among incomers**. Thus, we feel that the non-hierarchical structure concerns a multitude of dimensions in relation to the operations of the social clinics that extend beyond the doctor/patient relationship.

In **our non-hierarchical model**, collaboration between professionals occurs on a horizontal plane, including group discussions and decision processes for the care of each incomer. Supervision processes are established between more experienced and less experienced professionals. Similar processes can involve collaboration between doctors and other specialists.

This non-hierarchical model between different professionals shows the importance of these alternative practices. It helps to create a more relaxed atmosphere in which all participants feel confident to talk freely with other professionals. Social care is also a very important part of guaranteeing better health. The voice of each professional has the same power, so we can give better care to our incomers. The diverse points of view of different professions and their specificities contribute to an environment of mutual trust and knowledge exchange. Each one of us accompanies incomers and contributes to decisions from our own experiences and perspectives.
In hierarchical models, often the important decisions are taken by managers that have no idea of the reality of the people who access the social clinic and how the professionals support people and the community. Instead, we tend to make well-informed decisions collectively. We believe this practice can support both incomers and us as workers. **We promote the development of spaces in which we can ethically think about our jobs and perform collective analysis of our professional practices.response, care, information, or referral to other services.**

## village 2 santé

At Village 2 santé, in order to challenge conventional hierarchy, we decided to pay everyone the same salary, regardless of their role. All decisions concerning the clinic are also taken collectively and not as individuals. This empowers us as professionals and gives us confidence to dismantle hierarchical structures among different professions, such as doctors and social workers. It also challenges the passive role of the incomer. All professionals have the same level of responsibility of taking care of an incomer. Each professional has a role to play in the care of the patients. Decisions are taken by professionals, not by a person of authority or a manager who does not know the reality of our work and our patients.

## KIA Thessaloniki

The "Psi" section was established at the opening of KIA in 2011. It consisted of psychiatrists, psychologists, and psychotherapists from various backgrounds. It established a horizontal assembly where every incomer's case and appropriate therapies were collectively discussed. Professionals with various degrees of experience shared knowledge, ideas, methods, and practices, allowing everyone to engage with various therapeutic approaches. A network of supervision was available when needed, so the young therapists were able to engage with health issues they would not have been able to address otherwise. Over the years, the Psi sector has operated without encountering serious incidents, such as suicide attempts or psychotic crises, showing the success of this collective approach to mental health care.

# section 7
# participation

Engaging **the community** in primary healthcare **is widely recognised as essential even within dominant healthcare models**. However, the marketization of healthcare and the rise of individualistic, commodified logic have overshadowed its social dimension. In general, healthcare systems usually restrict participation primarily to individuals, focusing on the specific diseases that affect them. However, local communities or the person's relevant communities are only sporadically involved. As a result, participation in dominant models is often reduced to **a process that objectifies patients**, transforming them into passive recipients of care who are identified only by their illness, rather than as whole persons. In this process, anything unrelated to the individual's illness is excluded and rendered invisible. Furthermore, participation rarely reaches the decision-making levels where healthcare services are designed and organized, so people and communities are excluded from having a say in the structure and provision of their care.

This process illustrates the approach of **individualising and delegitimizing** dominant health services, which consider people responsible for their behaviours—such as smoking or unhealthy eating habits—without acknowledging the broader social, environmental, and structural factors that affect health. This model assumes that individuals can change their health through their choices, without considering their lived realities as active citizens with complex health needs and knowledge of their own bodies.
In contrast, for us participation is a wider concept with multifaceted significance. It is a **structural aspect** within and across the spatial boundaries of the clinics, highlighting the role of the people who access the clinics but also the broader political aspirations of the core members of social clinics. We believe that anyone entering a social clinic should not be reduced to their disease and should be recognised as a **whole person** with their own body of experience, relations and knowledge. However, claiming the uniqueness of the individual does not mean that those who get sick get sick alone (and have to go through the process alone). Instead, we aspire to the development of new healthcare models where **community bonds are vital**, and where **personal and collective well-being are recognised as strictly interconnected**. In this regard, we state that only a sound and **caring community (in terms of environment, living conditions, nutrition, and networks of human and non-human relationships)** can allow people to live a healthy life and be capable of caring in turn.
For these reasons the members of the social clinics, through their political aspirations, egalitarian ethos and cooperative practices, transform and create new social relations and a new value system: they **cooperate as equals**, they **decide collectively and horizontally**, and they **nurture conditions to critique scientific, political and organisational models.** Within social clinics, we envision organisational models which can create safe spaces for listening and enhancing the mutual exchange of insights and visions. We believe that **mutualism** can be strengthened by sharing experiences of suffering and resilience.
These exchanges take on a whole new meaning once we stop seeing knowledge as a one-sided attribute. The 'problem-holder' is not just a silent patient waiting for an explanation, but a holder of knowledge of experience and their contribution is of fundamental importance in helping the 'medical expert' find a solution, not only in this individual case but in many others.

Moreover, we believe that mutualism can be practical, as it encourages acts of care by incomers toward the social clinic itself, as it often occurs in our daily practice (i.e translation and cultural mediation interventions by migrant incomers in favour of other fellow citizens, support in the preparation of events and/or social meals). However, we strongly believe participation in these terms should always be understood as voluntary, as an act of care in itself and it must never become mandatory.

## microclinica Fatih

At Microclinica Fatih we have implemented co-participative initiatives. One example involved an Arab-Italian-speaking woman, S, who came to the clinical service asking for some help in buying a very expensive therapy. Over time, S became involved in supporting her friends—who did not speak Italian—by facilitating their visits to the clinic and helping with language mediation, thus actively contributing to the process of care. Also, on the occasion of some social events organised by the clinic, S cooperated in the organisational process, proposing herself in helping to prepare food for the events.

## village 2 santé

At Village 2 santé we have “la place du village"-a group of women who decide with the health mediator (a community member who is structurally involved in the clinic) what events they can organise to help promote healthcare for the community. For example, they organised a sauna/massage session, prepared natural health products, organised a karaoke, and many other activities. This kind of participation offers real empowerment!

## ambulatorio popolare caracol olol jackson

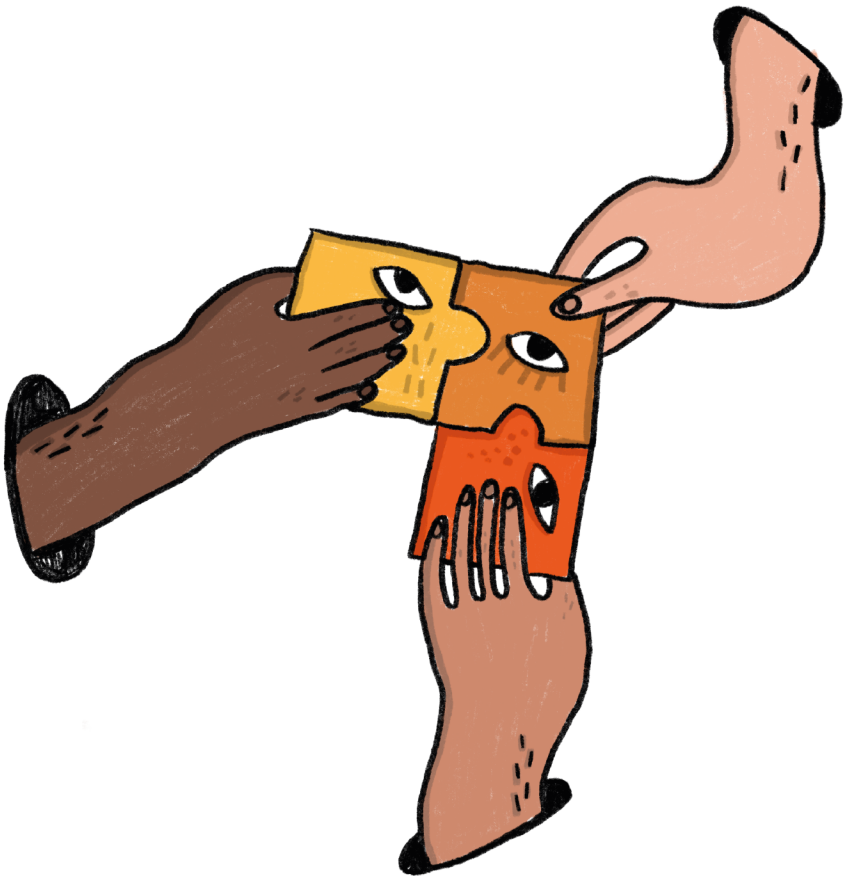
Our social clinic, in its various operational roles, is a place where it is possible to find a space for discussion, for receiving suggestions or support. It is open to members of the Association, non-members, and supporters of the Project. This is what we define as our Community.
We are also open to other projects and initiatives. We offer access and support to volunteers coming from various other projects, such as Social Workers, Civil Service, and people who operate in prisons. For each case, we look at their skills to identify how they can contribute to the Community of our Association. We focus on their present condition, aiming to appreciate and improve it, while respecting their past and life trajectories as personal and private matters, without pressuring them to share unless they choose to do so.

## laboratorio di salute popolare

During the pandemic, activists from the social clinic Laboratorio di Salute Popolare set up a project aimed at meeting, supporting (bringing food, clothing and primary care) and helping people who lived on the streets in Bologna. The primary goal was to create trustworthy relationships with those in contexts of extreme social marginalisation. Over time, this project evolved, with many individuals spending their days at the Labas social center (where the clinic operates), participating in its activities and organizing events. They began to meet, organise and support the space. At the beginning of winter, they organised a demonstration against the housing emergency, which is a central issue in our city. From this event, in January 2023, a new project was born: A.I.R. (autonomy, inclusion, resistance). The courtyard of the social centre, after some renovations, has become a self-managed daytime space, equipped with showers, washing machines and a kitchen that everyone can use. Activists have intiated a process of continuing education as ‘health promoters’ bridging and connecting people who pass through the centre, including neighbours, whose health needs (and desires) are listened to and addressed in reguar assemblies, lunches and meetings.

# KIA

Based on the example of the KIA support network in the municipality of Thessaloniki, we can state that even the "minimum" of participation can be crucial for a self-governing social collective. In the almost 13 years of existence of the Social Solidarity Clinic, despite all the changes that have taken place in Greece on a social, political and economic level, the network of people who support our action and ensure that we have the opportunity to put into practice the provision of quality health care has remained stable. 400 pharmacies in every neighbourhood of the city collect medicines brought to them by their clients, external partners, private doctors of all specialities, psychologists and psychotherapists, as well as hospital doctors and nurses who provide free services to patients referred by the KIA. Various professionals help with maintenance and repairs in the clinic, and visual artists and musicians participate in exhibitions and concerts that we organise. All of this participation happens without financial gain and in alignment with KIA's values and principles.



# Conclusions towards future scenario

The International Network of Social Clinics (INOSC) is an open and ever-changing network of healthcare collectives which share a common vision of caring communities capable of guaranteeing everyone's right to health. As we believe that bonds are fundamental, we aim to reinforce and expand our interconnection to create a stronger and wider network capable of sharing theoretical and practical experiences to keep our struggles moving.

This Manifesto is meant to be a starting point rather than a conclusion. For this reason, we encourage other collectives and activists, regardless of the countries and contexts in which they are operating, to join us in our fight to rethink and reimagine healthcare collectively.

# collective health for healthy communities!

# List of Social Clinics subscribing to this Manifesto

CARACOL OLOL JACKSON

https://www.caracolol.it/salute/

POLIKLINIK SYNDIKAT
SOLIDARISCHE GESUNDHEITSZENTREN

https://www.poliklinik-syndikat.org/

POLIKLINIK
Solidarisches Gesundheitszentrum
Leipzig e.V.

https://poliklinik-leipzig.org/

ΚΟΙΝΩΝΙΚΟ ΙΑΤΡΕΙΟ ΑΛΛΗΛΕΓΓΥΗΣ
ΘΕΣΣΑΛΟΝΙΚΗΣ

https://www.kiathess.gr/

POLI

poliklinik1.org

https://geko-berlin.de/en/

Le Village 2 santé
CENTRE DE SANTÉ COMMUNAUTAIRE

https://www.levillage2sante.fr/

LABORATORIO SALUTE POPOLARE

https://www.laboratoriosalutepopolare.it

MICROCLINICA + FATIH
AMBULATORIO POPOLARE AUTOGESTITO

https://gabrio.noblogs.org/autonomie/microclinica-fatih/

Brigata Basaglia
rete solidale di supporto psicologico
0282396915

https://www.facebook.com/BrigataBasaglia