**SUMMARY OF THE MANIFESTO**

**OF THE INTERNATIONAL NETWORK OF SOCIAL CLINICS**

**What is a social clinic?**

Social Health Clinics are autonomous and self-managed community-based Health Care Collectives , providing primary health care services. We aim to challenge conventional organisational structures through innovative practices involving everyday transactions , procedures and medical practices. We strongly believe in people's ability to organize, self-govern and collectively make decisions with fairness and equity about their work, health and lives.

We strive to create new models of health care where community connections are essential and personal and collective well-being are recognized as inextricably linked. We believe that only a strong and collaborative community based on solidarity, and caring for vital issues such as the environment, living conditions, nutrition and networks of human and non-human relationships, can enable us to live healthy lives and care for each other.

Social clinics are anti-capitalist, anti-fascist, anti-racist and transfeminist structures. We are militant collectives that share a radical vision of health care. Through our actions, we are committed to being advocates for equitable and universally accessible public health systems that guarantee the right to health for all. Social clinics are a radical political paradigm, offering a vision of a more equitable, consistent and anti-authoritarian social structure that can extend beyond Health Care to various sectors. If it can be successfully applied to Health Care , it can be applied everywhere.

This Manifesto represents the opening word of the International Network of Social Clinics (INOSC). It is an open invitation to encourage other collectives and activists to join our struggle to rethink and collectively reinvent Health Care .

**Module 1: Neoliberal policies and relations with public health systems.**

In recent decades, neoliberalism has influenced global health by acting as a structural determinant of health. The belief that markets are more adequate and more efficient in allocating resources in an individualized society, motivated primarily or exclusively by economic and material interests, rejects any form of social welfare as interfering with the normal functioning of the market. Governments have applied the principles of neoliberalism to all aspects of social and individual life through privatisation and commercialisation of the public sphere, deregulation of the private sector (with an increasing role for health insurance), reduction of taxes on capital, cuts in public spending, reduction of the power of trade unions resulting in wage cuts.

The health system has been turned into a market and care into a commodity and countless 'medical deserts' have developed, areas where the shortage of health workers jeopardises access to health and welfare services.

Complete submission to the laws of the market means the deterioration of clinical medicine and the therapeutic relationship, as treatment is only about symptoms through strict protocols that prescribe

specific medical actions and drugs. The content and role of medical science is also affected. There is greater fragmentation into more specialties and promotion of very expensive treatments. In addition, doctors, due to time pressure, rely less on clinical work and more on examinations. Prevention is seen as a moral and individual issue and responsibility and all the structural, environmental and social factors (poverty, unemployment, precarious work, ecological degradation and pollution of food, water, air and nature) that influence and potentially determine individual and collective health are overlooked.

The global emergency event of SARS-CoV-2 made visible the failure of the neoliberal approach. COVID-19 also showed that where services are privatised, governments are unable to control the spread and severity of disease. Primary care was shown to be a key factor in the health system. However, this recognition has not been accompanied by a reversal in policy and resource allocation in health systems.

Although Social Health Clinics operate in different contexts, when we analyse health and Health Care in the neoliberal phase, we see that in similar ways , different national Health Care systems are being privatised and dismantled continuously.  Even in countries with universal health care coverage, long waits are frequent and there are often multiple barriers that make access to health services difficult: when people do not have a residence permit, when part of the population does not have access to a general practitioner or has difficulty finding appointments in certain specialties because the number of recognised doctors is not sufficient (Germany, France) or because of chronic understaffing of doctors and nurses and intolerable working conditions resulting in the resignation of workers (Greece),or there are obstacles when it comes to voluntary termination of pregnancy. In some cases, the application process for treatment is complex and waiting lists exceed time (Germany, mentally ill). Another issue is the trend towards 'corporatisation', where hospitals and health care facilities are becoming semi-autonomous entities with greater administrative independence, but with the consequence of deteriorating services (Italy). In Greece, where the primary health care sector is underdeveloped and the NHS is mainly hospital-oriented, the private sector has historically enjoyed a privileged relationship and support from all Greek governments, resulting in increased control over a range of health services. In general, too, public insurance rarely covers dentistry and its systematic exclusion from free public services is evident.

## Module 2: Critique of the dominant healthcare model

Social clinics seek to develop medical practices that emerge from a critique of dominant health care practices and models. We believe that health should be understood as a process rather than a condition, as a social, rather than an individual product, in which we must act collectively

Our aim is to overturn the divisions and disconnections on which biomedicine is based. The dominant model disconnects the physical from the mental, the individual from its social and ecological context, and the doctor from the patient. Biomedicine separates the single entity of the human body into distinct parts, each

of which is managed by a medical specialty or constitutes a specialized medical field. As such, it loses the ability to observe and recognize all those holistic patterns of functioning that unify and integrate the parts into a whole, the ways in which the complexity of the human body is unified into a totality, and the relationship between that totality and its social and ecological system.

Instead of the concept of health as a physical-mental-social process of well-being , biomedicine can be seen as a medicine of harm and urgency. Medical practices are limited to the symptom-drug or symptom-medical process relationship. Biomedicine has become fully driven and influenced by medical technologies, pharmaceutical and insurance companies, resulting in direct alignment with their own interests

The relationship between doctor and patient reflects the authoritarian and hierarchical regulation of the entire social field, where the doctor exercises authority over the physical, mental and social dimensions of human existence, while the patient is relegated to a position of ignorance and passivity. Thus, medicine has become a major mechanism for the production and reproduction of a particular conception of 'normality', making people 'passive' and subject to control.

**Module 3: Emerging Medical Practices**

The participating social medicine clinics in the network present a range of emerging practices characterized by inclusion and equity , contributing to the creation of communities of care.

At the Thessaloniki Solidarity Social Clinic (KIA), where services are free of charge, the Other Medicine Team set out to consider the human being as a physical-mental-social whole and patients as active participants in their treatment. To achieve this, the Other Medicine Group developed the following practice: It created the Health Team, consisting of a general practitioner, a psychotherapist and a non-specialist, a member of the Social Clinic, who in a joint session take care of the "incomer". Information is collected based on the formulated Health Card which addresses all aspects of life: This approach constitutes a cross-contextual understanding of the incomer ( i.e. understanding through linking their health problems in the present with the different contexts of life: work, home, relationships, health history, etc.) and indicates possible areas of risk.

At Village 2 Santé they try to de-medicalise the process, considering that the doctor is not the only professional who can treat, while at Ambulatorio Popolare Caracol Olol Jackson they go beyond simply identifying the main symptoms of the attendee looking forward to their overall personal situation and well-being. For the Laboratorio di Salute Popolare, care is a multidimensional process undertaken by the community, with the aim of solving urgent issues and developing a community context where the social network acts as a means of prevention. An assessment is

carried out through what is called "social screening", which consists of identifying the most critical health factors of the person who comes to the service, regardless of their expressed need. In this way they can refer to other services in the city.

### Section 4: Political importance of care

Health care is linked to the physical, emotional, spiritual and psychological well-being, safety and dignity of ourselves and others. We believe that beyond individual care for ourselves or others, there is a collective approach to care, including our families, friends, colleagues and community. We propose a politicized model of care and health, starting with the shared struggle - and ideological premise - for public and free health care for all.

In this sense, health care can challenge and subvert dominant power relations by advocating for more equitable systems. For example, care work is often undervalued and underpaid, and care workers are disproportionately women, people of diverse backgrounds and migrants.

The political dimension of care also extends to wider social and environmental issues. Caring for your neighbourhood, addressing known community problems, tackling climate change and caring for the planet are examples of the political dimension of care.

We believe that community clinics, in their thinking, in their organization, in their decision to be part of the community, can be a radical example of change. In doing so, they can help address huge humanitarian and ecological crises and the question of how to structure society in a just, equitable, cohesive and anti-authoritarian way.

### Module 5: Organisational Models, Self-Management and Decision-Making Processes

Our organisational models are based on the principles of direct democracy and self-management. Self-management as we practice it is a collective and egalitarian organizational practice that uses horizontal organizational decision-making in consensus-based assemblies. Each social clinic has different levels of assemblies. In addition, social clinics may participate in other decision-making processes, such as the general assembly of the space in which they operate or of other collectives with which they cooperate. Our experience has taught us that reaching consensus can sometimes be difficult, so some social clinics have developed specific strategies to facilitate the process.

We try to treat all participants equally, regardless of their professional background or qualifications. In addition, we organise discussions that are open to the incomers supported by the social clinic and open to the community. **Overall, self-management means trusting in the power of collective dialogue.**

## Module 6: Anti-hierarchical structures

Our anti-hierarchical structure concerns not only the way we make decisions, but also the way we interact between different professions within the same clinic, i.e. the way we treat each other as a team.

An important negative aspect of hierarchy is that, by maintaining it as a fixed factor, it encourages the development of distinct qualities and behaviours in all participants, which reproduce the hierarchical order, creating subjects who either demonstrate obedience or give orders according to their position within that hierarchical order. At the same time, it limits their creativity of thought and practice, as they too are subject to the same hierarchical structures.We believe that knowledge is dispersed among all care professionals and even among those who come in.

The non-hierarchical organisation of medical care between specialists can have a horizontal character based on medical expertise, such as group discussions and decision-making processes for the care of each incomer and the creation of supervision processes between more and less experienced specialists. All this can lead to more finely tuned support through the diverse perspectives of the different professions and their specificities.

In hierarchical models, often, important decisions are made by managers who have no idea about the reality of the people who come to the social clinic or how professionals support people and the community. In contrast, we tend to collectively make well-informed decisions, believing that this practice can support both those coming in and us as workers.

At Village 2 Santé, where workers are paid through the insurance of those coming in, one way against hierarchy is the decision made that everyone should have exactly the same salary, whatever their job. Also, in their hiring process they value experience as much as they vallue degrees so that the hierarchy of degrees is limited.

## Section 7: Participation

Community participation in primary health care is considered essential even by mainstream models of care. However, the commercialisation of health and the dominance of a commodified and individualistic logic in all aspects of life have overshadowed its social dimension. In general, health systems limit participation mainly to the individual, focusing particularly on the specific diseases that affect him or her. As a result, they systematically perpetuate a process of objectification, in which people lose their identity and become their illness, identifying more fully with patients than with (whole) individuals. In other words, anything that is not related to the identity of illness is excluded and rendered invisible

This process also highlights the individualistic and delegitimizing approach of mainstream health services, which hold people responsible for their individual behaviours (as in the case of smoking or eating habits), and therefore potentially capable of changing their health, while not considering them as active citizens with health needs and empirical knowledge about their bodies. When we stop seeing knowledge as a one-sided attribute, that the 'problem bearer' is not just a silent patient waiting for an

explanation, but a holder of empirical knowledge, and their contribution is fundamental to helping the 'expert' find a solution,

We aspire to develop new models of care where community links are vital and where personal and collective wellbeing are recognised as closely interconnected. Through our political ideas, our ethos of equality and our collaborative practices , we are creating new social relationships, a new value system and safe spaces for listening and enhancing the mutual exchange of views and visions in a democratic dialogue

In addition, we believe that mutuality can be realized on a more practical level by encouraging acts of care from people accessing the clinic to the social clinic itself, as is often the case in our daily practice (e.g. translation and cultural mediation interventions by migrants coming to other fellow citizens, support in preparing events and/or social meals). However, we firmly believe that participation in these terms should always be understood as voluntary, as an act of care per se, and should never become compulsory.

## Conclusions with a view to the future

As mentioned above, the International Network of Social Clinics (INOSC) is an open and ever-changing network that aims to connect health collectives that share a common vision of health care communities capable of guaranteeing the right to health for all. Since, in our vision, links are fundamental, we aim to strengthen and expand our interconnection to create a stronger and wider network capable of sharing theoretical and practical experiences to continue our struggles.

This Manifesto is intended to be a starting point and not a conclusion. For this reason, we encourage other collectives and activists, regardless of the countries and contexts in which they operate, to join us in the struggle to collectively rethink and reinvent health care.

POLIKLINIK
SYNDIKAT
SOLIDARISCHE GESUNDHEITSZENTREN

Le Village 2 santé
CENTRE DE SANTÉ COMMUNAUTAIRE

CARACOL
OLOL
JACKSON

MICROCLINICA
+ FATIH ★
AMBULATORIO POPOLARE AUTOGESTITO

POLIKLINIK
Solidarisches Gesundheitszentrum
Leipzig e.V.

LABORATORIO
SALUTE
POPOLARE

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