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'No healthy life in a sick system' - Studying policlinics as emerging health care commons and radical counter-imaginaries to biomedicalized and neoliberal health care

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Abstract (English)

This thesis examines policlinics in Germany as emerging health care commons and radical counter-imaginaries to biomedicalized and neoliberal public health. At a time of increasing marketization, privatization, and growing health care inequalities, policlinics position themselves as solidarity-based health centers that seek to restructure health care beyond individualizing and profit-oriented paradigms. Drawing on Science and Technology Studies (STS), activism and commons scholarship, this study combines the concepts of counter-imaginaries, radical imaginaries, and (care) commons to analyze how policlinics both oppose to hegemonial health care and prefigure their alternative counter-models.

Empirically, the thesis is based on qualitative interviews, participant observations, and document and podcast analysis, analyzed through reflective thematic analysis. The findings show how policlinics rethink health as a social product and public good, foreground multiprofessional cooperation, participatory planning, and community-based prevention. At the same time, they face tensions related to financing, professionalization, and the ambivalences of commoning with and against existing structures.

Rather than portraying policlinics as inherently transformative or as fully co-opted by neoliberal structures, this thesis conceptualizes them as ambivalent spaces in which radical counter-imaginaries are continuously negotiated, contested, and stabilized. Their emancipatory potential does not lie in their mere existence, but in their capacity to reflect upon and engage with structural constraints and internal tensions. By empirically studying policlinics as health care commons, this thesis contributes to STS debates on health care activism, marketization, and the role of social movements in shaping medicine and public health.

Abstract (German)

Diese Masterarbeit untersucht Polikliniken in Deutschland als entstehende *health care commons* und als *radical counter-imaginaries* zu einem biomedikalisierten und neoliberalen Gesundheitssystem. In Zeiten zunehmender Ökonomisierung, Privatisierung und wachsender Ungleichheiten in der Gesundheitsversorgung verstehen sich Polikliniken als solidarisches Gegenmodell, welches Versorgung jenseits individualisierender und profitorientierter Logiken neu strukturiert. Aufbauend auf Science and Technology Studies (STS), (Gesundheits-)Aktivismusforschung und Commons-Theorien kombiniert diese Arbeit die Konzepte der Counter-Imaginaries, Radical Imaginaries und (Care) Commons, um zu analysieren, wie Polikliniken hegemoniale Gesundheitsordnungen zugleich kritisieren und präfigurativ alternative Modelle erproben.

Empirisch basiert die Studie auf qualitativen Interviews, ethnographischen Beobachtungen sowie der Analyse von Dokumenten und Podcasts, die mittels reflexiver thematischer Analyse ausgewertet wurden. Die Ergebnisse zeigen, wie Polikliniken Gesundheit als soziales Produkt und öffentliches Gut rekonzeptualisieren, multiprofessionelle Zusammenarbeit und partizipative Planungsprozesse etablieren und community-basierte Prävention praktizieren. Gleichzeitig stehen sie vor Herausforderungen in Bezug auf Finanzierung, Professionalisierung und die Ambivalenzen des *commoning* mit und gegen Strukturen.

Anstatt Polikliniken entweder als inhärent transformativ oder als vollständig in neoliberale Strukturen integriert darzustellen, begreift diese Arbeit sie als ambivalente Räume des *commoning*, in denen *radical counter-imaginaries* kontinuierlich ausgehandelt, stabilisiert und auch infrage gestellt werden. Ihr emanzipatorisches Potenzial liegt nicht in ihrer bloßen Existenz, sondern in ihrer Fähigkeit, Spannungen und strukturelle Begrenzungen reflexiv zu bearbeiten. Damit leistet diese Arbeit einen Beitrag zu STS-Debatten über Gesundheitsaktivismus, Ökonomisierung und die Rolle sozialer Bewegungen in Medizin und Gesundheitspolitik.

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1. Introduction

When visiting the website of the policlinic syndicate, the umbrella organization of 15 solidarity-based health care centers across Germany, two things catch your eye. First, their motto *'there is no healthy life in a sick system'* visualizes the policlinics radical opposition to a 'sick' health care system, and how their definition of health connects health with society[1]. Differently put, it illustrates policlinics' healthcare activism operating beyond the medical realm and formulating a fundamental social criticism.

Policlinics are activists organized in grassroot projects working towards justice and solidarity within health care and the development of solidarity-based health centers. For policlinics, health is not understood only in individual terms but depending on living conditions and politics. Patients are treated by multiprofessional teams and prevention centers around community work, the local neighborhood, living conditions and politicization. These projects exist in different German cities and rural areas, their number growing, and they are connected through the policlinic syndicate and the broader network of European social clinics (inosc)[2].

The second eye-catching aspect is the syndicate's logo. It is an optical illusion of an impossible cube consisting of three crossbars (Figure 1). This figure is a paradoxical geometric structure appearing consistent locally, but whose overall perspective is spatially impossible. I argue that this captures the current tension policlinics are facing, namely, how to realize their radical counter-imaginaries of health care commons when being confronted with structural limitations and impossibilities. Or to stay with the optical illusion: Wanting to be a cube while not being able to - I will come back to this metaphor in the discussion. But let's start at the beginning:

Figure 1 - The policlinic syndicate's logo

Policlinics are growing in Germany to counter growing trends of privatization and access inequalities (Bůžek, 2025; Bůžek et al., 2022; Gerlinger, 2018). While the costs of the German health care system are rising, quality and access are worsening and there is significant difference in provisioning supply density across city and regions, leading e.g. to long waiting times in certain places (as discussed in detail in3.3.2). The newest political responses to this problem are the idea of charging

[1] Within the policlinic syndicate, there are many projects that sometimes use the terms 'solidarity health center' or 'health collective' instead. For coherence, I will from now on refer to all projects in the syndicate as policlinics.

[2] From now on 'the syndicate' will refer to the policlinic syndicate.

fees for seeing specialists or advancing telemedicine (BR24 Radio, 2025). Therefore, new political initiatives or health care activists, like policlinics, do not strive to foster technoscientific innovations, but to restructure health care with social innovations, by empowering neglected communities and rethinking health care provisioning. These policlinics seem like a new, promising approach worth examining more closely, but beyond idealization or conservative cynicism.

Scholarly literature on health care activism centers questions of expertise, evidence and scaling strategies but also how sustain alternative conceptualizations of the collective good when work with or against markets (Epstein, 1995; Geiger, 2021; Pushkar & Tomkow, 2021; Ribera-Almandoz & Clua-Losada, 2021). Generally, STS studies often examine how and through which technoscientific advancements and infrastructures health care markets are constructed or how economics-centered valuation like profitability displace or make alternative valuations in health care more difficult (Datta Burton et al., 2022; Zuiderent-Jerak et al., 2015). With this thesis, I want to complement this focus and analyze how alternatives to health care marketization, like policlinics, look like and how they are limited or challenged by current health care and society. Thus, my research asks *how policlinics counter-imagine and counter-act the current neoliberal and biomedical healthcare system and through which imaginaries and practices they envision and develop their counter-model as health care commons.* My research questions focus on policlinics' imaginaries of health, care and community and how these are negotiated and put into practice by working towards health care commons. Thus, my analysis will include the challenges and tensions within and between policlinics' imaginaries and practices and how they deal with them.

Like the three crossbars in the logo, I combined three theoretical sensibilities for my analysis. Firstly, I use counter-imaginaries, which are often formulated by activists in opposition to dominant sociotechnical imaginaries. Such alternative visions on a specific technoscientific topic suggest different configurations of knowledge, governance, and social relations. Secondly, radical imaginaries describe the prefigurative politics and collective vision of movements as they combine structural critique and material enactment. Thirdly, I employ the concept of commons, meaning prefigurative spaces or experiments of organizing resources or services with the aim of resisting both market and state logics, which have been studied as a type of radical imaginaries. Thus, health care commons are attempts to practice health care in commons, thus resisting the individualization and privatization of life and health. I combine these three concepts to grasp not only the opposition of policlinics but their prefiguration in form of health care commons and how their health care activism ties into wider societal transformations and radical critique of society and capitalism. The radical counter-imaginaries and commons help me to make sense of the debates and divergences within policlinics and the overall tension of envisioning and attempting to put into practice their alternative health care model.

My thesis tries to answer the question of how care -, community-, participation- and solidarity-based alternatives like commons can be an (successful) answer to neoliberal, biomedicalized and marketized healthcare. I care for this topic since as an STS student interested in biomedicine, healthcare

and (bio)politics, I learned, read and discussed various problems and critiques throughout my master's degree. However, what I always asked myself at the end of a course was: *How could healthcare be different and better? What would have to change? What are alternatives to neoliberal paradigms of health and medicine?* My work aims to contribute to the little amount of (STS) works on emerging *counter-radical imaginaries of health care commons* and fill the gap of empirical case studies on policlinics as concrete examples for such commons. With my thesis I want to contribute to the wider debate on what strategies activists have to achieve change in a marketized and neoliberal healthcare system and broadly, to the question of what role social movements play in technoscientific fields like health(care). To answer my research questions, I did a triangulation of methods, combining interviews, online and on-site patient observations, document and podcast analysis and used the reflective thematic analysis method to extrapolate relevant themes from my data.

I begin by tracing how modern biomedicine and health care systems develop in Western Europe: From Jewson's (1976/2009) medical cosmologies in 18th and 19th century, surveillance medicine, over public health as historical intertwinement of science and politics to today's ideas of precision public health. The second subchapter will describe the development of and discussions on health care's marketization and sketch how STS researchers and feminist scholars study and understand (health) care markets. The third literature review chapter will focus on health care activism and its strategies regarding evidence, knowledge and expertise. Then, I review scholarship concerned with activism against markets and the role of civil society. Additionally, I look at existing case studies of grassroot health care infrastructures and care commons, including one article describing policlinics.

The third chapter describes my research approach, starting with my research questions, my theoretical sensibilities, the concepts of counter- and radical imaginaries as well as commons which help me capture the complexities and nuances of policlinics. Then, to give an overview over the research field, I provide the context of the German health care system and current political debates and privatization critiques. The subchapter on methods is concerned with my data collection, ranging from interviews, participant observation, podcasts and documents which allowed me to find both explicit and implicit imaginaries, practices and tensions. Moreover, I explain how I used reflective thematic analysis to extrapolate relevant themes from my data set in dialogue with my research questions, the literature and my theoretical sensibilities.

In the fourth chapter I try to weave my themes and findings together with the literature and concepts of counter and radical imaginaries, practices, commons and challenges. I start out with how policlinics rethink health care and society, by reconceptualizing health as social product in opposition to biomedicine, but also as public good and thus contrary to neoliberal public health. Additionally, policlinics rethink health care as participatory and as non-hierarchical, both within medical teams and regarding patients. In policlinics' radical counter-imaginaries, collective care figures as means to improve and transform health care, communities and society. In the second empirical subchapter, I describe how policlinics redo health care by establishing multiprofessional cooperation and participatory

planning based on needs-assessment. Furthermore, policlinics work towards accessible and discrimination-free spaces. Their central counter-practice is Verhältnisprävention, targeting local living conditions with their prevention projects and thereby also fostering communities through their community work. The third subchapter focuses on policlinics' challenges of financing, professionalization and sustainability and on two projects, Navigation and Utopia, which figure as beacons of hope for members. These projects illustrate 1) how policlinics aim to collect evidence and become part of standard care; and 2) how they simultaneously develop radical political ideas on how to socialize health care.

In the fifth chapter, I will discuss these findings against my three research questions. I will explain how policlinics' dual strategy defies the typical categorizations of invited and uninvited activists and exemplifies the typical ambivalence of radical counter-imaginaries of commons, and the practice of commoning with and against structures. And while policlinics acknowledge their own potential tensions and conflicts, they strive for small changes in the near future while still working on the bigger changes in an (utopian) far future. Thus, policlinics do not attempt to eradicate this tension of not being able to realize their vision but instead see this tension as inherent. This makes them a special case of health care activism, and I will explain how this thesis contributes to (STS) studies on health care activism and commons. In the conclusion, I will summarize this work and zoom out to questions on the role of social movements in the formation of new medical cosmologies.

2. Literature Review

2.1. Modern (Bio)medicine and public health

To understand how policlinics develop their counter imaginary, I introduce the currently hegemonial understandings of health, disease, healthcare, patients and doctors prevailing in Western European societies over the past 200 years until today. Describing the development of modern biomedicine, public health care systems and the establishment of the empowered and self-responsible patient serve as background against which to understand the policlinics' critique.

2.1.1. A short history of Western modern (bio)medicine

Medical sociology and history scholars have long been concerned with how Western medicine developed and how (technoscientific) developments in medicine, societal changes and the understanding of patients, doctors, health, disease, oneself and one's bodies are co-produced. In his influential work, Jewson (1976/2009) outlines three medical cosmologies guiding transformations in medicine in the 18th and 19th century, thus during the industrialization of Western societies. Cosmologies for Jewson are "conceptual structures" constituting "the frame of reference within which all questions are posed, and all answers are offered". For Jewson, a cosmology both "prescribe[s] the visible and the invisible, the imaginable and unconceivable" (2009, p. 622). Thus, they represent not distinct knowledge, but rather ways of knowing (or ignoring). For Jewson, medical cosmologies are not "cultural artefact[s] (..) outside of social discourse" but rather "modes of social interaction" framing the production of medical knowledge and discourse (2009, p. 623).

Jewson identifies three medical cosmologies: bedside medicine (BM), hospital medicine (HM) and laboratory medicine (LM) and I will shortly sketch the corresponding understanding of health and disease, patient and doctor roles and medical knowledge production have changed (Figure 2). In bedside medicine, disease is "defined in terms of its external and subjective manifestations rather than its internal and hidden causes" (2009, p. 623). Emotions and spirituality are important aspects in finding the cause of illness and individuals were understood as having their "unique pattern of bodily events" (2009, p. 624). In hospital medicine, this integration disappears, and the sick human becomes a "network of anatomical structures" (2009, p. 629). Due to innovations like "structural nosology, localized pathology, physical examination and statistical analysis", the physical examination of the patient (alive and dead) becomes more important, and the disease diagnosis results from observation rather than interpretation of the patient's subjective experiences (2009, p. 625). In laboratory medicine, the focus lies on "fundamental particles of organic matter" thus "further eradicating person from patient" in medical discourse (2009, p. 629). Jewson's (2009) argues that in the 19th century, German or Prussian universities become the key sites for the formation of LM. Innovations in histology, physiology and cell theory, enable the application of natural science to solve medical problems. German scientists shared a strictly materialist interpretation of biological phenomena, launching what he describes as a concerted effort to

eliminate vitalist explanations from biology (2009, p. 231). Additionally, the strong boundary between the sick person and the medical professional becomes essential for the creation of medical knowledge, fostering the sick person as uncritical and passive. Previously in BM, doctors prove their worth to patients, sick people (who could afford it) pick their doctors based on empathy and explanations, and treatment suggestions are based on patient's expectations. In contrast, in LM, the role of the doctor has inherent authority.

These changes also affect the medical knowledge production and medical profession. Instead of the relationship to sick people, the professional network becomes the focal point for medical professionals' careers. Medical cosmologies cease to function as a "two-way channel" and, with the rise of LM, become institutionalized as a system of hierarchical status distinctions between patients and medical investigators, as well as among medical professionals themselves (2009, p. 628). Jewson observes that medical professionals become "an insulated intellectual cocoon", with exclusive and strict criteria for who counts as an insider (or outsider) and who produces medical knowledge and how (2009, p. 629). Any new findings, rather than leading to a reinterpretation of earlier medical cosmologies, contributes to the emergence of more medical specialties – which Jewson describes as: "ambiguity and confusion were replaced by certainty and order" (2009, p. 628).

Diagram 2 Medical Cosmologies, 1770–1870

	Bedside Medicine	Hospital Medicine	Laboratory Medicine
Subject matter of Nosology	Total symptom complex	Internal organic events	Cellular function
Focus of Pathology	Systemic – dyacrasis	Local lesion	Physio-chemical processes
Research Methods	Speculation and inference	Statistically oriented clinical observation	Laboratory experiment according to scientific method
Diagnostic Technique	Qualitative judgement	Physical examination before and after death	Microscopic examination and chemical tests
Therapy	Heroic and extensive	Sceptical (with the exception of surgery)	Nihilistic
Mind/Body Relation	Integrated: psyche and soma seen as part of same system of pathology	Differentiated: Psychiatry a specialized area of clinical studies	Differentiated: Psychology a separate scientific discipline

Figure 2 - Medical cosmologies from 1770-1870 by Jewson (2009, p. 624)

Jewson further emphasizes the role of a unifying and modernizing state in centralizing medical education and institutionalizing LM, shaped by Prussia's concerns of gaining national prestige and power within Europe (2009, p. 237). Although not a designated STS scholar, Jewson refers to technological advancements enabling shifts between medical cosmologies. Thus, Jewson's (2009) work illustrates how medical knowledge production, social organization of medical professions, statehood, technological advancements and understandings of health, disease, patients and doctors shape one another.

Another important work in this regard is Foucault's (1975) arguments on the role of authority, expertise in modern science, statehood, and the relationship of power and knowledge. In his book 'Birth of the clinic - An Archaeology of Medical Perception', he studies the shifts in medical perception – thus

the epistemic frameworks structuring what can be observed, said, and known in medicine (Foucault, 1975). According to Foucault (1975), the establishment of hospitals, a space for systemic observation and with standardized records, leads to a new authoritative 'gaze', the clinical or medical gaze. Like Jewson's observations, disease becomes a material object anchored in lesions, tissues, and spatial localization rather than in the patient's lived experience. These radical transformations are not only scientific but also linguistic and institutional, reshaping the idea of what counts as (medical) truth, like the STS scholar Kuhn's concepts of scientific revolutions and paradigm shifts or Fleck's idea of thought styles (Fleck, 1935/1979; Sismondo, 2004). These fundamental changes in medicine as an epistemic rupture have profound effects, such as the favoring of quantification and standardization, the separation between the sick person and the disease and the rise of modern biomedical rationality. Additionally, Foucault argues that the rise of scientific medicine produces a medicalization of social relations in which illness came to be treated as a form of deviance, thereby expanding the professional authority of medicine to regulate and police health (Porter, 2020). These arguments proved highly influential and informes Foucault's later development of biopolitics (Lemke, 2007b, 2007a). This theory describes the ways modern states seek to manage populations through the regulation of life, health, reproduction and hygiene. Closely related to Foucault's concept of biopolitics, as it is one dimension of governmental power, are governmentality studies, examining how power operates through rationalities, mentalities, techniques, and practices shaping conduct of citizens thus governing individuals and populations beyond formal state institutions (Lemke, 2007a, 2007b).

Building on Foucault's work, Armstrong's (1995) observations about surveillance medicine are often cited when it comes to understanding how risk enters medicine in the mid-20th century[3]. Armstrong (1995) argues the paradigm of HM is not only shifting towards LM, but towards surveillance medicine (SM), as monitoring techniques, screening and health promotion programs expand. With the beginning of WW2, medical surveillance, or medical expertise and practices focused on surveilling and collecting data, are no longer bound to the space of the hospital but expand to the wider population, thus blurring the lines between sickness and health.

The author considers socio-medical surveys during WW2 as a starting point for SM, challenging the "biomedical model's binary separation of health and disease" by emphasizing the continuum of distributed medical variables across a population (Armstrong, 1995, p. 397). Thus, a continuum of classified bodies emerged where each individual body is at all times compared to the whole of the population and the 'normal'. The consequence of SM, in Armstrong's words, is that "*everyone was normal yet no-one was truly healthy"* (1995, p. 397). Another implication of SM is the shift from clinical inference being a disease or lesion towards the illness being a risk factor for another. This leads to "symptom, sign, investigation and disease (…) [becoming] conflated into an infinite chain of risks"

[3] Of course, the argument of Gidden's risk society (1991), where he conceptualizes modern societies as organized around individualized risk management, has to be mentioned here as well.

(1995, p. 400). Thus, medicine's focus is no longer the symptom as an indicator of pathology, but the risk factor as a marker of potential future disease. Thereby, medical attention progressively relocates to the 'lifestyle'. In HM, disease is located within the corporal volume of the human body, and in contrast, in SM the "risk factor network" unfolds "across an extracorporeal and temporal space" (1995, p. 401). All in all, Armstrong (1995) observes how these techniques of SM provide forms of anticipatory care by seeking to shape future health outcomes through the modification of present-day health attitudes and behaviors.

2.1.2. History of public health

In parallel and partly due to the development of modern (biomedicine), public health was established in Western Europe. To contextualize my case study of policlinics changing public health (PH) provisioning and planning, I briefly describe the history of PH in Western Europe. A widely accepted theory positions the scientific advancement in germ theory by Koch and Pasteur as the main driver for the professionalization of PH in the 19th century (Rosen (1958) as cited in Porter, 2020)[4]. Moving beyond miasmatic and environmental explanations, microbiology redefines disease as the result of specific, identifiable microorganisms, thereby enabling new forms of prevention and intervention (Latour, 1988; Porter, 2020). However, moving beyond linear explanation like this, Porter (2020) discusses bacteriology as one factor among others - including the medical gaze, eugenics, regional history, industrialization, colonialism, and statehood – all of which have shaped the development of (professional) public health (Porter, 2020). The author's analysis shows how the historical development of PH is complex and marked by significant regional variation. In some cases, such as Sweden, PH structures precede the centralization of governance, whereas in others, such as in Germany, central PH initiatives coexist with a high degree of regional autonomy. The result is not a uniform system built linearly in a top-down manner through centralized governance, but rather a "diverse patchwork" of arrangements situated within nationally specific configurations of power and administration (Porter, 2020, p. 12).

For Porter (2020), one starting point for PH are the industrialization and its impact on workers, environment and health inducing sanitary reform in the 19th century, especially in urban realm. Simultaneous with early PH reforms, social medicine begins to consolidate as a professional field "dominated by an idiosyncratic collection of political radicals, civil servants, philanthropists, and moral crusaders" (2020, p. 14). During 1848 revolutions, European physicians increasingly call for social medicine, seeing medicine as a moral and political force capable of reshaping modern society. For instance, the Prussian pathologist Rudolf Virchow links health conditions and socioeconomic

[4] And I have to mention Bruno Latour's (1988) work on Pasteurization as socio-technical process shaping modern biomedicine, describing how laboratory-based knowledge gains authority through its integration into institutions, technologies, and everyday practices, contributing to scientific expertise's centrality in modern forms of social ordering (Latour, 1988).

inequalities, and asks doctors "to become advocates of the poor" (Porter, p.14). According to Green and Montenegro (2023), he represents "the mix of empirical research and political advocacy that [still] characterizes contemporary public health" (Green & Montenegro, p.309). Another prominent 19th century proponent on the health and socio-economic inequalities is Friedrich Engels (as referred to in Green & Montenegro, 2023). For him, the unequal burden of disease reflects sociohistorical power relations between capital, industrialists, and the proletariat amid changing modes and technologies of production (as referred to in Green & Montenegro, 2023). Thus, social advocates like Virchow and Engels "straddled the boundaries between social medicine as purely technical expertise, and socialist medicine as political action on health" (Green & Montenegro, 2023, p. 19). Virchow's claim that medicine in part is a social science, and politics are means of achieving good medicine, remains influential in legitimizing the intertwining of political activism and evidence production in PH (Green & Montenegro, 2023).

Despite these calls for social medicine, major changes only happened after Koch and Pasteur's discoveries, the establishment of academic hygiene leading to PH becoming a national policy priority. To curb both socialist influence and reinforce Germany's industrial potential, Bismarck introduced the world's first system of social health insurance in Prussia in 1883, which became a "turning point in the evolution of the modern welfare state" (Porter, 2020; Weindling, 1994, p. 119). As Nandi et al. (2020) aptly summarizes, the evolution of European welfare states is "interconnected with social movements pressuring governments" and thus the universal health coverage as we know it today in many European countries "has its roots in rising discontent among the working class" (quoting Sengupta, 2013, p.12, from Nandi et al., 2020, p. 44).

Against the background of rising nationalism and growth of eugenics, Porter claims that "anxieties over population quantity and quality" led to pronatalism and increased maternal and infant welfare in the beginning of the 20th century (2020, p. 17). Health matters got "recast in biologistic language of social Darwinism" after the WW1 – the most prominent example being the German Nazi regime (2020, p. 18). After the second World War, the World Health Organization (WHO) emerged from the United Nations and thereby citizens' health entered the agenda of international politics (Porter, 2020). Much later, in 1986, an international agreement is signed, the Ottawa Charter for health promotion, to advance the goal of "Health for All" by 2000 and beyond through improved health promotion efforts (World Health Organisation (WHO), n.d.). The AIDS pandemic further emphasized the relevance for PH measures, coherent policies and the health for all approach for Porter (2020).

Porter (2020) argues for a shift away from teleological accounts of PH's development, challenging narratives depicting it either as an inevitable march of progress or as the unambiguous expansion of medical authority. She emphasizes that the "differentiated and diffuse" influence of medical knowledge on the professionalization of PH as part of "an eclectic mixture of expert knowledge from both the medical and the social sciences" (2020, pp. 16, 19). The authority of PH professionals was therefore shaped by broader sociopolitical contexts, including varying governments' priorities

across national settings and historical periods, and encompassing free-market demands, anxieties over imperial decline, colonial economic imperatives, or commitments to health equality. Thus, Porter highlights how some objectives within the development of PH were fundamentally political rather than professional in nature. This is also mirrored in Green and Montenegro's work (2023), underscoring that PH has historically been entangled with social injustices, industrialism, and colonialism but also revealing that it combines activism, political ideology, and scientific knowledge throughout its development (Green & Montenegro, 2023; Porter, 2020).

Overall, Porter constitutes a historiographical divide between "heroic" and "anti-heroic" accounts of PH: heroic histories, exemplified by Rosen, depict PH as the product of scientific and medical rationality enabling societal progress, whereas anti-heroic accounts, oftentimes following Foucault's biopolitics, emphasize PH's regulatory power and its potential for repression, considering 20th atrocities as "murderously repressive public policy" (Porter, 2020, pp. 1–4). Porter concludes that neither framework captures the full picture; instead, understanding PH requires attention to its varied and often contradictory enactments across contexts.

To follow Porter's (2020) the call for more nuance in debates about PH and to look at late 20th and early 21st century developments, I will turn to the work on biomedicalization by Adele Clarke and colleagues linking PH developments and the establishment of biomedicine with Foucault's theory of biopolitics, economic developments and technoscientific advancements. To capture these dynamics, Clarke and her colleagues coined the term *biomedicalization(s)* and examine how stratified biomedicalization(s), precision medicine, and precision public health (PPH) connect to this broader process. The process of medicalization, coming from medical sociology, means the expansion of Western medicine into priorly non-medical areas of life, such as obesity, thereby redefining aspects as medical issues, framing them as requiring medical expertise and extending medical authority and practices onto these (Conrad (2007) as cited in A. E. Clarke et al., 2023, p. 92). Expanding this, STS scholars like Clarke claim that the role of technoscientific advancements, especially digital monitoring tools, in this process needs to be highlighted more. Thus, the term biomedicalization moves away from medicalization, evolving around control, and focuses more on overall societal and medical transformations.

The prefix "-bio" refers to three aspects. Empirically, it describes the growing significance of the biological sciences for medicine. Theoretically, the prefix alludes both to the centrality of biopower and biopolitics in biomedicalization and to biocapital and bioeconomy concepts, highlighting the importance of economics and reconceptualization of capital "vis-à-vis life itself" (based on Cooper (2008) and Sundar Rajan (2017) as cited in A. E. Clarke et al., 2023, p. 94). Clarke et al.'s biomedicalization encompasses five processes. Firstly, there is the "biopolitical economy of medicine" marked by a co-constitution of "biomedical knowledges, technologies (…), devices, services, and especially biocapital" (2023, p. 93). Secondly, a rise of risk-assessments and surveillance, a trend of optimization or enhancement of bodies both representing a new intensifying focus on health. Thirdly,

Clarke et al. describe the "technoscientisation of biomedical practices" basing medical interventions on new, costly and more 'modern' scientific and technological innovations (2023, p. 93). The fourth process is transformations in how biomedical knowledge is produced, managed, distributed, and used through computer and information sciences and media. Lastly, biomedicalization also means a redefinition of life itself and new emerging individual and collective identities.

In their paper from 2023, the authors acknowledge that macro-level shifts analyzed do not always determine medical practices globally. Referring to the debate over whether the biomedicalization concept describes a US or broader phenomenon, they ultimately suggest using the plural *biomedicalizations* to account for the "considerable geopolitical variation" (2023, p. 93). Additionally, the authors highlight the intertwining of biomedicalization with the genomification and pharmaceuticalisation (A. E. Clarke et al., 2023, p. 94, see also Sundar Rajan (2017))

A recent development within biomedicalization is the precision medicine (PM) and precision public health (PPH) paradigm – which also belongs to the neoliberal biomedical health and medicine paradigm criticized by policlinics. What characterizes PM and PPH is the usage of information technology and data science to evaluate and enhance health outcomes for individuals and populations. This datafication encompasses clinical and genetic data but also social, environmental, and behavioral determinants of health get incorporated through epidemiology-based methods. I quote from Clarke et al.:

> *"PM and PPH together shape what kinds of subjects, "risks," and responsibilities come to matter, what problems are deemed important, which solutions are framed (e.g., Marshall 2009), what technologies are built, based on which assumptions (Benjamin 2013, 2019), and ultimately what kinds of futures are deemed possible and desirable. PM and PPH are biomedical imaginaries ultimately shaping what many hope for, expect, and fear from science, technology, and medicine" (A. E. Clarke et al., 2023, p. 101)*

This increased importance of collecting data extends into the private realm, also known as self-quantification, where individuals collect data about themselves, becoming "subjects and objects of biomedical surveillance" and thereby reimagining data collection as expertise (A. E. Clarke et al., 2023, p. 101). Moreover, in PM and PPH, scientists "molecularise" environment and social determinants of health, redefining them based on molecular components and eliminating the social from medical and public health research (A. E. Clarke et al., 2023, p. 102).

For the authors, although PM and PPH are achieving more equitable health (care), the proposed solutions can amplify the very disparities intended to mitigate, enhancing marginalization of individuals and populations "without changing their social and economic circumstances" (A. E. Clarke et al., 2023, p. 103). Additionally, PM and PPH redirect resources and attention away from approaches to health disparities that fall outside biomedical or bioinformatics frameworks. Thus, Clarke et al. (2023) suggest using the concept "stratified biomedicalization", as "a framework for examining power relations and

inequities in the processes and outcomes of biomedicalization" and to emphasize the rise of inequalities in access, treatment or definition. Stratified biomedicine centers around "the mutual imbrications of race, gender, sexuality, class, age, and other social categories of difference" (A. E. Clarke et al., 2023, p. 101). Particularly salient in the COVID-19 pandemic, these inequalities in biomedicalization processes are a "defining feature of 21st-century biomedicine and public health" and continue and extend historical patterns of inequity (2023, p. 102). This fits to policlinics, whose critiques ties persisting health inequalities with biomedicalized public health, as described in 4.1.1.

2.1.3. Empowered patients in critical public health

Clarke et al.'s work represents the growing scholarship of critical public health. Another example are Peterson and Lupton who identify a lack of socio-constructivist approaches and critique in PH, nursing or medicine –because these three disciplines portray themselves as "built upon an objective knowledge base unsullied by questions of power" (2000, p. 3). Apart from Feminist-Marxist perspectives on exclusions, insufficiencies in provisioning or "the 'victim-blaming' approach in health education", students not sufficiently engage with the culture and sociology of PH (2000, p. 2). Furthermore, researchers have underemphasized the critical and theory-informed perspectives or epistemological analysis of knowledge, "principles, discourses and practices of public health" (Petersen & Lupton, 2000, p. 2). They analyze how 'the new public health', as "an area of expert knowledge and action", comes to be perceived as "antidote to all kinds of problems linked to modern life, particularly problems of the urban milieu" (2000, pp. 1–2). Taking a socio-constructivist approach, they investigate how new PH knowledge and practices are generated, reproduced and based on certain assumptions. The authors particularly look at the significance of risk as a sociocultural concept within new PH, the dependence on the 'rationality' and 'objectivity' of science to manage PH's disorder; the representations of human body, individual subjects, and social groups, and the construction of citizenship through aims and narratives of contemporary PH.

Thereby, Peterson and Lupton follow Foucault's theories of biopolitics and governmentality, arguing that new PH in Western societies figures as "a new morality system", based on modernist oppositions such as "healthy/diseased, self/other, controlled/unruly, masculine/feminine, nature/culture, civilized/grotesque, clean/dirty, inside/outside and rational/emotional" (2000, p. 4). Concurring with Foucault, power is conceptualized as restricting thinking and action through expertise, science and "creating knowledge about the normal human subject" rather than as violence alone (Petersen & Lupton, 2000, p. 4). This new morality and power exercise ties into new citizen duties such as being "expected to take responsibility for the care of their bodies", preventing harm to others and increasingly also "to manage their relationship to the risks of the environment". Referring to governmentality studies, the authors describe this as the emergence of "the entrepreneurial self" in relation to health, disease and associated risks (2000, p. 5). In this new PH paradigm, health is an "unstable property (…) to be constantly worked on", enabling subjects to demonstrate their ability to self-control their body and

govern their emotional expression, making them “a dutiful citizen” and thus “governable” (Petersen & Lupton, 2000, p. 6). Thus, citizenship or civil rights do not only entail rights anymore but implies responsibilities and obligations – not only but significantly in terms of health and disease. This new concept of self for them is “the product and target of 'neo-liberal' forms of rule that employ technologies for 'governing at a distance' by seeking to create localities, entities and persons able to operate a regulated freedom” (2000, p. 5). Thus, this development coincides with a retreat of welfare, an expansion of markets and neoliberal governance.

Here, Lupton and Peterson (2000) emphasize that this discourse on health and self-improvement has a significant gendered dimension. Lastly, the authors critically observe that the city and participation play an increased role in PH policies, at least within WHO. The book by Lupton and Peter (2000) represents only a starting point of a vastly growing research field of critical public health reflecting and scrutinizing PH politics, infrastructures, risk(s), technologies and practices with reference to socio-constructivism, biopolitics and governmentality studies (e.g. Rose, 2007).

Critical scholarship also investigates how patients are increasingly framed as consumers of medical care and medical knowledge, which in turn enables them to become empowered – thus to regain “power, hope, control over one’s own life, independence and the like” (based on Hardey (1999) as cited in Mager, 2010, p. 30). This also ties into Gidden’s notion of the “reflexive self” consciously managing one’s life as a self-directed project (from Giddens (1991) as cited in Mager, 2010, p. 21). These debates about empowered patients, also focus on the doctor-patient-relationship, where patients gain agency, engage in medical decision making and can challenge doctor’s authority due to the digitalization and increased availability of medical knowledge nowadays (Mager, 2010). Thus, the empowered patient is also often referred to as the “informed patient” (Hardey, 1999; Henwood et al., 2003) because being able to access and retrieve knowledge is where the patient’s agency lies – although this equation of internet-based knowledge and actual empowerment or increased patient agency is also critically discussed in the literature (Mager, 2010). This aligns with policlinics’ critique about the hierarchies in the medical system constraining meaningful empowerment of patients and participatory forms of care (4.1.3.)

I have now established that medicine has changed profoundly between mid / late 20th century up until 21st century with an increased focus on prevention, risks–assessment, self-surveillance and patient empowerment (Armstrong, 1995; A. E. Clarke et al., 2023; Green & Montenegro, 2023; Petersen & Lupton, 2000; Porter, 2020). We have also noted on several occasions that changes in public health, medicine and society can never be understood as determined by but as co-constructed together with technoscientific advancements, scientific findings or epistemic changes, socio-cultural-political and historical phenomena (Porter, Armstrong, Clarke). Thus, medicine and PH need to be analyzed and understood as intertwined with broader societal, economic and political developments – which is a central tenant within the policlinic movement as well.

2.2. Marketization and economization of health (&) care

In this second part, I want to focus more on marketization of health care, which the policlinics oppose. I will look at marketization from a STS lens and complement it with feminist economic perspectives – partly because of my own positionality (cross ref) and because policlinics serve as positive example in and refer to feminist debates on (socialization of) care.

2.2.1. Understanding health markets

Clarke et al. (2023) mention the co-production of bioeconomies, biocapital and biomedicine and Lupton and Peterson (2000) describe how the emergence of self-governing healthy un-risky subjects coincides with retreat of welfare state and establishment of new markets under neoliberalism. According to Geiger (2021), marketization of health (care), is a process of three interrelated dynamics:

> *"The gradual defunding of public services, which left healthcare systems with little spare capacity, the increasing privatization of broad elements of the healthcare system, (...), [and] the adoption of market tools, measures, and logics in those domains that remained under public management"* (2021, p. 3)

Thereby, marketization of health care is part of a "a broader historical move toward neoliberal governance regimes across public life" (Geiger, 2021, p. 3). The framing of healthcare as matter of economics, by using "language, concepts and models of neoclassical health economics" has progressed economization of healthcare – informing EU health policies since the end of the 20th century (Bůžek, 2025, p. 4). This "paradigm shift" is described by Nandi and colleagues (2020) as neo-conservatives seizing power across Europe, introducing cost-cutting policies as part of austerity politics. Additionally, a shift towards 'new public management' took place, applying private sector management practices – promising more efficiency –in health care institutions (Nandi et al., 2020). According to Nandi et al., these shifts impact understandings of health but also "how healthcare is rationed for different segments of the population" (Nandi et al., 2020, p. 44).

I will complement marketization and neoliberalism with economization and financialization. According to Caliskan and Callon, economization describes a process ''through which activities and behaviors and spheres or fields are established as being economic'' (from Caliskan and Callon (2009, p. 370) as cited in Chiapello, 2015, p. 14). Financialization describes a "colonialization by specific 'financialized' techniques and calculation methods", leading to "a redefinition of the object being valued (…) from the investor's viewpoint" (Chiapello, 2015, pp. 15, 30). Even politics in areas where very different values are prominent, such as social, cultural or environmental issues, financialized and economic reasoning is spreading and shaping policies. Lastly, Chiapello (2015) explains that this development comes from the need in capitalism "to commodify and marketize more and more activities in order to grow and expand its field of operations" (Chiapello, 2015, p. 32).

The neoliberal restructuring of health care is based on neoclassic health economics, endorsing markets as optimal tools for resource allocation, cost reduction and improvement of quality, although acknowledging problems such as "limited consumer sovereignty" (Bůžek, 2025, p. 4). In these theories, markets balance supply and demand most efficiently and effectively, establishing prices "where value for both parties is maximized" (Geiger, 2021, p. 3). However, for Geiger, health care markets are not ideal markets but rather characterized by market failure. Geiger and Gross (2018) note that healthcare markets are marked by unpredictable demand, low price elasticity driven by essential need, unequal distribution of expertise, and patent systems distorting markets and restricting access for the most vulnerable (as cited on Geiger, 2021, p. 3). Thus, critical scholarship on marketization notes its impact on access to and equality within health care systems (Geiger, 2021; Nandi et al., 2020).

Even in countries with universal healthcare, private actors and markets matter play an increasing role, as behind every medical product or service "there's buying and selling; price-setting; negotiations and procurement; supply chains, research and development (…); and manufacturing" (Geiger, 2021, p. 2). Even comprehensive public healthcare systems can therefore be "marketized in [their] logics and practices" (2021, p. 10). Under neoliberalism, market models extend into multiple areas of public life, configuring individuals as market actors or *homo economicus*, a rationality that individuals themselves may come to invest in (2021, p. 10). As Geiger puts it:

> *"Marketization, in this sense, can lead to a point where the market logic is used implicitly or explicitly to value and evaluate persons, situations, events, choices, or encounters in such terms as return on investment, efficiency, competition, or human capital, to the detriment of other alternative moralities or values."* (Geiger, 2021, p. 10)

More critical and normative than Geiger's assessment, the German medical sociologist Deppe (2010) argues health care fundamentally cannot work as a market and that it *should* not be organized as one. For Deppe (2010), health and illness cannot take on the character of commodities, as health care works different than market goods or services in four distinct ways. First, based on Marxist terminology, health's value is more an existential use value (in contrast to exchange value) and, in most Western societies, it is seen as a collective and public good. Second, individuals cannot choose to be ill or healthy in the way they can choose whether to consume a commodity or not. Third, patients' demand for medical care is non-specific, because patients usually present with symptoms not with a demand for a treatment, which must be defined by medical experts. Finally, patients are situated in conditions of vulnerability, uncertainty, dependency, and need, often accompanied by fear or shame. Thus, the chronically and seriously ill often bearing the greatest disadvantages of commercialized and marketized health care. Thus, Deppe concludes that the universal provision of health care "cannot be reconciled with the mechanisms of supply and demand" (2010, p. 31). Instead, he argues that decisions over delivery and distribution of health care must be made by the state as a (or the only) potentially democratic instrument of society.

Deppe (2010) further challenges the dominant justifications for marketisation, namely rising health care costs. He argues that resource scarcity in health care is not primarily a technical or economic problem but one of distribution, thus ultimately "a question of social choice and political power", even within medical science (2010, p. 32). Treating health care costs solely as a burden on economic development has contributed to a broader conceptual shift: from being understood as a collective response to social risk, health care is increasingly seen as a mechanism that supports private capital accumulation. One consequence of this shift is the increasing influence of economic considerations in medical decision-making. Given that health care is person-oriented, uncertain, and complex, financial incentives, competition, and professional pressures shape clinical decisions consciously and unconsciously. Deppe (2010) illustrates this through examples of unnecessary medical interventions and unequal treatment patterns. The response is, in an industrial mode, is establishing evidence-based-medicine (EBM). However, economic pressures continue to shape clinical practice, also in the public health system in Germany (Bůžek, 2025), as further discussed in 3.3.2.

Another consequence of marketization is the commercialization of the physician–patient relationship. For Deppe (2010), this relationship should be based on trust rather than contract, which arise from mistrust and make up commercial relations. This will affect patient care and leave patients confused. The economic pressure also influences statutory health insurance organizations, which increasingly adopt features of private businesses, including co-payments, differentiated coverage levels, and reimbursement-based payment models – also in Germany. Overall, Deppe (2010) argues that marketisation and commercialization deepen social polarization, not only between countries but also within richer countries, while the social question is being pushed aside and neglected. For Deppe, the argument that health care markets are inevitable and "objective necessities" does not hold, because "economic models are man-made constructs, not conditions of nature" and thus changeable (Deppe, 2010, p. 36). As an alternative, he calls for the protection of non-commercialized spheres based on solidarity, equity, and cooperation. Solidarity, he argues, is historically rooted in labor movements and other politically and economically oppressed groups and means to focus on "common values, (…) common experiences (…) [and] collective consciousness" (Deppe, 2010, p. 37). For Deppe (2010), solidarity represents the central alternative to neoliberal commercialization of health care.

2.2.2. STS perspectives on markets

Less normatively, STS scholars study how infrastructures and practices enact market logics, how markets are *constructed* rather than understanding them as imposed from above or at something to be embraced or abandoned. For Geiger (2021) markets, research and technological advancements within healthcare are co-produced. The increased marketization of PH systems, the rise of personalized medicine and ongoing digitalization of healthcare services are "interlinked to produce a seemingly unstoppable move toward individualization in healthcare" (Geiger, 2021, p. 1). This intersection is for instance discussed in Saukko's work on digital health as the new medical cosmology, examining how

digital health "configures its consumers as 'co-creators' of health data and knowledge" or in growing critical studies of corporatization of health care, called Googlization of Health care (Saukko, 2018, p. 1312; Sharon, 2016). Additionally, STS works study classifications and standardization turning patients and healthcare into something markets can work with, like Timmerman and Berg's analysis of evidence-based medicine and 'rationalized' medicine (Berg, 1997; Timmermans & Berg, 2003). Furthermore, STS literature on health and markets often revolves around the construction of values and the understanding of valuation as performative practice. An example studying both the co-production of markets, medicine and values is Zuiderent-Jerak, Grit, and van der Grinten's (2015) study of 'diagnosis-treatment combinations' (DTCs) as an alternative public health funding scheme in Dutch healthcare. The authors examine the (un)intended effects of DTCs, the work required to make healthcare markets function, and the values enacted through these practices, drawing on Star and Strauss's notion of the visible and invisible work of making markets and Latour's concept of value composition (1999, as cited in Zuiderent-Jerak et al., 2015). With DTCs defining quality primarily in financial terms, cost savings are prioritized while other policy-relevant values are neglected. The authors conclude that, rather than debunking markets, social scientists should focus on improving how public values are composed within marketized governance arrangements.

Works from valuation studies or the social studies of economization and marketization (SSEM) critically engages with financialization of practices, such as health care or other areas. Thereby valuation studies (VS) take a pragmatist standpoint (Dewey (1939) as cited in Chiapello, 2015, p. 16) enabling "to displace analysis of the concept of value towards the concept of valuation" (2015, p. 16). In social studies of economics and markets (SSEM), economy is "an effect of temporarily stabilized arrangements of performances enacted through things and science or market devices and economics" (Bůžek, 2025, p. 4). SSEM can help to identify efforts of framing and legitimizing health care as compatible with markets and allows scholar to critically examine "preformation struggles", seeing them as incomplete and contested (Bůžek, 2025, p. 4).

An example studying valuation in healthcare is Datta-Burton, Kieslich, Paul, Samuel, and Prainsack's (2022) article on "Rethinking value construction in biomedicine and healthcare" including their case study of hospital care. The authors draw on VS to analyze value construction(s), operationalization of values in hospital care and value measurements in hospital reimbursement. Datta-Burton et al. (2022) identify a broader shift towards value-based pricing in healthcare, whereby providers are paid for outcomes achieved and performance improvements, not for interventions performed, exemplified by the US Medicare program 'Hospital Value-Based Purchasing'. This system disadvantages already less-equipped public hospitals, which achieve lower performance scores than private hospitals and thereby may exacerbate existing health inequalities in the US. According to Datta-Burton et al., such pricing systems fail to account for "systemic injustice and equity," a shortcoming characteristic of value-based healthcare (Datta Burton et al., 2022, p. 407). The authors argue that defining health outcomes primarily in terms of cost-effectiveness and economic value is problematic, as

it challenges the "principle of solidarity-based healthcare systems" in "an increasingly profit-driven hospital sector" (2022, p. 408). Instead of narrow value definitions centered around cost-effectiveness and health outcomes, researchers and experts should systematically examine key actors' understandings of values, ask which practices define health values, and how these are measured and governed. Drawing on VS, they warn that taking value as given conceals "different value repertoires" and "the social practices, institutions and infrastructures through which health values are constructed and operationalized, whether top-down or bottom-up" (2022, p. 408). Because valuing is a social practice shaped by context, norms, and stakeholders such as "policymakers, practitioners, patients and publics", the authors argue that this "heterogeneity in value construction" is overlooked when "easily quantifiable and monetized inputs" are prioritized (2022, p. 408). This "discursive advantaging" risks reinforcing existing structural biases (Datta Burton et al., 2022, p. 409). Thus, their work can be considered a call for diversifying values in health care markets – but not as seeing this as an inherent contradiction.

Thus, from my education in STS and from Geiger (2021) I take, that recent technoscientific developments are intertwined with the development of health care markets and negotiations around the collective good and vice versa, understanding markets and technoscientific developments and values as co-produced. VS approaches enable valuable questions about alternative values or how certain assessments prevail (e.g. by being embedded or reproduced in technoscience). VS approaches highlight the importance of not essentializing economic value and acknowledging the context-dependency and heterogeneity of valuations (or assessment of markets for that matter). However, I would like to address the VS/SSEM critique as well and follow Buzek (2025) in supplementing this theoretical approach with feminist perspectives.

According to Weiss (2017), a critique needs to be based on values as well – thus the question is what values the critique within valuation studies is based on. For Weiß (2017), studying valuation(s) should ideally coincide with the strategic demonstration of violence and oppression of weaker actors. Secondly, Weiß asks what the advantage of describing high complexity is. Quite fittingly, they argue that "when the map becomes as detailed as the landscape, it loses its function" (2017, p. 465). What understanding is achieved through VS-inspired approaches apart from "the acknowledgement of the ontological multiplicity and complexity of science and industry: the multiplicity of tropes, the multiplicity of interests in knowledge, and the multiplicity of organizational forms" (Weiss, 2017, p. 465). Lastly, Weiß (2017) argues that one cannot treat values as equally influential – and that the "leveling approach to values" prevalent in valuation studies risks doing so. This is important to keep in mind because:

> *"Economic capital is still and perhaps more than ever the dominant force, not only in the biosciences, as the critique of biocapitalism rightly stresses, but also in our societies at large. Leveling the hierarchies between economic capital and other forms of value, between processes*

of economization and so-called stake-making only plays into the hands of neoliberalism" (Weiss, 2017, p. 465)

I argue that, although it gives important sensibilities, only using the VS or SSEM lens does not fully capture the social circumstances of financialized and simultaneously devalued care as a crisis phenomenon of late capitalism and thus need to be complemented with feminist reproduction theory and feminist political economy. Following Buzek (2025), it is essential to understand the contradiction of value extraction under financialization of health care and the solidarity-based health care system, as it exists in Germany by turning to feminist critiques of economization of health care.

2.2.3. Feminist perspectives on care (markets)

Such feminist-economic debates on care, capital and markets are on the one hand, situating policlinics as possible alternatives, and on the other hand policlinics refer to these debates and see their critique of current health care as intertwined with feminist care debates, as discussed further in 4.1.4 (Fried & Wischnewski, 2022). Moreover, and due to my own feminist convictions, I concur with Buzek's (2025) theoretical approach of combining SSEM perspective with feminist political economy critiques. The author combines SSEM together with heterodox and feminist critiques of economization of health to emphasize two critical points in neoclassical health economics: the hegemony of value efficiency and the externalization of care. For Buzek, the fact that health care systems strive for efficiency – in the sense of "economic use of available resources for the purpose of healing" is not per se a problem – although he also criticizes that there is a hegemony of value efficiency neglecting other values like accessibility or quality (2025, p. 4). With neoclassical health economics, efficiency is not based on needs but turns into "means to achieve primarily exchange value rather than aiming to achieve healing (use value) as economically as possible" (2025, p. 4). This means, efficiency is reduced to profitability-oriented goal of efficiency – leading to value extraction from public health. Based on his case study of private-equity chains in German primary health care, Buzek asks who ensures public or patient's benefit in an increasing financialized health care system following this efficiency-understanding. The second problem in neoclassical health economics is how care becomes an externality thus something external to (health) markets and analytically subordinate or insignificant, rather than a central precondition. Buzek in concurrence with the sociologist Emma Dowling, who works on financialization of elderly care, defines care as "involving the affective dispositions and ethical relations of social reproduction activities aimed at meeting others' needs and enhancing their wellbeing" (Dowling (2022, p. 106) as cited on Bůžek, 2025, p. 4). Therefore, like in the policlinics' view, care cannot be separated from medical practice. However, care or - to account for practice-theory - caring, can be hardly captured in quantifiable metrics – making it a difficult category for healthcare evaluation. This leads to a devaluing of care in neoclassical health economics and due to resource allocations under the paradigm of marketisation, medical professionals' "capacity to care" is restricted (Bůžek, 2025, p. 5).

I will now take a closer look into this contradiction of financial valuing and caring from a feminist political economy perspective. To grasp this theoretically, I will describe how care and social reproduction are understood and how these two get reorganized under capitalism (in crisis). The care debate assumes that people should not be understood as fully autonomous individuals, but rather as constituted through relationships within networks of care and dependence. Thus, care and caregiving labor are continually required and conceptualized as relational process (Aulenbacher, 2020, p. 128). Care research focuses on the concept of relationships in its critique of the idea of the independent individual and the autonomous subject, while acknowledging the difference of social relations and care across time and local context – "from the colonial servant society to the Fordist male breadwinner model to today's adult worker model" (Aulenbacher, 2020, p. 129). Investigating how different care forms arise in relation to institutions and norms, discourses and practices, illustrates how care arrangements and regimes changes interplay with "the functioning of modernity and capitalism and their power relations" (Aulenbacher, 2020, p. 130). For Aulenbacher care research therefore bridge between "ontological considerations of humans (…) and considerations of the institutional and normative, discursive, and practical aspects of care" (Aulenbacher, 2020).

Before defining social reproduction, I want to briefly mention that within feminist theory, whether to use care or social reproduction as term is debated[5]. According to Nancy Fraser, social reproduction processes refer to "a key set of social capacities: those available for birthing and raising children, caring for friends and family members, maintaining households and broader communities, and sustaining connections more generally" (Fraser, 2016). The social reproduction term is often connected to a core argument in feminist theory of capitalism, namely on the "fundamental contradiction in the social formation with regard to social reproduction" (Aulenbacher, 2020, p. 130). Fraser (2016) describes this contradiction as:

> *"On the one hand, social reproduction is a condition of possibility for sustained capital accumulation; on the other, capitalism's orientation to unlimited accumulation tends to destabilize the very processes of social reproduction on which it relies."* (Fraser, 2016)

Thus, Fraser does not only consider this a contradiction inherent in social reproduction under capitalism but "a deep-seated social reproductive 'crisis tendency'" inherent in any form of capitalist society (Fraser, 2016). The current care crisis is part of a general economic, ecological and political crisis – in which the social or care aspect is often neglected compared to economic or ecological dangers. Feminist economic scholarship describes how this contradiction or crisis-tendency always takes different historically specific forms "in the liberal, competitive capitalism of the 19th century; in the state-

[5] For instance, feminist scholars like Haug argue that care research criticizes inequality and devaluation but often fails to systematically analyze the forms of value, commodities, and labor from which this devaluation arises, thus moves to close to reform-oriented welfare state and policy research and away from radical social critique (see discussion in Aulenbacher).

managed capitalism of the postwar era; and in the financialized neoliberal capitalism of our time" (Fraser, 2016).

Works based on social reproduction theory, examine on a "mesosociological level" how "in a structurally careless capitalism, people are still cared for" (Aulenbacher, 2020, p. 131). This caring in a careless society unfolds in three ways: First, care and reproductive needs are both abstracted and disregarded. Second, there is "the appropriation of care and social reproduction", which are "functionalized for the capitalist economic system and the corresponding social order" (Aulenbacher, 2020, p. 131). The third process is the valuation of care and social reproduction through their absorption into capitalist economies, in which these spheres are reoriented toward serving broader economic imperatives like profitability.

Over the last decades, as Aulenbacher and Abraham (2019) aptly describe, care was discovered by "the forces marketization" and with intensive commercialization came an increasing "transnationalisation of labor and politics" of care (2019, p. 535). Simultaneously, care gained traction in sociological debates and other academic debates outside of feminist theory. Additionally, social movements criticizing the care provision regimes, also develop "alternative, community-based forms of caring" – such as policlinics (Aulenbacher & Abraham, 2019, p. 535).

A prominent feminist scholar Gabriele Winker, writing about care and capitalism in Germany (or the German-speaking context) and demanding a care revolution "to build a society organized around the need for care and social reproduction" (Aulenbacher & Abraham, 2019, p. 527). Winker's work is also a civil society initiative, the care revolution network in Germany (Winker, n.d., 2015). According to Winker, Germany is facing a care crisis, in the sense of more care work being needed, e.g. through an aging population, but less time, money and social recognition given for those who do care work – which are predominantly women. The care workers, both paid and unpaid, suffer from overwork, burnout, exhaustion, low wages, working conditions characterized by time pressure and staff shortages. And because unpaid care work is done by women, this exacerbates gender inequalities like lower income, lower pensions and economic dependencies. Additionally, care work is made invisible although being indispensable and the way capitalist societies organizes care work, caring systematically comes under pressure. This care crisis reveals the limitations of a patriarchal system prioritizing growth and efficiency over care. Therefore, Winker (2015) calls for a fundamental redistribution of time, money and recognition and concrete measures such as reduction in working hours, expansion of public care infrastructures and a re-valuation of care professions.

Against this background of feminist scholarship, Fried and Wischnewski (2022), argue that reorganizing social reproduction on a local level is a good way of challenging capitalism. Thus, instead of only fighting privatization, feminists should demand socialization of all social reproduction work – across healthcare, elderly care, education, nutrition, cleaning and childcare:

> *"In many places, alliances are forming to bring important parts of public services back into public hands. After years of destructive privatization policies, it has become clear that these services can no longer be left to the market. It is no coincidence that many of these struggles are taking place in the area of social reproduction. Housing, hospitals, energy supply, and local transport are all infrastructures that are indispensable on the one hand and can only be used locally on the other."* (Fried & Wischnewski, 2022)

Such calls for a transformation towards infrastructure socialism takes both professional and private care into social responsibility and "undermines the foundations of the profit-driven and patriarchal system". Socialized infrastructure could become a new common ground and reinforcing factor for different political fights/ approaches, like feminism, anti-racism or anti-privatization concerns or struggles for good work and social justice (Fried & Wischnewski, 2022).

Fried and Wischnewski (2022) argue that we need is a double de-privatization and a socialization of care. Thus, this entails not merely the elimination of private ownership of hospitals and the market-oriented organization of eldercare, childcare, and domestic services, but above all "liberating" care activities from private regulation within families and households, as well as from historically entrenched gender roles. A socialization of care aims to overcome the gendered division of labor stabilizing binary and hierarchical gender arrangements, by transferring responsibility for care into the collective sphere rather than leaving care work—both unpaid and privatized—to women, where it often undermines economic autonomy and personal development (Fried & Wischnewski, 2022).

Concretely what feminist scholars envision with care socialization is "more daycare centers, community centers, family centers, health centers, care centers, commercial kitchens, youth centers, homeless shelters, etc." (Fried & Wischnewski, 2022). However, this would not mean a state-driven nationalization of all care work, but local care arrangements based on local needs, which must be assessed in the first place. Additionally, this should include the care needs of previously marginalized people, such as health care for migrants without residence permit. Furthermore, while governments should support self-organized and collective solutions in concrete ways, they should do so without exploiting them - contrary to current government practices promoting volunteer work "as a stopgap for inadequate public services" (Fried & Wischnewski, 2022). Instead, care socialization means to redistribute resource to achieve *a good life for all*. This requires not only redistributing and changing the social division of (any kind of) labor and a radical reduction of paid work for care work to be "performed without causing exhaustion" (Fried & Wischnewski, 2022).

One concrete vision for such care commoning or care socialization approaches are caring cities. Fried and Wischnewski (2022) discuss existing examples from the municipalism movement in Spain and Latin America – which I will not describe in detail here. This concept of caring cities combines feminist urban planning, transformative care debates and practices, socializations or democratic

planning calls and a focus on local needs and local decision-making. Thereby, the caring cities movement calls for feminist socialization and "revolutionary realpolitik" (Fried & Wischnewski, 2022):

> *"Every left-wing strategy needs three elements: a critique of the present, a vision of a better future, and concrete proposals for getting from one to the other. The concept of "caring cities" does exactly that and offers a way out of the everyday care crisis: everyone's (care) needs are democratically negotiated and met through public or community-oriented services. Feminist-socialist local politics develops concrete projects that enable a start to the transformation" –* (Fried, n.d.)

Fried and Wischnewski constitute that there are already many existing initiatives in Germany, working towards a socialization of care. They name as example the Care revolution network, labor union strikes in nursing or social and educational services, the Medibüro (described in 4.2.3) and the policlinics' model of community health centers. For Fried and Wischnewski (2022), these existing examples illustrate the importance of collective decision making in public services. Moreover, they argue for the establishment of "a care council" which identifies needs and negotiates interests, acting as "democratic mediation between movements and parliaments" beyond local projects (Fried & Wischnewski, 2022). Although starting off successfully as completely self-organized, such local initiatives need "institutional and financial security (…) in the medium term" to realize the vision of caring cities and socialized care (Fried & Wischnewski, 2022).

2.3. Health care and activism

As these examples of the caring cities movement show, there are already many bottom-up practices and attempts to formulate alternatives to marketization of care. Additionally, in the realm of health and PH, the subchapter 2.1.3 shows the importance of seeing the tension, conflicts and resistance within developments. Following Nandi et al. and Deppe (2010; 2020), the history of PH cannot be understood without studying the role of social movements and social and political fights. Overall, the authors claim that social movements "have played and continue to play a critical role" in shaping health care (Nandi et al., 2020, p. 39). This is mirrored in the following quote by Deppe, serving as a reminder to understand health care and health care systems as socially embedded and as results of ongoing social and political struggles[6].

> *"A healthcare system mirrors a society. (…) It reflects its development and its character. This means that the transformation of a healthcare system implies more than mere technical changes.*

[6] There is a lot of literature on health care activism in the global south in the context of global public health and postcolonialism. However, as my own case study is in Germany, I will not focus on this literature (Campell, Cornish, Gibbs, Scott 2010; Campell 2020). However, I want to acknowledge that the social fights are interconnected, and some policlinic members partly also envision their model on a global scale, including global insurance (I2).

> *Structural change in a healthcare system is in fact always the result of social and political struggles: a given system of health care has always been fought for. (…) But the struggle for a given healthcare system is never finished in a single battle. It is a permanent struggle."* (Deppe, 2010, p. 30)

In the following part, I will now focus on literature discussing struggles, negotiations and strategies in health care activism, first more in the realm of knowledge and expertise and then more in the realm of marketization of health care, as both areas are relevant for analyzing policlinics activsim (as seen in 4.1.2. & 4.2.2).

2.3.1. Challenging knowledge & expertise

Foucault's theory on medicalization and the medical gaze already mentions scientific expertise and knowledge production (Foucault, 1975). In STS, sustained attention has been paid to the process of determining legitimate knowledge and experts – and how these boundaries change and are challenged through (patient) activism. A prominent example is Steven Epstein's (Epstein, 1995)work from showing how in the history of AIDS research and treatment, the boundaries between scientific insiders and lay outsiders were crossed and reconfigured. For Epstein (1995), the AIDS movement transformed biomedical research practices by developing novel strategies for establishing credibility, leading to non-scientist AIDS activists acquiring sufficient authority— 'lay expertise—to influence state-funded AIDS research (Epstein, 1995). This blurring of roles and responsibilities between experts and lay actors departs from conventional models of scientific practice and biomedical knowledge production.

Epstein demonstrates that activists employed multiple, differentiated strategies to gain credibility within biomedical research. Crucially, they did not rely on conventional political pressure alone but "presenting themselves as credible [experts]" while simultaneously "changing the rules of the game" by redefining what counted as scientific credibility (Epstein, 1995, p. 409). This required a significant transformation on the part of activists themselves, having to "undergo metamorphosis" to become a new kind of 'lay expert' (Epstein, 1995, p. 417). The expert activists learned to speak the language of biomedical research while insisting on the legitimacy of non-scientific forms of communication in interactions with scientists. Through these practices, activists became an "obligatory passage point" between researchers and clinical trials, mediating access to research while actively pushing for trials to take place (based on Latour (1987) Epstein, 1995, p. 420).

Another key strategy for establishing credibility involved explicitly linking epistemological and methodological arguments with moral and political claims. For example, activists argued for broader admission criteria in clinical trials—including participants with previous AIDS treatments—claiming that "such trials not only would be fairer, they would also be better science" due to more generalizable data (1995, p. 421). Activists further gained authority by taking sides in pre-existing scientific debates over trial design and by adopting the vocabulary and cultural frameworks of mainstream biomedicine.

At the same time, Epstein highlights tensions generated within the movement itself – whch also applies to policlinics as discussed in 4.3. Internal debates emerged around risks of co-optation and conservatism, fears of becoming "detached from constituencies (…) and seduced by the aura of science", and critiques about expanded access to governmental clinical trials disproportionately benefitting white male activists (1995, p. 424). A particularly significant tension concerned the democratization of expertise: while the movement aimed to disseminate knowledge and foster grassroots empowerment, the emergence of recognized activist experts reproduced a division between "lay expert activists" and "lay lay activists" (Epstein, 1995, p. 429). Activists were thus often torn between commitments to participatory democracy and concerns about scientific progress being necessarily facilitated by hierarchical arrangements grounded in trust and authority.

Based on the AIDS case, Epstein argues that such "new social movements" in medicine must be studied as active participants in scientific knowledge production rather than as passive audiences(1995, p. 430). Drawing on Foucault, he conceptualizes activists as "producers of subjugated knowledges" (429), emphasizing that engaging with science in distinctive ways also reshapes the movements themselves (Epstein, 1995, p. 429). Consequently, AIDS research cannot be understood as a top-down scientific enterprise but requires attention to the "micropolitics of power (…) throughout the cracks and crevices of the social system" (Epstein, 1995, p. 411). This example is particularly relevant for my case study on policlinics, which seek to make public health, (urban planning and) medical decision-making participatory and democratic, thereby raising critical questions about the limits, enactment, and consequences of democratizing expertise and medical authority.

A more recent work on health care activism is Campell and Cornish's special issue on critical public health. The authors start out with emphasizing how COVID-19 has exacerbated health care crisis, particularly reinforced inequalities in countries of the global north. The authors focus their special issue on different and neglected forms of critical public health activism, being more "subtle, and slow-acting" than the "stereotype of noisy public health campaigns" as in Epstein (1995) (Campbell & Cornish, 2021, p. 125). For the authors, critical public health activism is "any attempt to redistribute power in ways that create more health-enabling social environments", enabling previously disadvantaged groups to gain greater control over their health and well-being, referred to here as health-related agency (Campbell & Cornish, 2021, p. 125). Although such social movements, "often referred to as transformative, emancipatory or radical", are considered "gold standard" in critical public health, there is a growing body of research criticizing "a 'one size fits all' template" for studying such activism (Campbell & Cornish, 2021, p. 126). Social change is not understood as "planned, linear strategy" anymore and "blueprints" of definitions, criteria and evidence for a successful impact of activism are challenged (2021, p. 126). Based on this, the authors start out with a new conceptual toolkit could emerge, changing the "being, seeing and doing in critical public health theory and practice" (2021, p. 128). Therefore, they look at 1) how current social conditions impact traditional social movement, 2) how "bottom-up public health activism" are emerging amid contemporary political changes and 3) what forms of collective

agency arise and how they are shaped by current political environment, reassessing and discussing theories of social change and collective action.

Two papers in the volume are of interest for the case study of policlinics. The first, by Ribero-Almandoz and Clau-Losada (2021), looks at health activism against austerity measures in Spain and UK. Drawing on theories of scale, the authors understand the activists' strategies as 'multi-scalar movements', consisting both of "scaling up" and "scaling down" (based on Swyngedouw (2004) as cited in Ribera-Almandoz & Clua-Losada, 2021, p. 182). The former describes practices aiming at "organizing at higher scales and building networks across them", like statewide campaigns and international movements (2021, p. 184). The latter means "'localizing' the spaces of engagement" to "give voice to local communities or to organize place-based actions" (2021, p. 184). Health activists are 'jumping scales' to "relocate collective agency and to challenge commodification in healthcare policies and services" and to find new strategies for resistance and contestation (2021, p. 183). The authors note that scaling allows activists to fill "the inter-scalar gap between local, everyday life spaces and broader political, socioeconomic and cultural processes" (2021, p. 190). Furthermore, they highlight the importance for health care activism to build and strengthen community relations with downscaling practices, centering around local needs and demands. The scaling processes are described as experiments with "grassroots organization, collective deliberation, and horizontal decision making" and important factors for the establishment of alternative collective narratives (2021, p. 190).

However, multi-scalar strategies also have limitations (figure 2). For instance, networking with other organizations with differing goals, alliances, and tactics may produce internal tensions and challenge collective unity. For instance, some local groups choose to forge closer ties with trade unions, while others embrace more overtly "disruptive tactics" (Ribera-Almandoz & Clua-Losada, 2021, p. 190).

Table 1. Summary of the main opportunities and risks of social struggles' rescaling practices.

	Social struggles scaling upwards	Social struggles scaling downwards
Strengths and opportunities	Construction of trans-local networks of struggle. Trans-scalar diffusion of knowledge, experiences, ideas and discourses. Gain visibility and influence.	Develop distinct contextually based, territorially embedded campaigns. Generation of local networks, alliances and solidarities rooted in everyday community relations.
Weaknesses and threats	Need to find commonality in demands. Increase in the costs of participation can overshadow certain viewpoints.	Difficulties of adapting to multiple local contexts. Excessive action diversification and over-fragmentation.
	Difficulty of maintaining a complex multi-scalar strategy.	

Figure 3 - Summary of advantages and disadvantages of scaling practices by activists from Ribera-Almandoz and Clua-Losada (2021), p. 184

Overall, the authors conclude that such scaling practices require time and resources and "heterogeneous movement cultures, ideologies, and material needs" can therefore generate tensions and internal conflicts within the movement (Ribera-Almandoz & Clua-Losada, 2021, p. 185). This article provides fruitful concepts for my analysis as it engages activist groups challenging commodification of health care and fostering collective agency both on local and wider level which fits to the policlinics as well.

The other article relevant for this case is about a specific type of health care activism, clinician-led evidence-based activism (CLEBA) by Pushkar and Tomkow (2021). To understand this subtype, I will review evidence-based activism (EBA) first. Originally formulated by Rabeharisoa, Moreira and Akrich (2014), it builds on evidence-based medicine and case studies of Alzheimer and ADHD patient activism. EBA helps to capture how patients and health activists prioritize knowledge production and knowledge mobilization:

> *"[In] contrast to health movements which contest institutions from the outside, patients' and activists' groups which embrace 'evidence-based activism' work 'from within' to imagine new epistemic and political appraisal of their causes and conditions"* (Rabeharisoa et al., 2014, p. 111)

As in Epstein's work, the activists' focus lies on access to treatment and upstream questions of diagnosis and disease definition. With EBA, patient groups nowadays are "active contributors to methodological and research questions" (Pushkar & Tomkow, 2021, p. 236). Thus, knowledge is more than a resource for patients: it becomes the goal of activism because "knowledge and the collective negotiation of what counts as such" are central in healthcare systems and governance (Rabeharisoa et al., 2014, p. 114).

Coming back to Pushkar and Tomkow's (2021) critical analysis of clinician-led evidence-based activism based on two UK campaigns: against privatization and against charging forced migrants for healthcare. This activism draws attention to structural inequalities and is often delegitimized by political opponents. In clinician-led evidence-based activism (CLEBA), doctors strategically use their clinical authority to lend legitimacy to their activist partners – the "loony left" who fight against privatization and the "exhausted and powerless migrants" (Campbell & Cornish, 2021, p. 127; Pushkar & Tomkow, 2021, p. 237). This CLEBA reinforces clinicians' authority even as it supports marginalized groups, reproducing a hierarchy of legitimacy rather than dissolving it. Or as Campell and Cornish describe it: "unintentionally and somewhat ironically re-inscribing medical power in the process" (2021, p. 127). Thus, while EBA sought to redistribute legitimacy, CLEBA may instead reinforce hierarchical forms of legitimacy privileging clinicians.

These two concepts are interesting for my own case, as doctors also work in the policlinic movement and more importantly, policlinics also aim is to collect evidence for their alternative model, such as in their research project Navigation (see 4.3.3). However, different to EBA cases evolving around specific diseases, policlinics are a broader social movement aiming for changes within public health. From Pushkar and Tomkow (2021), I take their nuanced approach to the term legitimacy, arguing that challenging knowledge production is only seen as legitimate if it stays within norms – norms which in turn are shaped more strongly by those with power and influence.

2.3.2. The Triangle of state, market and civil society

Building further on the last case studies mentioned, I will focus more on health care activism regarding marketization of health care. Nandi et al. (2020) argue that due to diversity of privatization efforts, resistance against also takes different forms - globally and within Europe. What often unites the different movements is a critique of commercialization, understanding themselves as grassroot movements and referring to social determinants of health as well as Health for all (2020, p. 40). All these aspects also apply to the policlinic movement in Germany (see 4.1).

Based on Nandi et al.'s case, the People's Health Movement (PHM), a global network of local organizations united against commercialization of health care and with different strategies (Nandi). As already mentioned, resistance against neoliberal reforms can be "evidence-based critiques of commercialization", based on monitoring practices (2020, p. 46). Other types are campaigns or mobilizations targeting health care legislation or working conditions, such as with strikes against understaffing in Germany. A third type for Nandi et al. are solidarity clinics in Greece, discussed in the next section, as examples for "health activists and workers (…) [coming] together to provide healthcare (…) on the local level" (2020, p. 45).

The PHM in Europe undertakes initiatives to align these different efforts and to build broad alliances with other social movements and "affected communities" (Nandi et al., 2020, p. 47). This enables the PHM to generate robust resistance to neoliberal policies across multiple levels – similarly to multi-scaling practices (Pushkar & Tomkow, 2021). For Nendi et al., although movement face repression, such examples show that "an alternative to commercialization of health can still be imagined" (47) – highlighting the importance alternative imaginaries within (healthcare) activism (2020, p. 47).

An important contribution to debates on activism against marketized healthcare is Geiger's special issue concerned with the role "civil society and activists [play] in defining and defending the collective good in healthcare" when this good is strongly "shaped by market dynamics" (2021, p. 1). The need to study these negotiations becomes especially visible when market failures occur, such as drug shortages or conflicts over vaccine patents during the COVID-19 pandemic.

Geiger defines healthcare activism as "political and pragmatic action aimed at criticizing and/or achieving change in the status quo of research, practice, and market structures in the healthcare domain" (2021, p. 2). She prefers the term activism over social movements to emphasize the precariousness of such work, and stress that activism occurs outside and within institutions or markets. While earlier studies, such as Epstein (1996), focus on how scientization of activism, Geiger emphasizes how healthcare markets "trigger certain types of healthcare activism", while acknowledging the intertwining of markets and technoscientific developments, since "a certain kind of science always presupposes a certain kind of economic governance" (2021, p. 4). This co-production of scientific developments, economic and social orderings, and healthcare activism is central to my own analysis. Additionally, the boundaries between public/activist and private/market interests have become increasingly porous:

> *"What used to be seen as 'hostile worlds'—those of private firms and those of civil society and activists, so acutely opposed for instance in the early days of AIDS activism (Epstein 1996)—have arguably become more and more entangled with the biomedicalization of healthcare"* (Geiger, 2021, p. 14)

Based on this entanglement, activists' conceptions of the collective good may be engulfed by market logics and rhetorics, or "enmeshed in the economic functioning of the market" (15), making activists no longer a threat to markets (Geiger, 2021, p. 15). Marketization weakens alternative conceptions of public life and social exchange. For instance, personalized and data-driven medicine with neoliberal prevention paradigms and a "rhetorical trajectory from patient empowerment to fully individualized consumer choice" sideline solidarity-based and activist approaches addressing the socioeconomic causes of diseases (Geiger, 2021, p. 14). Based on this and challenging the market–moral dichotomy, activists cannot position themselves outside the market. Instead, those seeking to embed their visions of the collective good within market governance structures "walk a moral tightrope" (Geiger, 2021, p. 11). Engaging with market moralities entails a constant risk of co-optation and of reinforcing the market as the primary institution responsible for the collective good. Yet such compromise may also be "the only route to achieve change in a world where alternatives to the neoliberal order have become almost unthinkable" (Geiger, 2021, p. 11).

Geiger proposes a continuum of healthcare activism, ranging from invited activists, enhancing the moral legitimacy of market institutions, to tolerated activists seeking to improve or tame markets, and deviant activists rejecting market rationality altogether and maintaining a "hostile" relationship with it (2021, p. 15). While invited and tolerated activists consciously pursue change from within the market, for Geiger, the most "provoking" activism is refusing the market-based production of the collective good entirely, pointing to alternative economies (2021, p. 15). Nonetheless and rather pessimistically, Geiger suggests that the expansion of personalized and data-driven medicine will strengthen markets further while shrinking spaces for negotiating the collective good, making invited and tolerated activism more likely.

In terms of analyzing health care activism, health care activists' vision of the collective good, meaning "what is 'moral' or 'right'", can stay implicit in practices, in "the discursive and/or embodied negotiations" within the collective (Geiger, 2021, pp. 5, 7). This is important for my own work – as I will try to dismantle the policlinics' envisioned collective good in healthcare, how they realize it through practices and what tensions arise. For Geiger (2021), negotiations of the collective good can concern the economic organization of the good, including its innovation, valuation, and distribution. With this active and dynamic conceptualization of collective good, she deemphasizes the question of property.

Geiger's continuum of healthcare activist is useful for policlinics case. I will keep her warnings not to see health care activism per se as 'morally better' or something that necessarily leads to improvements in mind. However, I would add the role of governments (local or national) and how

activists relate to the state *and* the market as a third dimension for Geiger's continuum of healthcare activists.

Like Geiger's (2021) argument on tolerated and invited activists being important because they contribute to markets conceptualizing a more diverse collective good – other scholars call for more participation and engagement of civil society to solve problems such as the current health care crisis, sometimes by framing is alternative model(s) of local (and social) innovation (Moulaert et al., 2005; Prainsack & Wagenaar, 2021). Prainsack and Wagenaar (2021) ask how COVID-19 crisis has shaped the social, economic and political forces underlying the practices of activists, the market dynamics in health care and the conceptualizations of collective good. This article is interesting because it argues that civil society regains importance due to changing solidarity forms and that we need a new model of government for a moral landscape post-COVID-19. For the authors, more participation – meaning people who need and use health services and goods take on provisioning and control – is needed (Prainsack & Wagenaar, 2021). The state should function merely as supporter for this participation and reconfiguration of control, as "promoter and steward of the collective good" – not as sole provider (2021, p. 232). The authors argue that current political-economic systems cannot be part of an improved provision of services like healthcare, highlighting the need for reform and a new model of governance. According to the authors, civil society is an important but neglected stakeholder with potential to turn around the health care crisis. Civil movements are "incubators of creative solutions", working pragmatically and problem-oriented and fulfilling a major monitoring role (2021, p. 231). In an optimistic vein, the authors argue that civil society shapes political agendas by pressuring governments and businesses to deal with social problems. Additionally, such civic movements teach democratic skills. Overall, they argue that besides increased participation, health needs to be reframed not individualized but in collective terms and in its social dimension. This reframing task is a collective one – for citizens, politicians and other decision-makers[7].

2.3.3. Grassroot and alternative health care infrastructures

In debates on how to solve the multiple crisis in our contemporary societies, grassroot activism and concepts of commons and care communities, like the feminist project of Caring cities, are gaining traction (De Angelis & Harvie, 2014; van Dyck, 2019). Such commons – according to Dawney, Kirwan and Brigstocke are "spatio-temporal and ethical formations that are concerned with ways of living together that resist the privatization and individualization of life" (Dawney et al., 2015, p. 2). Commons both in political practice and scholarly debates are seen as possibilities for societal transformation (Asara, 2025). Based on this definition, I argue that policlinics can be considered as health care

[7] The ambiguous role of civil society in the triangle with market and state is discussed more critically in Aulenbacher et al. (2018, p. 520) as process of third way marketization: "the role of the state is ambivalent in regulating and deregulating markets and encouraging or restricting civil society's initiatives; civil society's engagement can be captured by the market and the state; the state is reorganized under the auspices of the market". The role of civil society is further discussed in the section on commons and their ambivalence (3.2.3.).

commons. In this last section, I will discuss two European examples of grassroot health care activism evolving around communities or commons and resembling policlinics. Lastly, I will review the only academic paper I found engaging empirically with policlinics.

Sanchez (2023) analyses the Athens Community Policlinic and Pharmacy (ACP&P) which is, together with the policlinic syndicate, part of inosc (International Network of Social Clinics (INOSC), n.d.). The ACP&P provides free health care services, drugs and social and psychological counselling for Greek nationals and migrants – enabled through financial support by political parties, voluntary work and donations by neighbors. For Sanchez (2023) such new, diverse and transformative infrastructural configurations are experimenting with alternative provisioning of social and material needs. Positioning this policlinic as "emerging infrastructural configuration", these civil activists are "infrastructuring care through commoning" (2023, p. 2456). This infrastructuring comes from the scholarship on the role of the grassroots in infrastructural reconfigurations in cities. Infrastructures are considered "sites of continuous political negotiations among different actors" and engaging with it is a way of "performing agency and yielding change" (Sanchez, 2023, p. 2459). With "infrastructural reconfigurations" broader socio-political paradigm(s) can be challenges and changed (based on Dalakoglou (2016) and Dalakoglou and Kallianos (2018) as cited in Sanchez, 2023, p. 2457). Engagement with and composition of infrastructures is already an act of political agency and yields change (at the local level). Infrastructures are always tied to collective imaginations and have a political dimension because they are linked to specific ideas of political participation and citizenship – in this case imaginations of an alternative social reproduction. Because these Greek solidarity initiatives' engagement and re-composition of infrastructure happen through evolving around care and establishing collective agency – they are more transformative and sustainable. Furthermore, the author positions the social clinics as part of an infrastructural paradigm shift in the realm of social reproduction towards "people-driven initiatives and movements" (Sanchez, 2023, p. 2459).

Additionally, for Sanchez (2023), this grassroot infrastructuring practice is bridged with Feminist-Marxist theories on social reproduction, care and life sustenance in capitalism. Thus, the social clinics figure as *care commons* (2023, p. 2458). They challenge "the modernist infrastructural imaginary in the West" replacing modernist values (connected to centralized infrastructure) with relationality, conductivity, care and repair, thereby enabling transformative politics "amidst crisis yet against crisis regimes" (2023, pp. 2466, 2470). In contrast to centralized institutions, grassroot infrastructuring is more flexible and "more porous to power re-adjustments and re-arrangements" and can accommodate emerging local needs (2023, p. 2459). Furthermore, grassroot infrastructuring contributes to a re-politicization of social, material needs and to increased participation, bringing back collective and political life to often neglected and deprived neighborhoods. This contributes to delegitimization and contestation of politics during crisis and the underlying values like progress, centralized control and homogeneity.

Sanchez identifies two essential elements for solidarity projects: their ethics of care and their infrastructuring of social networks. Firstly, the social clinics are spaces where the "personal relationships and affects prevail over pre-established rules" (Sanchez, 2023, p. 2470). Thus, affect and affective labor are fundamental for social movements' infrastructuring, decision-making and management procedures. This includes for instance taking time to care for one another outside the official roles and tasks and sharing "a chat or a (…) tea" (2023, p. 2467). Secondly, next to inosc, the social clinics are part of a wider solidarity grassroot network in Greece which has also been described as "decentralized infrastructural system" or the "hidden welfare system" (based on Rakopoulos (2016) in Sanchez, 2023, pp. 2467, 2468). The care commons' spatial and social networking activities, the alliances and ongoing relation-making provides them with "endurance and agency" and "self-protection and care", increasing their political power (2023, pp. 2468, 2469).

However, such initiatives are often temporary and prone for internal structural, organizational, ideological, organizational or personal conflicts – such as on the question of how to relate to the state and the third sector. Foregrounding personal relationships and affects can lead to conflicts around power imbalances and injustice. Additionally, such care commons are no guarantee for "democratic or sustainable modes of social provision" in the future nor for necessary transformations of capitalist structures (Sanchez, 2023, p. 2471).

Another case study on care commons is Smit's work (2024) on a caring community in a Dutch village, faced with a shrinking population, institutional failure and private companies pulling out of care services due to lack of profitability. As response, a cooperative was funded by the locals, taking ownership of a previously privately owned care center, turning it into a communal care center for disabled people, pensioners and preschool children. Such developments are part of the broader so-called community turn and as "caring community" were supported by national government (following Macmillan & Townsend (2006) in Smits, 2024, p. 949).

Smit studies how emergent care commons are (re)produced in practice and how a communal infrastructure is cared for and sustained in practice, focusing on often neglected materiality and infrastructure in commons and taking a more-than-human approach to commons. Smit is turning the famous sentence by Federici – "no commons without community" – around to stress the importance of infrastructure for commons: "no commons without infrastructure" (based on Federici (2014, p. 229) in Smits, 2024, p. 962). Taking a relational approach to commons, Smit does not presuppose community nor the shared things of commons as given or stable entities (following Gibson-Graham (2016) as cited in Smits, 2024). The author argues that both this scholarship as well as her case study show how "communities and their commons are formed in dialectic process" (Smits, 2024, p. 951). For instance, by tracing a controversy within the care community, Smit emphases how not all members relate to and care for the commons' infrastructure alike. Based on the uncommons concept, Smit describes the shared things in a common "may be an object of divergence (…) [and evoke] (…) a heterogenous 'we' and diverging ways of relating to [shared things]" (based on by Blaser and de la Cadena (2018) as cited in

Smits, 2024, p. 952). Although I do not focus on infrastructure or maintenance, this relational approach and the uncommons made Smit's work an interesting case.

Both the caring communities in the Netherlands as response to unprofitable elderly care in rural areas and the solidarity clinics in Greece as response to a cut-back and inaccessible health care system exemplify the broader trend of new grassroot health care infrastructure and care commons emerging in crisis-affected and neglected places. Furthermore, they show that commons and infrastructural reconfigurations in social provisioning are not just an urban phenomenon, but like policlinics, also being planned and built in rural areas (Poliklink Syndikat, n.d.-a).

This literature review end with the only academic paper engaging empirically with the policlinics in Germany. Buzek and colleagues from field of critical urban geography, analyze urban health initiatives working in a "participatory, self-organized, structural or patient-related way, beyond the private and public institutionalized healthcare system" (Bůžek et al., 2022, p. 42). They describe policlinics and similar projects as working upstream, starting out at the source of the problem - social inequality. Focusing on the spatial dimension, such initiatives examine how health and illness are embodied unequally but in "concrete and site-specific terms and with spatial impact" (Bůžek et al., 2022, p. 41).

Building on the global health and medical anthropology scholarship describing health as produced in interaction and relation to political-economic structures, Buzek et al. (2022) argue for moving beyond the dualism of the social and the spatial and for a more-than human approach to health and illness including the environment. The urban health initiatives illustrate the importance of such a relational understanding of health and illness but also of space itself. The space, the local neighborhood is the starting point for the political and participatory work of community health centers like policlinics. It is where "illness producing conditions are experienced and embodied in daily life" and where these conditions can be addressed and changed (page). Thus, community health centers politicize health on a local and spatial level, referring to broader socio-economic inequalities and highlighting structural causes for seemingly personal problems. Focusing on a concrete space, helps health initiatives to not loose people in abstraction Additionally, Buzek et al. foreground the activists' knowledge production in a participatory manner, based on policlinics' 'Verhältnisprävention'[8] (as discussed in 4.2.4). Buzek et al. describe urban health initiatives as having a "loudspeaker function" – collecting knowledge locally and then turning it into political demands in a collective manner and contributing to the neighborhood's empowerment (Bůžek et al., 2022, p. 63).

[8] Can be translated to prevention of conditions and I will from now on I will use the German term "Verhältnisprävention".

3. Research Approach

3.1. Research Questions

The literature review described different activisms against the growing importance of markets in health care and medicine (Campbell & Cornish, 2021; Geiger, 2021; Nandi et al., 2020). Since community-centered political movements and grassroot solidarity-based initiatives, often times categorized as commons, are gaining traction, there is a growing need for examining such imaginaries and practices and their contradictions and challenges (Geiger, 2021; Sanchez, 2023; Smits, 2024). Although health (care) activism is well studied, there is scarce STS literature engaging with health care *commons* as counter-model or counter-narrative to marketized, biomedicalized and neoliberal health care systems and almost no literature on policlinics in Germany. Thus, policlinics' health care activists figure as interesting case study to understand emerging health care commons and their alternative visions and practices.

My thesis thus continues the tradition of examining health and medicine activism as entangled with political, social, moral and scientific negotiations (Campbell & Cornish, 2021; Epstein, 1995; Geiger, 2021; Porter, 2020). From the literature above, I identify several tensions of working against and with an existing system to achieve change, managing this "moral tightrope" of doing activism with and against markets (Geiger, 2021, p. 11). Activists might use different strategies, such as establishing themselves as knowledge producers and legitimate actors, using scientific evidence to achieve their aims or even the authority of doctors to enhance the legitimacy of their (political) aims (Epstein, 1995; Pushkar & Tomkow, 2021, Rabeharisoa et al., 2014); or creating both global and local networks in multi scaling practices to enhance their political agency (Ribera-Almandoz & Clua-Losada, 2021). Another strategy might be to engage in bottom-up infrastructuring their alternative vision outside of science, state and market, like in Greece, and focus on social relations, care and community as counter values like other commons (Sanchez, 2023; Smits, 2024). Against the background of these tensions and strategies, I formulate the following research questions for the case of policlinics:

MQ: *How do policlinics position themselves as counter-model to current health care and through which alternative imaginaries and practices do they envision and develop health care commons?*

SQ1: *How do policlinics (re)imagine health, care and community in their counter-model?*

SQ2: *What are the policlinic's strategies to realize their counter-model? How are their imaginaries negotiated, modified and put into practice as health care commons?*

SQ3: *What are tensions and challenges for policlinics and how do they deal with them?*

My main question is how policlinics understand the problems to which they see themselves as the solution or alternative to, thus how they 'counter-imagine' and counter-act' biomedicalized and marketized health care (Mager, 2023). With my research, I study the policlinic's imaginaries, but also

their current practices through the lens of counter-imaginaries, radical imaginaries and (health) care commons. I will describe these three theoretical sensibilities in the next section. My first sub-question focuses on health, care and community (re)imaginations and is based both on the above discussed alternative understanding of health in policlinics, and on existing health care commons centered on social relations and care (Smit, Sanchez), thus my theoretical sensibility of commons, but also on the concepts of counter- and radical imaginaries in activism(Bůžek et al., 2022; Sanchez, 2023; Smits, 2024). I want to understand how exactly policlinics envision their counter-model and what central elements of their critique and alternative are.

The second sub question looks at how policlinics aim to realize these counter-imaginaries, thus looking at their practices of redoing health care and their strategies (Campbell & Cornish, 2021; Geiger, 2021; Pushkar & Tomkow, 2021; Ribera-Almandoz & Clua-Losada, 2021). With such prefiguration, I describe policlinics as health care commons, a central notion for my work which I will further discuss below. Thereby I already allude to the centrality of care, community and participation in policlinics, negotiations and modifications of radical counter-imaginaries and the limitations and tensions of their commoning practices.

The third question then focuses more on the internal tensions and conflicts in commons, reviewed in detail in the next subchapter, but also above-mentioned accounts of diverging imaginaries or practices within activism (Epstein, 1995; Sanchez, 2023; Smits, 2024). I want to identify these negotiations and tensions and how they are dealt with by policlinics. In my analysis, I remain aware of not idealizing activists, seeing them as inherently morally good (or better) (Geiger, 2021). Different to Sanchez (2023), I will not presuppose that policlinics are successfully resisting markets and modern imaginaries or making health care per se better (Nandi et al., 2020; Sanchez, 2023).

With this research, I will contribute to debates about how counter-imaginaries can be developed and implemented, how corresponding alternative practices and values are developed and negotiated, and more broadly, what strategies are available to social movements in the health sector (or other technoscientific fields) to achieve social or political change. Furthermore, my case study on policlinics is concerned with the question in how far community, care, participation and solidarity-based alternatives, such as commons, can be (successful) answers to an increasing neoliberalisation of health. Therefore, my work also ties into feminist-economics debates on how far care can be the antidote to capitalism and how (health)care and market are contrary and/or compatible. What drove me to this case, was the question of what needs to change and how commoning activism may contribute to that but also whether policlinics, or health care commons more generally, can be considered as transformative as claimed by Buzek (2022). Thus, I want to bridge STS with these debates on commons and socio-

ecological transformation as I believe there could be more fruitful connections between them, since these questions gain urgency and relevance in our times of crisis[9].

In line with Lehtiniemi and Ruckenstein (2019) aims for data activism, but by studying policlinics imaginations, I want to move beyond obvious critiques, and contributes to formulating health futures and maybe, ultimately by constructively deconstructing their imaginaries, contribute to making health care activism more sustainable. By analyzing policlinics, I want to contribute the overall debate on what kind of activism and changes in healthcare is needed to improve health inequalities. As Aulenbacher and Abraham argue, the role of sociologists[10] in times of transformation or contestation of capitalism is "to question and explain the causes, the contradictions and forms of contestation that underlie economic, social and political developments and relations" (2019, p. 541).

3.2. Theoretical sensibilities

I combine three theoretical sensibilities in this thesis to capture the phenomenon of policlinics. First, the concept of counter-imaginaries from STS and secondly, radical-imaginaries from scholarship on post-neoliberal activism will inform my analysis of policlinics' visions (Asara, 2025; Haiven & Khasnabish, 2014; Kazansky & Milan, 2021; Mager, 2023). Additionally, I take concepts and sensibilities from the commons literature, including STS perspective and case studies on housing commons, as I argue that policlinics can be understood as a form of health care commons against neoliberal and biomedicalized public health.

3.2.1. Counter-Imaginaries

STS scholarship is known to critically analyze future visions entangled with technological advancements, scientific research or infrastructure projects – so-called sociotechnical imaginaries (STIs) (Jasanoff, 2015; Jasanoff & Kim, 2009). Jasanoff and Kim define them as "collectively held, institutionally stabilized, and publicly performed visions of desirable futures, animated by shared understandings of forms of social life and social order attainable through, and supportive of, advances in science and technology" (2015, p. 4). STIs encompass more than e.g. narratives, visions, framings or other policy analysis or political theory concepts as they are entangled with their enactment and performance, thus experiments, demonstrations or practices (Jasanoff, 2015). As Jasanoff describes STI as "interplay between positive and negative imaginings (…), between utopia and dystopia", the desirable vision "correlate, tacitly or explicitly with the obverse" (2015, pp. 5, 4).

Initially STIs was employed to study large-scale processes, often in national contexts, and recently scholars have complemented this with studies on commodified, contested and multiple imaginaries instead of linear and state-driven (Mager & Katzenbach, 2021). Thus, it is not only the

[9] Of course, transformation can mean different things and these debates are broad and diverse, for an overview see:

[10] and although this is an STS master thesis, I think this applies as well

vision of experts, scientists or policymakers but the private sector or activists like patient groups also (re)frame technologies and science to shape political agendas[11] (Epstein, 1995; Jasanoff, 2015; Jasanoff & Kim, 2009; Mager & Katzenbach, 2021). The case study by Mager (2023) on European search engines shows how visions entangled with values, new sociotechnical practices and alternative infrastructures and technologies are employed to counter-imagine and counter-act hegemonial technology projects. Kazansky and Milan (2021) use the concept of counter-imaginaries (CIs) to examines how civil society makes sense of and responds to increased datafication. The counter-imaginaries represent a form of sense-making by making threats like surveillance thinkable. Additionally, the counter-imaginaries' mobilizing function is important as they help with "making publics" and "rallying people" (based on Maress (2012) in Kazansky & Milan, 2021, p. 367). However, Mager's case (2023) also shows how such alternative projects and their scaling-up processes are characterized by difficulties, trade-offs and value pragmatics. This means, alternative projects make tradeoffs between ideology, feasibility and scalability to become sustainable. Over time social values change, allowing the project to grow beyond "communities of practice" (based on Wenger (1998) in Mager, 2023, p. 3). Thus, the concept of counter-imaginaries suits my case study, as the policlinics' imaginaries operate on a smaller, community-driven scale than large, societal STIs.

Scholars have shown how within activist groups different sometimes overlapping or contradicting imaginaries can be at play. In Lethninmi and Ruckenstein's (2019) case of data activism, they describe how activists move between a sociocritical and technological imaginary. Their "alternative social imaginaries" are tied to different social aims like social justice and political participation, leading to a new collective knowledge-production (based on Baack (2015) in Lehtiniemi & Ruckenstein, 2019, p. 2). The authors look at materiality, knowledge production and practices to not study imaginaries as vision alone.[12] Furthermore, the different imaginaries they identify, shape how activists relate to the project and infrastructure envisioned differently (like in Smits (2024) and this may lead to certain tensions (Lehtiniemi & Ruckenstein, 2019). Identifying such tensions is crucial – because it enables a "productive way forward", "[reworking] different social imaginaries (…) into a shared dialogue" (2019, p. 2). Such a constructively-pieced-together critique provides activists with "a robust enough conceptual ground for advancing the public good" and make their projects and their collectively imagined (data) future more sustainable (Lehtiniemi & Ruckenstein, 2019, p. 9).

Lehtiniemi and Ruckenstein (2019) do not use counter-imaginaries but the modern social imaginary concept by Taylor (2003), to examine how activists make sense of society and how through these imaginaries new practices advance. Through alternative social imaginaries and new practices by smaller collectives wider social imaginaries can be transformed (Lehtiniemi & Ruckenstein, 2019; Taylor, 2003). The social imaginary (SI) focuses more on alternative social values, aims and practices

[11] And other groups such as private sector, patient groups etc.

[12] Thus, I would say they manage to strike the balance between "the theoretical poles of abstract idealism and deterministic materialism" like sociotechnical imaginaries scholarship aims to do (Jasanoff, 2015, p. 22).

by smaller collectives, carried "in images, stories, and legends" (Taylor, 2003, p. 106). However, in contrast to the authors' usage, Taylor (2003) argues that social imaginaries are shared by larger groups – making this not an ideal concept for the scale of policlinics (Taylor, 2003, p. 106). However, the question remains whether their different understanding of health and health care might inform new health care practices and infrastructures as in the case of Lehtiniemi and Ruckenstein (2019).

3.2.2. Radical Imaginaries

I will complement counter-imaginaries from STS with the radical imaginaries concept from scholarship on activism because I believe this combination better captures policlinics prefguration and structural critique. Furthermore, it bridges STS scholarship on counter-imaginaries in activism with commons literature. As outlined in chapter 5, and by combining these two concepts, I conceptualize policlinics as radical counter-imaginaries. Radical imaginaries (RIs), individual or collective, are "informed by the understanding that social, political, economic and cultural problems are outcomes of deeply rooted tensions, contradictions, power imbalances, and forms of oppression and exploitation" (Haiven & Khasnabish, 2014, p. 5). Radical imaginaries in social movements are not steady or coherent, but activists develop a "common imaginary landscape" animated by their dialogues, conflicts and tensions (2014, p. 7). Scholars examining activism and related understandings and transformations of society and the role of social movements use the concept of radical imaginaries (Asara, 2025; Haiven & Khasnabish, 2014; Khasnabish & Haiven, 2012). An example for this is Asara's (2025) study of the three interrelated imaginaries of commons, autonomy, and ecologism in the Indignados' movement in Barcelona. These future visions cannot be separated as one cannot be achieved without the other. All of them reconceptualize the public in a post-neoliberal way (Asara, 2025, p. 160). For Asara, these radical imaginaries are not "immune" against contradictions – instead this makes the projects possible (2025, p. 161). Imaginaries in general are described by Asara as ambivalent "sites of contestation with the instituted social imaginary (2025, p. 145).

As opposed to the social imaginaries being an "instituting doing", radical imaginaries are "ex-nihilo representations, affects and intentions" outside the instituted society's social imaginaries and doings (Castoriadis, 2007, p.152 in Asara, 2025, p. 144) and their focus on doing "implies the imagination of the not yet, which doing can actualize" (based on Castoriadis, 1994 & 2007, in Asara, 2025, p. 144). The radical imaginary is formed in "alternative spaces of social reproduction, values and cooperation", in the process of establishing "prefigurative experiments in living otherwise" (Asara, 2025, pp. 145 & 148).

Based on Haiven and Khasnabish (2014), Pötz develops the notion of utopian imaginary to capture the prefiguration as "activist practice of utopian imagination" (Pötz, 2019, p. 136). With utopian imaginaries, community building and storytelling activists can turn resistance into proactivity, create hope, stay motivated and sustainably engage in activism. The prefiguration and the RIs are "important vehicles for social change" (Haiven & Khasnabish, 2014, p. 14). Asara (Asara, 2025) describes radical

imaginaries as a bridging process between diverse imaginations which ultimately leads to a united common imaginary with reshaped subjectivities and everyday lives. These radical imaginaries have significant overlap with the definitions of commons, or commons can be considered a form of radical imaginary (Asara, 2025).

To methodologically and empirically study imaginaries in social movements, it is important to remember that they can be explicitly formulated such as in vision and strategy discussions or manifestos but mostly stay implicit as "unspoken assumptions", best examined using interviews and ethnographic methods (Asara, 2025, p. 145). However, in line with Haiven & Khasnabish (2014), Asara highlights that imaginaries should not be reduced to "cognitive schemata" as they are embodied in social practices which distinguishes them from concepts like frames, values and ideologies (2025, p. 145).

Haiven and Kashnabish do not deem RIs a value statement but rather an analytical category helping to understand how social movements work. Furthermore, they argue that researchers do not need to study what radical imaginations are but rather how they work. Disagreeing with this, I think, it is important to critically assess the imaginaries as their content or effects might not be unproblematic (Haiven & Khasnabish, 2014; Khasnabish & Haiven, 2012). However, this does not mean I want to smash this project in my thesis, quite on the contrary, I am deeply impressed and inspired by policlinics, and I believe they are doing important work. With the aim of investigating potential tensions in policlinics, I concur with Erin Wright's claim about the need for research on real utopias to have a nuanced view:

> *"The temptation is to be a cheerleader, uncritically extolling the virtues of promising experiments. The danger is to be a cynic, seeing the flaws as the only reality and the potential as an illusion"* (Wright, 2011, p. 38)

3.2.3. (Care) Commons

The contestation and ambivalence also plays a role in commons (Asara, 2025) commons represent radical imaginaries, bringing me to my second theoretical influence, the commons scholarship[13]. Similar to radical imaginaries, commons are described ambivalent spaces of contestation and as "prefigurative spaces of resistance" (Dawney et al., 2015, p. 3; De Angelis & Harvie, 2014). Commons are characterized by "flat systems of management and decision making" (…), the "making of alternative worlds" and resistance to neoliberal individualization (Dawney et al., 2015, p. 3). The political language of commons foregrounds promise and hope instead of struggles and builds bridges between different political activists. The common's political languages - despite being problematic at times – are important "imaginary architectures of idylls of collectivization" and "resources for thinking

[13] This is a broad and complex debate – which I cannot do justice when only summarizing it in two paragraphs, so for more details see also: (Blencowe, 2015; Caffentzis & Federici, 2014; Gibson-Graham et al., 2016)

about how to be and live otherwise" (Dawney et al., 2015, p. 3). These imaginations emerging in and through commons are like a romance, but a progressive one because they provide "a counter-narrative to that of the inevitable and uncontrollable force of neoliberalism" – connecting to both counter and radical imaginaries (Dawney et al., 2015, p. 3). With this romance, commons offer hope and assertion about the importance of incremental changes.

However, some scholars in the volume explicitly warn about "the seductive imaginaries of common life ensnaring emancipatory drives" (Dawney et al., 2015, p. 4) and the romanticized narratives of pre-capitalist life. To grasp "the lure and promise" of commons, Dawney et al. urge scholars to critically examining the emergence context, tensions, and reifications of commons, debating their possibilities and limits (Dawney et al., 2015, p. 4). Similar to Geiger's (2021) engulfment into market's rhetorics, Dawney and colleagues are aware that commons' language, ideas and imaginaries might be "tied to and operate through the neoliberalising forces" (2015, p. 2). This is also echoed in De Anglis and Harvis (2014) discussion of co-dependance and co-evolution of commons and capitalism or van Dyck's (2019) analysis of responsibilisation of communities in the neoliberal paradigm.

De Anglis and Harvis describe how commons exist in a "web of antagonistic social relationships in which (…) value practices clash with other value practices", reminding of value pragmatics described by Mager (2023) (De Angelis & Harvie, 2014, p. 291). The ambiguity of "commons-within-capital and commoning-beyond-capital" is nicely described by the authors as "a razor edge" which needs to be negotiated by every movement (2014, p. 291). Despite not all commons being antagonistic to capital, those that are, do "open (…) cracks in capitalism" (Holloway, 2010, in De Angelis & Harvie, 2014, p. 290) and offer the "material base and power of a social force alternative to capital" (2014, p. 291).

Taking this ambivalence of commons further, Van Dyck (2019) sees them as example for a new type of community capitalism. Coming from a governmentality and Foucauldian inspired perspective, she observes a "civilization of the social question", when civil society's unpaid or low paid activities for social tasks beyond state, market and family are increasingly "mobilized by a community ethic" (van Dyck, 2019, p. 279). In times of decentralized social politics and decreased social security, the "'imperative of participation'" and the romance of community become pivotal points of the so-called "community capitalism" characterized by using unpaid work of volunteering as new resource (based on Bröckling, 2005, p.22 in van Dyck, 2019, p. 279). This development happens from above through crisis-driven "politics of omission and cost-saving" from below through a "renaissance of public spirit and community" like in commons (2019, pp. 280, 282). Citizens are then motivated and mobilized to close the emergent gaps in infrastructure and basic provisioning through community-based projects. Based on governmentality and self-governing individuals, van Dyck compares this to "governing through community" (based on Rose, 2000, p.81 in van Dyck, 2019, p. 282). The author outlines both the problems of this development and the hegemonial potential of community capitalism in times of neoliberalism's crisis. For van Dyck, volunteerism can contribute to social inequality and the informalization and precarization of care work under the guise of "community spirit" (van Dyck, 2019,

p. 288). In narratives of community-based volunteering, class differences, inequalities, access, and the precarious implications of unpaid work are de-thematized, while community capitalist projects gain popularity through the "romance of community" promising "homogeneity, immediacy, naturalness, locality and proximity, personal attachment, solidarity and harmony" (based on Joseph (2000) in van Dyck, 2019, pp. 285, 286).

However, this idealization of community as the antipode to capitalist modern society has a long discursive tradition, as the "dichotomy of community versus society" is inherently modern (van Dyck, 2019, p. 286). Because emotions and personal relations are positioned against rationality and anonymity, questions of guilt and duty are rarely addressed; thus, like Dawney et al. (2015), van Dyck (2019) concludes that for such projects to gain emancipatory potential, their problems and tensions must be discussed—a concern also acknowledged by members of the policlinic and in feminist-Marxist debates on commoning care (Braunschweig, n.d.; Fried & Wischnewski, 2022; Gerlof, 2024).

Thus, the reviewed scholarship evolves around the question where the emancipatory or transformative potential and limits of commons lies. Similar to Geiger's (2021) argument on health care activism, they remind me to understand policlinics as commons though not as opposite or antipode to neoliberalism or capital(ism) per se. Van Dyck's (2019) theory serves to me as a reminder to not understand the policlinics in themselves as grassroot but to see their emergence both as top-down and bottom-up process. Additionally, I take a sensibility towards the responsibilisation of community (members) and the risk of caring communities increasing (self-)exploitation, precariousness and social inequality, bringing more nuance to the claim of some authors that caring communities are inherently transformative (Sanchez, 2023; Smits, 2024). This scholarship on commons highlights that social scientist should take them seriously and try to understand them. Again, in accordance with Wright, I argue that despite the potential critique of being too normative, social sciences should "diagnose [real utopias] limitations, dilemmas, and unintended consequences" and "understand ways of developing their potentials and enlarging their reach" (2011, p. 38).

3.2.4. STS perspectives on commons

Lastly, I want to discuss STS perspectives on commons based on housing activism in Vienna (Schikowitz, 2025; Schikowitz & Pohler, 2024). Schikowitz and Pohler (2024) study Baugruppen, collectives building and organizing housing together as response to a growing, unequally accessible and increasingly privatized housing market. Their work gives important theoretical impulses on how to analyze commons, their communality and their relationship to state and market. Different ways of experimenting with alternativeness co-exist, relate to one another *and* to the private and public markets they are entangled with. According to Schikowitz and Pohler, the Baugruppen are "commoning (…) with and against the state and market" – but in different ways depending on the composition of the group (2024, p. 303). Some groups are more about influencing the political agenda to achieve sustainable city and again others are establishing and maintain an autonomous anti-capitalist movement. Despite these

differences, the authors ascribe a transformative potential to all groups as their difference is a virtue not a problem, preventing a "monolithic 'alternative'" as a standardized and universal model for alternative living (2024, p. 318). Thus, for them, ongoing experimentation with varieties of alternatives should be the goal.

The authors understand Baugruppen as 'alternative spaces', where people experiment with utopias in a combination of creation and resistance. Commons activists develop "socio-ethical and counter-cultural practices (…)" to challenge and change "mainstream (…) institutions and discourses" (from Fois (2019, p. 107) in Schikowitz & Pohler, 2024, p. 304). Similar to Sanchez (2023), they conceptualize commons as foregrounding care, social relations and solidarity in their realization of alternative(s), formulating new subjectivities other than homo economicus and establishing collectivity. For them commons hold transformative potential through establishing togetherness and communities (Schikowitz & Pohler, 2024, p. 304). However, Schikowitz and Pohler stress that the "drawbacks, enclosure and co-option" of commons into capitalist logics, the realization of commons and respective challenges remain crucial avenues for closer investigation (2024, p. 303).

Schikowitz and Pohler take a post-structural approach to commons and combine it with and pragmatist sociology sensibilities[14]. For them, building and maintaining commons requires active and ongoing relational work, highlighted with the term commoning (Gibson-Graham et al., 2016; Kornberger & Borch, 2015). This is why my second subquestion focuses on practices of policlinics. Like Smits (2024), this reminds us to not see the community in commons as a fixed identity and gives an awareness for the procedural and ongoing character of enacting alternatives.

In another work on Baugruppen, Schikowitz (2025) focuses on their ambiguous relationship to the municipality and how the groups manage this ambivalence of maintaining both their "alternative and subversive character" and values, resist "pre-framed agendas", while being collaborative and getting involved in urban planning (2025, p. 1). Schikowitz (2025) identifies a scale from uninvited to invited forms of engagement, similar to Geiger (2021). She observes how the groups engage in infrastructuring activities – allowing them to stabilize and enact both their inevitability and their resistance through three aspects: relevance, expertise and reliability. This infrastructuring means "bottom-up practices for facilitating cooperation between different actors" on three dimensions: material, organization and narrative (2025, p. 4). This "narrative infrastructure" connects to imaginaries, as Schikowitz describes the importance of "shared stories and arguments" and "shared narratives (…) legitimizing the Baugruppen's participation in urban planning (following Felt (2017) in Schikowitz, 2025, p. 12).

Interestingly, the author describes how the Baugruppen see themselves as "lighthouse projects" and "counter models", which connects to counter-imaginaries (2025, pp. 11, 12). This aspect is similar to policlinics, as they also call themselves a counter-model and at the same time stress that structural

[14] They also apply post-ANT approaches, thus they acknowledge the multiplicity of such urban assemblages and the human and non-human relational practices making up commons and commonality. Since this is not my focus, I will not go into detail about this.

changes are necessary and that their project cannot be scaled-up under current conditions (Behrmann & Ihßen, 2023; Gerlof, 2024). The policlinics also rely on collaboration with cities and funding by cities, while trying to keep a critical political stance towards current health care politics (more details in 4.3.2.).

To conclude, the combination of counter-imaginaries, radical imaginaries and commons help me to capture policlinics' reimagining and redoing of health care but also related tensions and challenges, and the overall ambiguity of commons and capital. Now, to situate the case of policlinics, I describe the context of German health care, including current pollical debates and critiques of privatization. The last research approach chapter describes the specific policlinics I studied, the syndicate and inosc – as these three groups are analyzed in chapter 4.

3.3. Case study and context

3.3.1. The German health care system

As a federal state, Germany's public health responsibilities are divided between the federal government, the federal states (Bundesländer), and statutory health insurance providers. While both federal and state levels formally share responsibility for social security legislation, in practice, decision-making power over health insurance law lies with the federal government. The federal states are responsible for public health services and planning, including investment in infrastructure. Municipalities retain a "certain scope" to organize local health promotion and prevention independently (Gerlinger, 2024). Thus, Germany's healthcare system is characterized by a separation between prevention and healthcare provision: prevention primarily lies with the state, implementation of care is the responsibility of statutory health insurance. Overall, the system can be described as a "corporatist" or "collective agreements" control system (Gerlinger, 2024).

German primary healthcare is characterized by the free choice of doctors: patients are not assigned a general practitioner and can consult specialists in hospitals, private practices, or medical care centers (MVZ), without referral. Despite this "the dual specialist track" - hospitals play a marginal role in outpatient care. Generally German primary and stationary health care are very separated (Gerlinger, 2024). Health insurance in Germany is divided into statutory and private schemes, with almost 90% of the population covered by statutory health insurance (SHI). Most employees are compulsorily insured, while higher-income earners and certain groups may opt out. SHI is financed through income-related contributions shared equally by employers and employees, supplemented by federal subsidies (Gerlinger, 2024).

Four principles define statutory health insurance. First, entitlement to benefits is needs-based: insured persons "are entitled to all services that are necessary for the treatment of the respective illness according to the current state of medical knowledge" (Gerlinger, 2024). Second, economic efficiency requires that benefits "must be sufficient, appropriate, and economical; they must not exceed what is necessary" (§ 12 Abs. 1 SGB V as cited in Gerlinger, 2024). Third, the solidarity principle links

contributions to income while entitlements depend solely on care needs. Finally, insured persons may freely choose among statutory insurers, none of which may refuse applicants.

Germany's public health system has been shaped by persistent regional variation. In the German Democratic Republic (GDR), primary care was delivered through workplace- or neighborhood-based policlinics[15] (Weindling, 1994, p. 194). Following reunification, this model gradually disappeared. Regional politics continued to shape public health, from divergent approaches to HIV/AIDS in the 1980s to differing COVID-19 policies (Gerlinger, 2024; Weindling, 1994).

3.3.2. Problems, privatization and political debates

In comparison, the German health care system is in a good state in terms of quality, technologies, and insurance coverage (Gerlinger, 2018). The insurance funds' catalog of services is extensive, and Germany is furthermore among the countries with the highest public health expenditure (Gerlinger, 2024). Despite this comparatively strong performance, Gerlinger (Gerlinger, 2018) identifies three main challenges facing the German health care system.

First, there is a need to improve prevention and health promotion. The "Health in All Policies" approach is only weakly implemented, and prevention policy largely neglects the reduction of social inequalities in health opportunities. Gerlinger argues that the current focus on behavioral prevention should be replaced or supplemented by "complex, life-world-related, and participatory projects" aiming "to improve the living situation of disadvantaged groups and strengthen their resources for action" (2018). However, such approaches are costly, their benefits are difficult to quantify, and political actors often engage in short-term planning. In addition, context-specific prevention is "difficult to evaluate", raising issues of legitimacy (Gerlinger, 2018). As a result, prevention policy tends to focus on "the doable" favoring concepts that require "the least amount of social change" (Gerlinger, 2018).

The second challenge concerns ensuring health care provision while meeting the growing demand for skilled health workers (Gerlinger, 2018). Despite Germany's overall high physician density, there is undersupply in rural areas and even in urban districts such as Berlin-Neukölln, alongside overprovision in other cities. Furthermore, there are long waiting times to see specialists for patients with statutory health insurance (Eckstein, 2026). One reason for the under- and oversupply is the lower share of privately insured patients in these regions; since reimbursement for private patients is significantly higher, "it is therefore simply not worthwhile for doctors" to open practices there (Gerlinger, 2018). Besides lack of doctors in neglected areas, there is a lack of nurses which most likely worsens with increasing pressure and poorer working conditions (Auth & Heinzelbäcker, 2022). This leads to the third challenge, the "necessary and long overdue" abolition of the separation between statutory and private insurance (Gerlinger, 2018). Overall, Gerlinger (2018) identifies "control problems

[15] Important to note here, that although todays policlinics intentionally chose this name, the historical policlinics and the current policlinics I analyze are not the same. For more details, see chapter 4.2.1.

and fairness deficits" within this insurance dualism and maintains that calls for a unified 'citizen insurance' remain important and justified.

Against the background of these problems, I turn towards the area of privatization. According to the hegemonial narrative, this allows modernizing health care despite municipal budgetary pressures (Mosebach, 2009). In contrast to the rise of private hospitals, the privatization or the financialization of primary care has gained much less public attention (Braunschweig, n.d.; Bůžek, 2025; Bůžek & Scheuplein, 2022). Private equity chains are forming in outpatient healthcare and spreading extractivist logics into physicians' practices (Bůžek, 2025, p. 2). Buzek and Scheupling define private equity (PE) firms as acquiring "established companies in contrast to venture capitalists – with the aim of a profitable resale" after 5-6 years (2022, p. 333). The critique towards private-equity-led primary health care is that it "extract[s] rather than reinvest[s] value from the healthcare system and thereby undermine[s] the SHI's core principle of solidary funding" (Bůžek, 2025, p. 2). The German Medical Association warns about "cherry-picking profitable treatments (…) while neglecting less lucrative specialties" as consequence of this financialization (Bůžek, 2025, p. 2). The overall consequences are not clear, but Buzek suspects a worsening of working conditions, access and quality of care (Bůžek, 2025) [16].

Within German health care politics, the current government of social democrats and conservatives has announced reforms in outpatient care, relieving medical staff, and reducing waiting times, including the introduction of a binding primary care physician model to save resources (Drucksache Bundestag 21/1018). In addition, telemedicine is to be expanded, to reduce "non-needs-based physician contacts" (Ärzteblatt, 2025). Furthermore, federal states are to receive a decisive vote in licensing committees, and a "more fine-grained needs-based planning" is envisaged, alongside a "fairness adjustment" between over- and undersupplied regions in Germany (Ärzteblatt, 2025). This means financial surcharges in underserved areas and deductions in oversupplied regions—a proposal sharply criticized by specialist physician associations (Ärzteblatt, 2025). Parallel to this, legislation has been passed to limit private equity involvement in healthcare, although critics such as Buzek argue that it still leaves significant loopholes (Braunschweig, n.d.). Furthermore, insurances and the state negotiate about who covers the rising health care costs (Neuhaus & Polke-Majewski, 2025). As of now, there are no concrete laws to fulfill these promises for the primary care sector (Ärzteblatt, 2025; Spinner, 2025). Earlier reform efforts in 2024, such as the Health Care Strengthening Act (Gesundheitsversorgungs-stärkungsgesetz (GVSG)), initially contained progressive elements like health kiosks and community health nurses, but ultimately failed, which was commented by policlinics and their political partners (Poliklinik Syndikat, 2024).

[16] Here, I want to stress that German primary health care also private before PE because it is "private enterprises, primarily independent physicians, operating within a profit-driven but strictly regulated framework" (Bůžek, 2025, p. 2).

At the same time, NGOs, like Medinetz or Verein demokratischer Ärzte und Ärztinnen (vdää), criticize both the social inequalities in access to healthcare and austerity measures (Bündnis Krankenhaus statt Fabrik, 2024; Groß, 2005; Rosa-Luxemburg-Stiftung, n.d.; Verein demokratischer Ärztinnen und Ärzte (vdää), 2012). These protests target the private ownership, investors making profits and the billing through DRGs-based flat rates, in both stationary and primary health care (Bündnis Krankenhaus statt Fabrik, 2024; Gerlinger, 2018; Mosebach, 2009) This flat rate leads to providers being in competition about production costs of health services – leading cost-cutting measures, e.g. hospital staff reductions or shortened or extended hospital stays (Gerlinger, 2018; Mosebach, 2009). These debates about problems, privatization and inequalities in German health care have regained momentum under COVID-19 – as also observed by social clinics (Bündnis Krankenhaus statt Fabrik, 2024; inosc, 2024).

3.3.3. Research field - the policlinic syndicate

The policlinic syndicate is an umbrella organization of local associations from fourteen different German cities, which either already run or are in the process of establishing a multi-professional district health center (Poliklink Syndikat, n.d.-b). This means, although every policlinic has its individual set-up, they share the same structure and organization, core values and aims (Bůžek et al., 2022; Poliklink Syndikat, 2023).

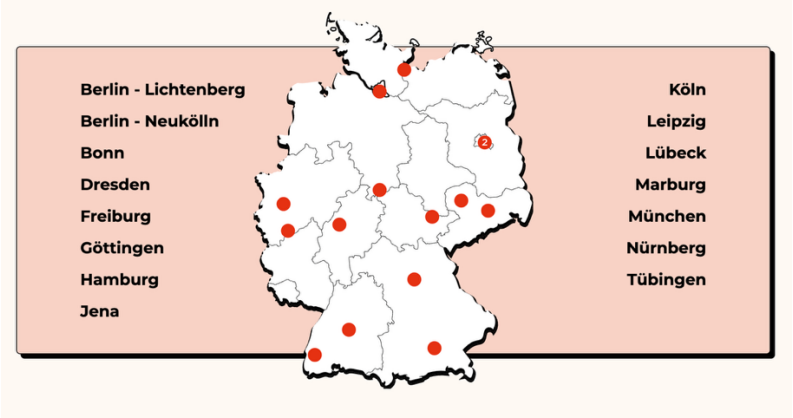

Figure 4 - Overview over policlinics in Germany (https://poliklinik-syndikat.org/)

In my research, I talked to members from four different local groups, two younger ones, Geko Bonn and Geko Dresden without provisioning, and the two older projects in Berlin and Hamburg with medical practices, thus provisioning responsibilities. Younger projects, like Geko Dresden, have health counseling or prevention offers, like a weekly seated sports class, psychological counselling, information events especially on women's health prevention or community events like an autumn contact café where you can craft lanterns together (Geko Dresden, n.d.-a). Geko Dresden exists since 2018 and already rents a space for their events and counselling (I4). The Geko Bonn is even younger than Dresden, established only in 2024, and currently focuses on funding and the needs-assessment (as discussed in chapter 4.3.2.).

Figure 5 - Picture of Geko Berlin, copyright: Geko Berlin e.V.

The policlinic in Hamburg and the GEKO in Berlin are the two most established community health centers and the only ones with medical practices within the syndicate. I refer to them as 'older' projects. The policlinic in Hamburg was set up in 2017 in Veddel, a district in Hamburg, and was the first policlinic project to realize a health center where provisioning in medical practices takes place (I1). The policlinic Veddel has two general practitioners' practices, health and social counselling twice a week, cooperations with midwives, community health nurses with nursing consultation hours, psychological counselling, free shiatsu sessions, health prevention projects organized by the community, and a TIN* consultation[17]. Additionally, the policlinic is engaged in political work and does substantial outreach. For instance, they are part of the working group 'outpatient healthcare' together with the vdää where they analyze and criticize the current health care system (Poliklinik Veddel, n.d.-d). The Geko Berlin was founded in 2016 and in 2022 they established their own health center in the Rollberg Kiez in Neukölln (Geko Berlin, n.d.-b). It encompasses a general practitioner practice and a pediatric practice, as well as counselling, psychotherapy, mobile health counseling, a sport program and a Café (Geko Berlin). In both Berlin and Hamburg more than 30 people are active (I1, I3) (Geko Berlin, n.d.-b; Poliklinik Veddel, n.d.-d).

I decide against focusing on one group only for two reasons. Firstly, on a practical level, the activists do not have many capacities to give interviews – which was what I expected and turned out to be true. Thus, I could not have done more than one or two interviews if I had focused on one local project. Secondly, on an analytical level, the regional variations and the different phases the projects– richer or poorer municipalities, older or younger projects– are significant variables within my analysis, as discussed in chapter 4.3.

[17] Trans, Inter and nonbinary

Besides the local projects and the national syndicate, on the European or international level, there is also the international organization of social clinics (inosc). Within this organization, there are nine different projects across Germany, France, Italy and Greece. Each project is named differently, social clinics or health center, and they vary in terms of organization, funding structure, types of care and activities, size[18]. The inosc is not the focus of my empirical work but I did decide to include their manifesto into my analysis – as this was co-written my syndicate representatives, members from Berlin and Hamburg, and members mentioned it at the vdää event that it was published recently (in October 2024).

Figure 6 - Picture of the Poliklinik Veddel, copyright: Deutschlandradio / Magdalena Neubig

3.4. Methods

3.4.1. Data collection

For my data collection, I did a triangulation of methods – both online and offline in a multi-sited fieldwork. I chose this combination of methods because it helped me to grasp the nuances in both imaginaries and practices of my participants being overlapping, diverging and entangled. The materials like videos, websites and documents helped me analyze the external representation or narratives of policlinics. My interviews and participant observations allowed me to go deeper than what is written, recorded or published. This learning about implicit aspects but also tensions and how members deal with these was enabled through interviews and informal conversations during my fieldwork. Thus, I could – although still partial – gain a small impression of how policlinics *actually* do things e.g. in health communication and *actually* talk about things e.g. at the vdää event. When studying imaginaries, both their explicit and other more implicit parts are important (Asara, 2025), which is why I analyze their visions as outlined in e.g. manifestos and public interviews and based on my participant observation.

I started my fieldwork, by getting in contact with vdää and joining an online event, where I also presented myself and got to ask questions in the discussion. After this I asked for contact details of

[18] Within this manifesto, the term "social clinics" is used, which is why I will use it as well when talking about projects within inosc. Thus, social clinic in this work is the umbrella term including policlinics in Germany.

Mathias and two other syndicate members who presented and asked them for interviews. This worked in one case, and Mathias, who remember me, agreed to an interview and invited me to visit Geko Berlin and join their events[19].

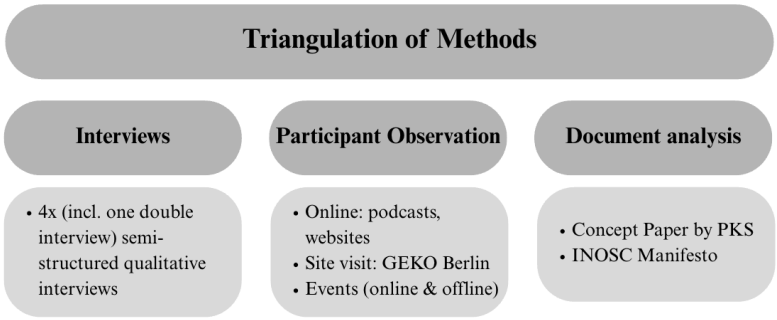

Figure 7 - My methodological approach: Triangulation of interviews, fieldwork and document analysis

Between June and August 2025, I conducted four semi-structured interviews with activists involved in policlinics and some sometimes involved in the syndicate (see appendix)[20]. This combination from local project and national syndicate was valuable as those from the syndicate could share trends and experiences made by other policlinics in Germany or even Europe.

My interview guide is attached in the appendix of this master thesis. I developed my interview guidelines in exchange with my peers in the Master seminar and my supervisor. After the first interviews, I also adapted some of the questions or phrasings. The interviews covered very different topics, depending on what members were passionate about e.g. Utopia working group for Niko, what professional background they have (e.g. Lukas as psychologist), how long they are in the project / the stage of their project (I4) and what roles they have in the syndicate or local project (I3). I started with asking them about the past and their personal history within policlinic movement and from there, the interviews developed in different directions. I asked every interviewee about current successes and challenges and how do they deal with them. In the end I would ask for their wishes and their vision(s) for the future.

It would have been ideal to conduct the interviews in person due to the personal rapport being established, however, as the scheduling was not that flexible due to the activist having little time, and because travelling to the different German cities was not always possible due to my work commitment here in Vienna, I did all of them except for Mathias' interview online. However, I met Ida in person before interviewing her – and in fact only through meeting her beforehand did she agree to the interview. Generally, approaching policlinic groups for interviews proved to be difficult – as I expected. Often, I did not receive an answer via email, or I was referred to the syndicate, which never answered my emails. Two of my interviews I got through contacting via email: when I contacted the local project in Cologne, they referred me to Niko from their sister project in Bonn. The policlinic Veddel also answered my

[19] An overview and explanation for the research memo (RM) abbreviations is in the appendix.
[20] Notably, three out of five were activist, thus volunteering, and one member was paid for his work.

interview request via email and forwarded me to Lukas – because he had capacities and was a long-standing member.

Concerning the selection of interview partners, I did not select in terms of profession or years of involvement in the project. Firstly, and practically speaking, because they, as already mentioned, have little capacities and I did not get so many positive answers to my requests, thus, I could not 'afford' being picky. Secondly, and on an analytical level, I believe the diverse backgrounds of my interviewees make my data more interesting - similarly to me approaching different local projects and not focusing on one. It would have been interesting to interview people involved in the Navigation project – however my interviewees Mathias and Lukas told me that those people do not have time to give interviews due to the recent launch of this project, and they did not even want to forward me their contact details to protect them from requests. As I complemented the interviews with fieldwork and document analysis, I got a rich and diverse amount of data in the end. And as already mentioned, doing research with activists, I also believe that I as a researcher must be careful not to further exploit the precarious situation of the activists (Khasnabish & Haiven, 2012; Temper et al., 2019).

I feel like most of my interviewees were open and honest in sharing their knowledge and thoughts with me – which was probably facilitated by the semi-structuredness of the interview or because my own political interest in ideas of democratic planning and commons (based on which I found the policlinics in the first place) may make me appear as a peer who understands the debates and the concepts they use. As Jensen and Laurie describe it, conducting semi-structured interviews ultimately connects my "behavior as the researcher with the data that (…) I collect" (2016, p. 174) and the researcher's identity and way of framing affect the participants' answers. This question of how to relate to my participants is something I reflected on and discussed with my peer group in the Master seminar and supervisor. On the researcher-participant continuum described by Trent and Cho (2020): I do not see myself as distant observer but rather as oriented towards the participant end - although not at the extreme end. In my research, I will stick with term participants and I do not want to make the activists co-researchers – while I do acknowledge their expertise (Trent & Cho, 2020). Thus, I do not want to keep a distance (and knowledge hierarchy) but neither do I want to 'act' as a peer and leave out the purpose (research) in my relation towards then and conversations with them.

Apart from that, I hope that the interviews also represented an opportunity to reflect on the interviewee's activism, vision and perceived challenges in a way that everyday life or their internal workflows may not always allow (Khasnabish & Haiven, 2012). For instance, Niko, thanked me for the interview because during the interview, they even stopped to write down something that they realized while talking with me and wanted to take back to their group's discussion on the Utopia working paper (I2).

Here, I kept the warning of Khasnabish and Haiven in mind, to neither make "an academic fetish of social movements" nor to simply "use" social movements to extract data to increase scientific capital without acknowledging the "privilege of the academic researcher" (Haiven & Khasnabish, 2014, p. 12).

From this the authors follow that, researchers studying radical imaginaries in activism should use their resources as researchers "to create new spaces of dialogue, debate, reflection, questioning and empowerment" (2014, p. 17). While I agree with this argument, there is not so much privilege in my position as a master student researching [21], thus there is not much I can give – other than H&K who used their financial resources to organize conference where different activists could meet, discuss and collectively reflect. Still, I hope that my thesis contributes to the visibility of the project and corresponding ideas about healthcare. Throughout my research, I tried to keep in mind to value the research and knowledge that social movements already do, thus continuing to question the boundaries of legitimized/ institutionalized knowledge production and expertise (Haiven & Khasnabish, 2014).

After the interviews I also sketched and wrote notes to capture my impressions and thoughts. I transcribed the interviews using the AI software noScribe Vers. 0.6.1 and I particularly chose this tool as the voice recordings and transcripts are not saved in a cloud, but the audio file is transcribed only locally on my laptop, ensuring my interviewees maximum data privacy. All my impressions or the data from each method approach of course informed each other, e.g. engaging with the documents helped with formulating questions for my interviews. Throughout my research process, I kept a research diary, to reflect continuously on my choices, impressions, interpretations, research questions and findings.

My participant observation consisted of the online event in May described above and three in-person meetings or visits: one at the Geko Dresden booth at the Fusion festival in June and visiting Geko Berlin at the street festival and their get-together event in July. These meetings enabled me to have informal conversations with members. The online event was also interesting because I could hear how they discuss their project with their political partners from vdää and how Mathias, Beatrice and the other two members also answer slightly differently to the questions asked. Joining medicine-related meetings, such as the multiprofessional case discussions, would have been very difficult in term of privacy, which is why I focused on policlinics' community work and health promotion activities. During my fieldwork, I took pictures, some of which are in the findings chapter, and I took notes afterwards to collect impressions – which I included into my data analysis.

Based on Harrison's chapter on ethnography (2020), for my participant observation, I tried to keep in mind the "empathetic engagement [and] attention to culture" as well as the "iterative modes of data collection and analysis" and the storytelling (350) inherent to the ethnographic method (2020, p. 350). The role of the ethnographer then is to:

> *"[To understand] that her job is to listen for meaning. She may participate—to extend the dialogue or maintain her own internal dialogue as she reflects on the grounded perspectives being shared around her. Above all else, she recognizes that people on all sides of a debate have*

[21] Apart of course of being a white, cis-female, middle class German citizen who is financially supported by her parents and does not face precarious working condition, poverty etc.

convictions, passions, and frameworks of understanding that should be respected and that, as researchers, we should aspire to better understand" (Harrison, 2020, p. 350)

I would consider my fieldwork as a short-term ethnography approach, following Pink and Morgan (2013). In contrast to long-term ethnographies, I could not do participant observation or embodied learning. In concurrence with Pink and Morgan (2013) I do not see short episode per se as a limitation but as viable alternative especially in a space where long-term encounters are difficult to realize. Short term ethnographies allow to pay attention to detail and encourage to use alternative materials such as audio-visual data – like I did with the podcasts. A short ethnography might be improved through increased "ethnographic-theoretical dialog" and "the post-fieldwork engagements with materials", which for me meant looking at my pictures, notes and listening to recordings from interviewees and visits but also revisiting my initial notes on the online materials, like video, podcast, websites and discussing these with peers and my supervisor (2013, p. 359). Additionally, researchers may use their own similar experiences when trying to understand the participant's practices. This was the case when I talked to Selina about how to communicate science versus health to a diverse audience (see 4.2.4), referring to my own experience of working as a science education facilitator and knowing that it is partly relational work (e.g. to regular guests visiting the Wissenssraum in Vienna[22]) and about taking time, following the principle of quality over quantity. One could say this also applies to my ethnographic fieldwork.

One of the materials I analyzed was the websites of the four local projects and the syndicate, their press releases on social media and the three podcast. The podcasts were with Beatrice from Geko Berlin, with four other members of Geko Berlin and the last one with Moritz from Hamburg. One of these podcasts I found when researching policlinics in the beginning and the two others were recommended to me by members. To analyze the podcast, I also transcribed them with the noScribe software. I received the concept paper through the syndicate via email. Through attending the vdää event and hearing from policlinics members about the recently finished inosc manifesto as well as seeing a post about the inosc meeting on the syndicate's website, I found this document and included it into my analysis.

3.4.2. Data analysis

For the analysis of my data, I used the MAXQDA software. Based on previous experience, I knew that MAXQDA offers versatile capabilities for mixed-methods data analysis. I did not use more than the regular features and did no quantitative analysis of my codes. I decided to follow the reflective thematic approach (RTA) by Clarke and Braun (Braun et al., 2022; Braun & Clarke, n.d., 2006; V. Clarke & Braun, 2017). Thematic analysis has the advantage of being a flexible and easily understandable method, due to extensive literature, examples and detailed explanation (Braun & Clarke, n.d.; V. Clarke

[22] https://wissensraum.info/

& Braun, 2017). Additionally, it allowed me to not feel pressured by the idea of formulating a theory based on my data like with classical Grounded Theory approaches (Braun & Clarke, 2006) .

As already described in Clarke and Braun's initial work on thematic analysis, the theoretical unboundness or flexibility of this approach makes it important to describe the researcher's assumptions about data, how data represents 'the world' or 'reality' thus making their ontological and epistemological stance clear (Braun & Clarke, 2006). This was even more highlighted when the authors further developed *reflective* thematic analysis, incorporating as a first step stating one's assumptions and positionings, thus centering more around researcher subjectivity and reflexivity. Besides, acknowledging the researcher's active role in data analysis, RTA allows a "organic approach" to coding and theme development (2017, p. 297). I will start with explaining my ontological and epistemological stance and then go on and explain how I followed RTA's steps for data analysis.

Following the feminist epistemological critique of "flawed conceptions of knowledge, knowers, objectivity, and scientific methodology" (Anderson, 2024), I am taking the postmodern claims of situated knowledge(s) and partial knowledge, "the political nature of practices of research and interpretation", the need for more reflexivity of researchers and especially shifting away from seeing researcher as "all-knowing analyst" serious (A. E. Clarke et al., 2022, p. 20). Clarke's claim of taking the situation of inquiry into account – including discourses, negotiations, history and other non-human things making up the situation into account resonates with me as well as her call for studying differences and accounting for complexity (A. Clarke, 2005). This is why I initially considered her situational analysis, as the postmodern successor of Grounded Theory, for my method. However, the analytical process of making maps seemed quite an effort and as I have little experience with qualitative data analysis and especially maps, I switched to a method that was easy to implement.

In line with RTA and the centrality of reflexivity in STS research, I want to acknowledge and appreciate the role my own subjectivity for this research. Thus, I will not try to keep my beliefs, opinions, biases out of the process but instead stay aware of them, make them explicit and address them in my work. In line with ´Trent and Cho's balanced approach, this means understanding subjectivity as enabling "rich, idiosyncratic, insightful, and yet data-based interpretations and accounts of lived experience" (2020, p. 965) – while not replacing the need for justifications and evidence for interpretations of the data (from Eisner (1991), on Trent & Cho, 2020, p. 965). This means, in the process of constructing knowledge, I understand interpretations as "socially constructed arguments" and thus the meaning behind social phenomena can be "multiple and even contradictory" (Trent & Cho, 2020, pp. 959, 958).

Reflective thematic analysis consists of six steps – although moving front and back between two steps is quite normal or invited (Braun & Clarke, n.d.). First researchers familiarize themselves with the data through reading, thereby becoming "immersed and intimately familiar with its contents" (Braun & Clarke, n.d.). At this stage, researchers are encouraged to take notes on "initial analytic observations" related to individual data items and the whole data set (Braun & Clarke, n.d.). The second and third step

is coding in one or two rounds, producing initial themes. I made codes based on coherent statements, thus ranging from parts of a sentence to a whole paragraph. I used the MAXQDA function of making notes for single codes, to remember why I chose a certain code and theme, especially since the data analysis was repeatedly interrupted (through e.g. work, vacation or sickness) and span over several weeks.

According to Clarke and Braun (2006), a theme refers to "something important about the data in relation to the research question" and represents a pattern of meaning or replies within the data set (2006, p. 82). The initial themes are then developed and reviewed in a fourth step – comparing themes to the whole data set, combining or splitting them up and assessing their "keyness" (2006, p. 82). This is not defined by quantitative measures but "whether it captures something important in relation to the overall research question" (Braun & Clarke, 2006, p. 82) .

The fifth step is then about "refining, defining and naming themes" which means to describe the scope and the "story" of each theme (Braun & Clarke, n.d.). During this time of coding and analyzing, I made a document called "ongoing observations" where I collected impressions, ideas for the discussion and noted down questions that I asked myself about the data while coding it. The last step is writing up, described by Clarke and Braun as "weaving together the analytic narrative and data extracts" (Braun & Clarke, n.d.). Here, I want to mention that I did not follow these steps one on one but for instance already started writing up and then went back to refining some of the themes, thus for me it was more of a cyclic or "recursive" process (Braun & Clarke, 2019).

Instead of my codes reflecting the entirety of my data as in a rich description, I chose to follow a detailed account of certain aspects. This means, I did not attempt to code the entirety of my data, nor do I include all my codes into my analysis. When I got lost in my data item, I tried to focus on specific quotes o passages which I had noted down afterwards because they stuck with me most. Drawing mind maps helped me to not get lost in my data. Additionally, throughout the coding and finding themes, I made memos for each theme and codes. This articulation of my thinking process behind coding and on emerging ideas and findings helped with my interpretation (Trent & Cho, 2020).

Furthermore, in the question of theoretical versus empirical thematic analysis, and in line with the detailed approach, I would position myself rather towards although not fully complying with a theoretical thematic analysis (Braun & Clarke, 2006). This means, I coded with my research questions in mind, and I already looked for health, care and community conceptualizations or challenges. However, my coding approach was also a bit deductive as well, as some themes such as growing up theme was something I did not envision when initially formulated my RQs and became salient in the analysis of my interviews. Moreover, I also switched between the familiarizing and coding, and I experience this interplay as useful and fruitful to make sense of my fieldwork and interview impressions.

In the last step of writing up, I then tried to map my themes onto my research questions, and my theoretical sensibilities – thus dividing them up into imaginaries, practices, challenges and how they are dealt with. This was challenging, because there is some overlap between them, like for instance with the

theme multiprofessional cooperation fitting to imaginaries, practices and challenges as well. A trend in my data analysis was that, from the documents, websites (but also partly from interviews) I gather the policlinics' radical counter-imaginaries and from my interviewees, the podcasts and my participant observation, I gathered more data on policlinics' practices and challenges. Completing this mapping process helped to formulate clear answers to my research questions.

4. Findings

4.1. Rethinking health care

4.1.1. Health as social product and process

Let's start at the beginning – when you enter policlinics as a new patient, it starts with extensive screening. This means to take elaborated notes on their whole medical history but also on their life, mental health, economic situation and the person's overall social context. This screening approach illustrates the policlinics understanding of health: namely as intertwined with the social and local ecological environment and as complex interplay between body, mind and environment (inosc, 2024).

For policlinics, the current German health care system is not equipped to consider the patient *as a whole*, but instead doctors focus on single body parts and only consider the individual patient and not their social environment (inosc, 2024; Poliklinik Veddel, 2019). In the inosc manifesto it says:

> *"This [biomedical] dominant model separates the body from the mental/psychological, the individual from their social and ecological environment, and the doctor from the patient. (...) It neglects how the human organism functions as an integrated system and its relationship with the surrounding social and ecological environment"* (inosc, 2024, p. 9)

For inosc the problem lies in biomedicalization, leading to a compartmentalization of the human body. In contrast to understanding the human body as *"a machine",* the inosc manifesto reimagines the body as *"an integrated system*" (inosc, 2024, p. 9). Thus, one cannot separate mind and body in the same way as one cannot separate an individual human body from its social and ecological environment. Furthermore, the inosc manifesto notes that the therapeutic relationship between doctor and patient has weakened due to time pressure but also more diagnostics, costly therapies and treating only symptoms (inosc).

These problems of biomedicalization are reinforced in a neoliberal health care system fostering an individualization of health (Geko Bonn, n.d.-a; inosc, 2024). According to inosc, the biomedical dominant model of health and body does not address structural factors, such as *"poverty, unemployment, and precarious work*" which are *"direct and indirect results of neo-liberalism, capitalism, colonialism, patriarchy, and racism"* or *"ecological degradation"* (inosc, 2024, p. 5). Instead, it *"perpetuates unhealthy structures rooted in Neo-liberal bio-politics"* (inosc, 2024, p. 9). Interestingly, the bio-politics aspect – described as the root to the problem – is not explained in more detail. Neoliberalism according to Inosc means *"disinvestment in public welfare"*, privatization of public sphere, deregulation, *"restricting union power leading to lower wages"* and *"applying managerial approaches to healthcare"* (inosc, 2024, p. 5). Thus, this critique from policlinics echoes marketization scholarship, but with the addition of referring to biopolitics, thus criticizing state power regulating bodies and life (Deppe, 2010; Geiger, 2021; Nandi et al., 2020).

To counter the reductionist (biomedical) understanding of health, the inosc manifesto reimagines health as *"body-psycho-social process of well-being"* (inosc, 2024, p. 9). Understanding health as process and focusing on the temporal dimension, highlights that it cannot be achieved once but is something to constantly work on and constantly shaping and shaped by the environment. Furthermore, for policlinics, health is not something to achieve solely as an individual but instead health is seen as a *"social product"* and thus as (also) dependent on collective action (inosc, 2024, p. 9). In this understanding of health as socially determined, policlinics refer to the concept of social determinants of health by the WHO and call for an implementation of this approach (I2, I3)(Poliklinik Veddel, n.d.-d). Going beyond social determinants and positioning themselves as counter model to current neoliberal individualism, inosc stresses that individual and collective health are interconnected and interdependent, making the community, its relations and strengthening their focal point.

At the same time, inosc acknowledges that collective health strategies should not undermine individual experience of health and disease, individual's knowledge of their own body and their realities. However, affirming uniqueness of individuals, does not mean that people must suffer alone as they currently do neoliberal health care systems (inosc, 2024). Similarly, for inosc, to see individuals and their health as embedded in their social and ecological environment, is not the same as the biomedical framing of social and natural conditions as pathologies like it is done with for instance mourning, aging or childhood (inosc, 2024). This mirrors Clarke et al.'s (2023) and Lupton and Peterson's (2000) observation of environmental factors being reduced to their biomedical components, neglecting complex socio-economic-cultural factors. Connected to this understanding of health and critique of biomedicalization inosc also scrutinizes the development towards a neoliberal (bio)medical science driven by techno-solutionism, pharmaceutical and insurance companies' interest and a competition for scientific capital, shaping medical truth.

4.1.2. Health as public good

For inosc, another consequence of neoliberal healthcare is the discrimination and exclusion from essential health care services due to dismantled health care and cost cutting measures[23]. Social clinics aim to *"overcome [access] barriers such as bureaucratic, economic, and language challenges"* (inosc, p. 3). Policlinics explicitly link the problem of access to healthcare not only to citizenship and residence status but also to socioeconomic status and inequalities more generally (I1) (Behrmann & Ihßen, 2023). A central pillar for policlinics is fighting for the right to free access to health care, which they deem *"a socio-political issue"* (RM1)[24]. Thus, policlinics and social clinics develop a *"politicized model of care*

[23] Although inosc also acknowledges that the context of the social clinics are different, thus neoliberal health care systems (and their consequences) might be different depending on the national context (inosc p.9)

[24] The quotes from my research memos (RM) are based on my memory and they are not verbatim but sometimes paraphrased/rephrased.

and health" – not only understanding health as embedded in environment but as having to be addressed through politics (inosc, 2024, p. 9).

The inosc manifesto mentioned two examples for problems in German health care politics: The unequal access due to insurance status and the outdated and not needs-based regulation and distribution of licensed practices. The latter problem leads to a lack of specialists, therapists in particular, and long waiting lists (inosc, 2024). Policlinics criticize how planning health care provision does not happen according to needs, or even on the basis of identified needs in the first place, but instead market logics and economic pressure shape the distribution of outpatient practices (1) (inosc, 2024). Although there is a solidarity-based insurance system in Germany, Niko, in line with Gerlinger (2018), observes that private companies are still able to make profit and thereby worsening working conditions, health inequalities and health care quality overall (I2) (see 3.3.2). To illustrate these inequalities and the over- and undersupply, members bring up the contrast between different districts in Hamburg:

> *"Class affiliation naturally also influences which healthcare facilities I have access to. If I live in Eppendorf or Blankenese [rather rich neighborhoods in Hamburg], for example, I have all the specialists I could possibly need within a five-minute walk, because there is simply such an abundance of healthcare services (...). And if you're in Veddel, for example, and just cross the Elbe, which is only a few kilometers away, there's already a difference of more than ten years in life expectancy. And I always find that to be such a blatant and egregious injustice. So, it's simply a question of where you live and how you can live for the question of how long I am able to live"* (Behrmann & Ihßen, 2023)[25]

For policlinics, the explanation for the difference in how many doctors there are on different districts results from market logics driving the planning of health provisioning (I1) (Behrmann & Ihßen, 2023). Medical practices can bill for private services and thereby increase their income and of course this is easier when the patient has the economic means to do so (I1, I3). This is important either because many doctors opening their own practices take out a loan which must be paid off, or because practices are owned by companies which aim for increasing profits (I1). This structuring of health care system under *"a profit-driven logic"* or market's logics is problematic because certain medical areas (e.g. orthopedics or dental) are just more profitable than others (general practitioner, pediatrics, gynecology) (I1, I2) (Gerlof, 2024). This problem of profit-logics influencing the distribution of outpatient care and the resulting health care gap, both in terms of access and quality, was mentioned by many policlinic members throughout my fieldwork and is exemplified by this quote by Lukas:

> *"So, in a district like Veddel, which has a high burden of disease and a high poverty rate, you don't go there as a provider to make money. That's why there is no provision in Veddel"* (I1)

[25] I translated German interviews and podcast transcripts using DeepL and sometimes adjusting them.

The quote also hints to another problem tied to economically less attractive districts, namely the problem of high disease-burden and complex cases in exactly those underserved districts. As Niko describes it, opening up your practice in such a neighborhood means "*much more stress, much more complex cases, much more chronic illness, much more psychological strain, and so on and so forth"* (12).

Additionally, when practices are being under economic pressure, they also are in competition with one another (Behrmann & Ihßen, 2023). This problem extends throughout the whole health care sector, as insurances are also under pressure to cut costs and thus find themselves in a *"merciless competitive environment"* for additional insurance payments (I3). Therefore, for some policlinics members, such as Niko and Mathias, ideally, and like Gerlinger (ref), there should not be two insurances but simply a *"citizen insurance (...) as the most important element of fair financing"* (I3). To summarize, policlinics criticize that although Germany has universal health care insurance, inequalities are prevalent and potentially worsened through marketization of primary care (I1, I3) (Behrmann & Ihßen, 2023; inosc, 2024).

To counter this problem of health care facilities being under economic pressure and increasingly privatized, policlinics envision good health care provisioning as public good as this *"has a positive impact on the quality of life of all citizens, including those who are healthy"* and can be compared to *"good air quality, traffic safety, or legal certainty"* (Poliklinik-Syndikat, 2020, p. 7). For them, an increasingly marketized health care provisioning contradicts the orientation towards the common good, similar to Geiger's observations (2021). This argument is central for policlinics, who reject the private ownership of medical facilities and infrastructure (I1) (Poliklinik-Syndikat, 2020). In contrast, they reimagine health care provisioning in the middle and long run *"in municipal or non-profit organization / ownership"* (Poliklinik-Syndikat, 2020, p. 7).

However, not only private, but also the ownership by local administration is questioned by some policlinic members, because then a reprivatization cannot be avoided (I2). Niko stresses how this already happened in Germany, where hospitals initially bought with public money were resold to private companies when local administrations were in financial distress (I2). Apart from owning the facility or practice, Lukas also questions why the license of practices is limited to private actors in the current health care system:

> *"Or the licensed practice, (...), why does it belong to me? Why doesn't it belong to the center, or even the district, or, I don't know, right?"* (I1)

To counter market-led organization and private ownership of health care infrastructure, policlinics envision themselves as collectively owned and run. They established a non-profit organization (NGO) and aim to increase participation, not only within, with multiprofessional cooperation, but also externally by working with neighbors or local actors, as discussed in the next

chapter. Thus, here again, policlinics explicitly understand their imaginary and model as being *"an alternative solution to these neoliberal solutions"* (Behrmann & Ihßen, 2023).

To illustrate this critique of private ownership, I will turn to a comparison often made by policlinic members: policlinics versus so called medical care centers (Medizinische Versorgungszentren, MVZ)[26]. Mathias explains how the MVZ initially was a concept they considered for their project in Berlin. However, they set the idea aside for *"financial and legal reasons"* and *"not for political reasons"* (I3). Mathias criticizes that MVZ would always be owned by a private actor and thus the clinics could not be *"collectivized"* or run as a nonprofit organization in the future. The private ownership was not a compromise they were willing to make, showing the centrality of non-private ownership of the infrastructure[27]. I find it interesting how Mathias insists on this decision being not political, which is not the only time he will attempt to frame policlinics as less political but also not non-political, as discussed in more detail in the subchapter on challenges (cross ref). However, despite the critique by policlinics, the practices in Berlin and Hamburg are still owned by private actors, by a doctor or a team of two doctors, because an NGO cannot own a practice (as discussed more in 4.3). However, members have assured me that although this legal separation exists, they cooperate and make decisions collectively as if it would not exist (Gerlof, 2024). Thus, a central tenant in policlinics' counter-imaginaries to marketized healthcare is the non-profit ownership, but also the need-orientation and participation. This means before starting a policlinic or starting a new offer, the policlinics envision that these will be *"planned and implemented in cooperation with the respective peers"* (Poliklinik-Syndikat, 2020, p. 7).

4.1.3. Participation without hierarchies

This questioning of MVZs also ties into policlinic's imaginary of health care without hierarchies and with increased participation – not only for doctors, nurses or other staff but also for patients and the local population. Tying back to the problem of reductionist understandings of health, policlinics criticize how patient is reduced to their illness and doctors are excreting (too much) power (inosc, 2024). Thereby, medicine makes people *"passive and subject to control"* (inosc, 2024, p. 9). For social clinics, such a doctor-patient relationship is representative for the *"authoritarian and hierarchical regulation"* of society (2024, p. 9). In the hegemonial doctor-patient-relationship conceptualizations, diseases and patients are not seen as embedded and interacting with social, ecological and economic structures. Instead, factors which seem unrelated to the illness are not included and *"rendered invisbible*" in and the passive and receiving patient is regarded as "*'problemholder', (...) [silently] waiting for an explanation"* (inosc, 2024, p. 18). Thus, for inosc, the reduction and objectification of patients is tied to both societal hierarchies and the biomedical model of health (care) (inosc, 2024).

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[26] Medizinische Versorgungszentren (MVZs); where different specialty doctors and sometimes psychotherapists can work together and which currently represents interdisciplinary work in outpatient care

[27] Although they cannot realize this – see section 4.3

This problem with hierarchies is also a problem within medical teams. The inosc manifesto describes the problem with hierarchies for the practice of health care as following:

"[Hierarchies] 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" (inosc, 2024, p. 16)

Thus, policlinics' demand of multiprofessional cooperation ties into the policlinics' overall critique of the injustices, power imbalances and hierarchies in health care and society overall, such difference in salaries or working conditions. Here gain to illustrate this counter-imaginary, I will turn to the rejection of an MVZ structure for policlinics. For Lukas, the reason is that only allowed licensed professions, doctors and therapists, can own and run an MVZs. This also means, other professions such as community health nurses cannot hold co-ordinational positions. Although one could say this is *"just pro forma"*, Lukas argues that "*that's exactly what creates realities"* (I1). Policlinic members see this requirement for higher positions or ownership as barriers for equal interdisciplinarity. Even if it is just *"pro forma"*, policlinics do not want to reproduce power imbalances and hierarchies (un) intentionally.

The idea that health care facilities should be run collectively also connects to participation as central element in their counter-imaginary. Beyond assessing the needs in the neighborhood, patients are invited to participate in the planning of health promotion offers, prevention projects and community work (Poliklinik-Syndikat, 2020). This ties into the social clinic's general idea of organizational model, based on direct democracy and self-management and the conviction that people can and should *"make collaborative and egalitarian decisions about their work, their health and their lives"* (inosc, 2024, p. 18). When patients become involved and their needs are being heard, policlinics envision a positive mutual influence between participation and health. Niko describes this as follows:

> *"There is an interaction here: (…) I have to muster a certain amount of initial energy or effort to get involved, but at the same time, there is of course self-efficacy that comes from participation, and we know that health is positively influenced by having a say and being involved in shaping things"* (I2)

Thus, participation is not only seen as important for the policlinic's legitimacy but also as a crucial factor in enhancing people's sense of self-efficacy –in turn a positively influencing their health. Thus, participation is central for policlinics both inside the health care facility, with regards to patients and staff but also in a wider scale in health care politics (I2) (Poliklinik-Syndikat, 2020). Existing patient participation is criticized as being only performative. Such initiatives are for a good public image but suggestions by non-medical expert groups are 'only' being heard but they do not reach the decision-making levels (I2). Furthermore, social clinics argue that participation often means a "*process that objectifies patients, transforming them into passive recipients of care who are identified only by their illness, rather than as whole persons"* (inosc, 2024, p. 18). Additionally, Niko criticizes the

powerlessness of patients in existing participation formats, where they are *"nice to have"* but "*have no power whatsoever"* (I2). Thus, for Niko, the problem is that certain groups, like patients or lower paid professions like nurses have less power than others and that especially those communities affected have no say in the design and organization of health care services (I2). Here, policlinics imagine health care centers as anti-hierarchical, as reducing power imbalances between patients and doctors through e.g. participation and as spaces for equal professional cooperation, as discussed in section 4.2.1

4.1.4. Collective and transformative care

Another theme I analyzed, was the policlinics' understanding of care, going beyond health care, treating illness, care for somatic and mental conditions and beyond caring for oneself and others individually (inosc, 2024). Instead, a collective care approach should include families, friends, colleagues, and the community. This means understanding politics and participation, such as fighting climate change or addressing community-problems as acts of care. The collective care approach links the idea of health being a social product and the understanding of empowered communities as a part of health care and health prevention – how policlinics practice health prevention and community work I will discuss in sections 4.2.44.2.5. Through participating and contributing to an improved environment for the community, individuals are performing acts of care – and they are contributing to healthy communities (I2) (inosc, 2024).

In the collective care approach, care is political. Inosc describes this political dimension of care as twofold: *"[care] is shaped by and shapes social and political structures"* (inosc, 2024, p. 12) For social clinics, the politics around care need to change to solve the problem of current care crisis because care work is often undervalued and underpaid as well as connected with oppression of women and migrants carrying out care work, in line with feminist care debate (inosc, 2024)(2.2.3.). Thus, social clinics are supporting political movements fighting against intersectional oppression and struggle (inosc, 2024). Furthermore, inosc highlights that through care transformation can and should happen. What is interesting here, is that, in terms of organization mode for labor and production, the inosc manifesto sees care as the contrary to profit as central logic:

> *"Rather than prioritizing profit, we should place collective well-being at the center of how we organize labor and production (...). Care can also challenge political systems and structures by questioning and subverting dominant power relations and advocating for more equitable systems"* (inosc, 2024, p. 12)

This collective care approach shows how policlinics want their own work to contribute to societal transformation with transformative practices and infrastructures. As health is inherently political and as health prevention is seen as ongoing sociopolitical fight (discussed in 4.2.4), health promotion as such *"is about (...) social transformation"* (Poliklinik-Syndikat, 2020). As Niko said about the policlinic projects aim to be "*a transformative force in a region, whether rural or urban"* (I2). Social clinics are

described as *"radical political model"* and representing *"a vision of a more equitable, just, (...) and anti-authoritarian societal structure that can extend beyond health care"* (inosc, 2024, p. 3).

Like their politicized understanding of health, social clinics aim to re-politicize care work. For instance, the Geko Berlin hosts a weekly meeting called 'Textilrezeptur' (textile prescription), where people from the neighborhood come together to do textile arts like knitting and crocheting together (Geko Berlin, n.d.-b). This Textilrezeptur is meant as a meeting place, an opportunity to connect and to build support networks, or even to plan political actions or protests, with textiles, in the public space. In the description, the Geko writes: *"Together we are starting the care revolution in our neighborhood"* (RM2) [28]. With this regular meeting group, the Geko Berlin aims to spark a debate about care, care work and its political dimension with a focus on personal relations and protest happening in the local neighborhood.

However, not only caring for community, caring for incomers but also care within the policlinic team is part of the collective care approach. Thus, the social relations within the collective are to be strengthens, maintained and prioritized – like other commons' foregrounding of care and social relations (Sanchez, 2023; Schikowitz & Pohler, 2024). For inosc, this is a way of *"transforming health care by pro is prioritizing care over medicine*", tying together social care within the collective with the vision for a transformed health care focusing on care (inosc, 2024, p. 12). One could interpret this phrasing as describing care and medicine as mutually exclusive categories pitted against each other and as problematizing medicine as such – when in fact the critique of social clinics is towards neoliberal or biomedicalized medicine and, as we have seen, medicine has meant and looked very differently throughout history (2.1.1).

4.1.5. Conclusion

These aspects - socially determined health, health as public good, participation and fighting hierarchies as well as collective care - show that policlinics criticize many aspects within medicine, health care and societies and formulate alternative values and imaginaries to hegemonial understandings of health, care, patients and healthcare infrastructure. Policlinics and social clinics want to and or reimagine health care systems and underlying societal and scientific values, practices and structures such as biomedicalization, markets, profit-orientation, individualism or devaluation of care.

In line with the concept of counter-imaginaries, policlinics formulate their vision as counter-model or alternative to current hegemonial concepts. Sometimes it is about criticizing and expanding the existing (and in trend) concept like policlinic's understanding of patient participation and empowerment or their idea of citizen-insurance as alternative funding system. Other times, the counter-imaginary entails new conceptualizations, like the collective care approach.

[28] In the original quote there is a pun referencing knitting: *zusammen knüpfen wir die Care Revolution im Kiez*

Beyond health care related imaginaries, policlinics also aim for their values and visions contributing to a societal transformation. This is because policlinics do not only try to imagine and establish alternative health care visions to problems like unequal access or distribution, but they attributed these problems to wider societal structures like neoliberalism and capitalism and the connected inequalities, power imbalances and oppressions (Haiven & Khasnabish, 2014). Moreover, policlinics also figure as prefigurative infrastructure and practice, on how health care and societies could be different. Thus, in these radical counter-imaginaries, as I conceptualise them, healthcare figures as concrete space to illustrate broader structural problems in societies. How policlinics realize their radical counter-imaginaries of redoing health care as commons will be discussed in the next subchapter.

4.2. Redoing health care

4.2.1. Caring multiprofessionally

Based on their understanding health, their opposition to hierarchies and the focus on participation, policlinics work as multiprofessional teams (Behrmann & Ihßen, 2023; Poliklinik-Syndikat, 2020; Schunke, 2022). This connection between social determinants and a multiprofessional structure of primary care is illustrated by this quote:

> *"This means that what makes people ill is not just individual behavior (...) but above all social conditions (...) which have a huge impact on health and therefore also on illness. And when you say that, then outpatient healthcare doesn't just need doctors who provide outpatient care, but also a multi-professional team of social workers, community workers, therapists, a place where people can meet... in other words, everything that we are now bringing together under one roof"* (Schunke, 2022)

The policlinics argue that interdisciplinary cooperation and in particular social work and nursing are necessary for a primary health care facility, because doctors simply do not have the training to be *"experts in [the] field of social determinants"* (Behrmann & Ihßen, 2023) . Instead of seeing the medical education as superior, important skills and knowledge are missing (RM1, I2). This argument fits to the overall narrative of decentering doctors within the policlinics – in contrast to clinician-led-evidence-based-medicine and hegemonial understandings of biomedical health care described in literature review (2.3.1). It ties to the understanding of knowledge prevalent in the social clinic movement, as something dispersed among different professions *and* between doctor and patient. Put differently, it is not only the nurse and the patient who can learn from the expertise of the doctor but also the other way around.

This decentering of doctors was already prevalent in the emergence of the policlinic movement and in the planning of the clinics. For instance, Lukas, a psychotherapist, joined the project when they were actively looking for non-medical students to contribute to the conceptual and organizational planning of the first policlinic (I1). This multiprofessional planning process is also described by

members from Geko Berlin (Schunke, 2022). As a member explains in a podcast, the multiprofessional cooperation is already in the name:

> *"Rethinking health care (...) and not only in terms of care, but also in terms of how professional groups work together. Namely, collectively, on an equal footing, as far as possible, making democratic joint decisions and thus truly seeing ourselves as a collective project. Hence, the health collective [Gesundheitskollektiv], abbreviated to Geko"* (Gerlof, 2024)

This quote also highlights that policlinic members understand themselves as being part of a collective. Instead of doctors being at the top in the line of command, as usually in medical settings, policlinics aims for cooperation between medical professions with as little hierarchy, thus as *'low-level'* as possible. The inosc manifesto clearly states that within social clinics *"the voice of each professional has the same power"* (inosc, 2024, p. 14). As already, policlinics understand themselves as participatory and grassroot structure (as opposed to hierarchical and power centralized systems) and this not only include patients but also professional groups within collective. Policlinics members criticize that medical staff other than doctors lack participation opportunities and agency and centrality of doctor expertise in health care (I2). Even innovative and non-profit health care centers, sharing some values with policlinics, members criticize them as *"too doctor-centered"* and that *"employees have no say"* (I2).

The multiprofessional care is also reflected in the naming; policlinics do not consider themselves a 'medical center' as this reproduces the focus on medicine. Instead, they prefer the term *"primary care center"*, capturing their ideas and values of the different professional groups caring collectively for the whole district (Gerlof, 2024). This example of naming shows how careful policlinic members are with their words, and they acknowledge the power of language in reproducing certain power imbalances or hierarchies. I would say, this is one of their ways of rethinking and redoing health care. Similarly, Mathias and Lukas both stress that although many projects refer to themselves as policlinics, referencing the concept from the German Democratic Republic (GDR), there is an important distinction between the historical policlinics and the projects today: back in the GDR, such clinics although having a form of community health nurse such facilities were still centered around and run by doctors (I1, I3). This shows that the counterpart of the decentering doctors is valuing the nursing profession. The policlinics want to *"strengthen non-medical care and in particular nursing work"* as an independent profession with important skills and qualifications (Poliklinik-Syndikat, 2020). This is why every policlinic should have a community health nurse (Poliklinik-Syndikat, 2020).

This call for more multiprofessional cooperation comes from a place of criticizing the increasing fragmentation within medicine. Members describe how within healthcare *"everything is so segmented and fragmented"* (Schunke, 2022). They also critique the lack of solidarity among medical professional groups such as nurses and doctors. For instance, when nurses were striking for higher salaries for nurses, doctors or medical students did not support these fights (Behrmann & Ihßen, 2023).

Contrary to this, the low-level cooperation within policlinics not only improves the cooperation and the overall quality of care provided (Schunke, 2022). Thus, interdisciplinary cooperation ties to another aim of policlinics, namely, to achieve good working conditions. Members often start their activism with a frustration about the working conditions, such as high payment differences, lack of solidarity and generally underpaid care work (I1, I2, I4). The Geko Bonn describes this aim on their website as *"new work",* as having *„a good tome together while doing the work we value so much"* (Geko Bonn, 2023). For Niko, *"the ideal"* would be that *"people enjoy working in health care"* again (I2).

To illustrate this cooperation and the enjoyment, Patricia describes how doctors in policlinic projects, after some adjustment, eventually appreciated this interdisciplinary cooperation:

> *"[Doctors are saying:] I can't imagine working anywhere else, not being part of this interprofessional team, not having a social worker right next door whom I can ask if something comes up in my practice that I can't deal with myself, knowing that there is a case discussion, knowing that there are others in the background who can do many things much better than I can as a doctor, who has never learned many things"* (Gerlof, 2024)

Other members find this cooperation in policlinics – where many different perspectives meet – *"enriching"* (Schunke, 2022). This idea of equal interdisciplinarity is what makes the policlinics special or to put it in Patricia's words – this *"attitude of mutual respect and appreciation among all professional groups, appreciation for the qualifications of the various professional groups*" is where *"the spirit"* of policlinics lies (Gerlof, 2024). However, it does come with the necessary recognition of different professions' perspectives on *"what is important and urgent in terms of care"* and that these need to be negotiated (Gerlof, 2024). Thus, Patricia says a certain willingness to challenge oneself and learn, and especially as a doctor to question one's own education, and to *"leave the high horse"* of the doctor is essential (Gerlof, 2024).

Thus, the equality within the interdisciplinary cooperation in the policlinics is achieved by dismantling hierarchies and fostering dialogue or group discussions. I overserved two mechanisms as essential for equal interdisciplinarity: the regular meetings and case discussions and the alignment of salary levels. Regarding the former, in the two older policlinics in Berlin and Hamburg, there are regular case discussion meetings with all the professions (Gerlof, 2024). In projects without a clinic but with counselling, there are also interprofessional case meetings, where every profession has an equal say (I4). The Geko Berlin for example uses several formats for interprofessional exchange, including the weekly *"coordination café"* described as *"a kind of institutionalized doorstep chat"* (Gerlof, 2024). Then there is *"a small case discussion"* with caregivers, social and psychological counselors and a less frequent, more *"labor-intensive (...) large case discussion"* where community work and café Praxis members join as well (Gerlof, 2024). While these larger meetings are more rare, they are *"especially important for those people or families who really connect with us in many different places"* to ensure that care is

coordinated and that *"we are all moving in the same direction"* (Gerlof, 2024). This illustrates that not only the big case meetings but generally interprofessional cooperation requires time and labor, as discussed in 4.3.1. The also applies to aligning salaries within policlinics as described in 4.3.1.

Apart from health care related meetings, policlinics aim to realize regular meetings for all members of the project as well – in the spirit of social care within the collective (4.1.4). For instance, the Geko Dresden members tell me that besides their regular two-week meeting, they do *"retreats"* to take the time for specific topics and specific *"emotional"* plenary meetings, in needed, to discuss how members are doing (I4). For these regular meetings, the idea is *"to create a plenary structure where everyone is equally involved in decision-making processes"* (Behrmann & Ihßen, 2023).

Many policlinics use a decision-making system based on sociocracy principles and the idea of consent, not consensus. This means, instead of simply asking a question where members can agree or disagree, they do *"discussion rounds and resistance checks"* (I2). With the resistance check, members rate this decision with a point value from 1 *("light resistance"*) to three (*"heavy resistance"*) (I2). Depending on how much points the decision has in the end, they can tell whether this was an easy or difficult decision to make and then assess collectively *whether "to talk about it again in six months because it just barely got through"* (I2). In this process, if anyone has *"stomach pains because of something (...), then it will be discussed"* within the local group and this *"is something special"* (I4). Thus, the aim is not to achieve a decision by majority but instead reach it with as little resistance within the group as possible. Social clinics believe in the *"power of collective dialogue"* and in the local group in Bonn, vetoes are not possible (I2)(inosc, 2024, p. 14). Additionally, they also included the possibility to exclude someone because sexual assaults within left-wing activist groups in recent years have made them aware that this can sometimes be necessary – and that power abuses also happen in settings which are trying to fight them (I2).

Having group discussions has the disadvantage of making processes slower and more elaborated but *"it pays off because we all share the responsibility"* (I4). However, when policlinics needs to *"act fast"*, for instance when there is a small-time window to apply for funding, then it becomes *"a challenge"* to decide as a collective (I4). I will elaborate further on the challenges of organizing within the collective and taking time for shared decision-making and discussions in 4.3.

4.2.2. Patient participation and need-assessments

Now I will describe two types of practices aimed at realizing the vision of non-hierarchical, needs-based and participative medicine and public health, described in 4.1.2 and 4.1.3. Firstly, regarding patients, the counter-model suggested by inosc and policlinics is a patient-centered approach, seeing the patient as expert of their own body and of their daily life. Patients are understood as active participants in their treatment (inosc, 2024). The inosc even rejects the term 'patient' because of its *"passive connotation"* and instead talks about *'incomers'*. Jonas from the policlinic in Hamburg describes this as follows:

> *"So, when in doubt, I am the expert on health issues, but you are the expert on your body and your life situation. And we need to bring these two areas of expertise together to see what the best solution for you might be. And that's not just a medical question."* (Behrmann & Ihßen, 2023)

This quote highlights how expertise is not just something that doctors or medical staff have but, policlinics break with the idea of *"knowledge as a one-sided attribute"* (inosc, 2024, p. 18). Instead patients' "*contribution is of fundamental importance in helping the 'medical expert' find a solution"* (inosc, 2024, p. 18). The quotation marks around medical expert highlight how inosc questions the decisive expertise as being solely medical, similarly to Jonas arguing that deciding on health care is more than a medical question. This argument by policlinics again ties to their understanding of health as socially determined.

The aim is that patients become actively involved in their treatment. Here, policlinics rely on the concept of shared decision-making, where patients and their relatives are involved in decisions that affect their care process (Poliklinik-Syndikat, 2020). The idea is *"to increase the self-determination of those receiving care"*, tying to policlinic's vision of empowering individuals and communities (Poliklinik-Syndikat, 2020, p. 3) (see 4.2.5).

Participation goes beyond health care and exceeds into prevention projects and community work. In line with the downscaling approach, local inhabitants and organizations are invited to participate in the planning of policlinics (Ribera-Almandoz & Clua-Losada, 2021). Participation and the need-orientation of policlinics go hand in hand: To make their policlinics need-oriented, projects, often as a first step, do a need-assessment in the local neighborhood, collecting data about the care needs and social determinants in the local neighborhood (inosc, 2024)(I2). They are doing this, partly because the local authorities do not collect data on a small-scale (I1, I2). To have better primary care, those who plan and provide health care need to know about gaps in provisioning and the needs of the local inhabitants (I1). For the need-assessment, projects also cooperate with local research institutes, to conduct interviews and carry out a qualitative analysis with stakeholders (I2). Policlinics also cooperating with universities to collect evidence for their alternative practices and fund these, such as in Hamburg with community health nurses (Poliklinik Veddel, n.d.-b). Thus, for policlinics, research also enables the "experiments" or their novel and alternative practices. For Lukas, *"research [is] something that should be inherent in every health center in every district"* and thus these approaches are like medical evidence-based-activism described above (I1) (discussed more in 5.4).

For instance, Ida and Laura tell me how they currently have a "doorstep conversation" project in the local neighborhood in Dresden in which the Geko is active. Here, they want to talk to inhabitants and to understand *"what motivates the people who live there, what do they actually want, what might they be missing in terms of what's on offer?"* (I4). They go to people's homes and thus they argue that they will reach more people and make it more accessible, in terms of mobility and language, for people

to contribute to their needs-assessment (I4). The local need-assessment is important as it allows policlinic members to gain knowledge and *"somehow start without coming across as condescending"* (I4).

This was also described by policlinic members from Berlin talking about approaching other NGOs or neighborhoods projects already active in the local area. This networking is important to avoid *"creating duplicate structures"* (Schunke, 2022). These connections in the neighborhood help them to not "*end up here like some kind of UFO"* (Schunke, 2022). This metaphor encapsulated why participation is so important – because else, a project like the policlinics will be regarded as foreign, as coming from above, being potentially perceived as a threat and as something utterly disconnected from the local area. Additionally, the concept paper of the policlinic movement suggests having a community board and to hold regular neighborhood meetings at the policlinic (Poliklinik-Syndikat, 2020).

4.2.3. Making policlinics accessible

Besides dismantling hierarchies within their organization but also fighting discrimination and barriers to health care services. For instance, at Geko Berlin, everything is signposted and there are multilingual flyers about the practice and the offers. When you enter the space through Café Praxis, there is a huge neon sign saying, 'Health for all' (Figure 8), illustrating a core element of the policlinics, the principle of free access to health care services. The Geko Berlin tries to create a welcoming space for everyone. The inosc manifesto describes the social clinic's as starting out from the *"common struggle and the ideological premise for free public health care for all"* (inosc, 2024, p. 1). This free access to health means *"everyone who enters our clinic is treated equally, regardless of their status or background"* (inosc, 2024, p. 1). For policlinics, their work and offers are based on their critique of the currently existing inequalities and exclusions in the German health care (I1)(Behrmann & Ihßen, 2023). This includes insurance status, residence permit, economic background, mobility and language (I1, RM2)(inosc, 2024). What characterizes policlinics with a medical practice, is that they treat people without insurance (Geko Berlin, n.d.-b). In younger projects, the health counselling this is also free of charge and open for anyone (Geko Dresden, n.d.-b). Thus, the principle that everyone has the right to receive health treatment and counselling is central for the policlinics. This fight against inequalities and for free access is based on the universal right to access to health(care) and the idea that health as a basic need that needs to be ensured (RM1)(inosc, 2024)[29].

This can be explained in part by the history of policlinics, emerging from the anti-racism movement and specifically from the Medibüro project. Medibüros offer free medical referral and counseling for refugees and migrants, regardless of their residence and insurance status. In my fieldwork

[29] Although policlinics acknowledge that what counts as healthy or normal is contested and so they have internal, critical and necessary discussions around definitions of health, disease and normality (RM1, I3).

I learned that many policlinic members were active in the Medibüro before they joined the policlinic projects, thus there is an overlap in personal and content (I1, I3)(Behrmann & Ihßen, 2023).

Figure 8 - Picture of the neon sign ‚Gesundheit für alle' at Café Praxis, GEKO Berlin, copy right: Luisa Gerstgrasser

Next to the free access and the problem of exclusion, the fight against discrimination in health care is another important element in the policlinic's practices and also ties to their imaginary of being an alternative to the inaccessible and discriminatory health care system. Policlinic members believe that *"a society with sensibility for discrimination is possible"* (RM1). As already described in 4.1.1., social clinics argue that social and economic marginalization are intertwined with health inequalities and neoliberalism is *"perpetuating discriminatory and exclusionary practices"* in health care (inosc, 2024, p. 5). The policlinics therefore want to address these negative experiences of their patients (I1, RM2). For example, there is a poster on the wall at Geko Berlin asking patients about previously negative experiences (Figure 9). To become a discrimination-free or sensible place, members are doing workshops and trainings on discrimination-sensitive care, and cultivate *"a certain attitude and willingness"* to learn about and collectively find strategies to prevent discrimination (Behrmann & Ihßen, 2023). These two examples illustrate an awareness in policlinics for the discrimination people might experience in health care and the need to fight and avoid reproducing these.

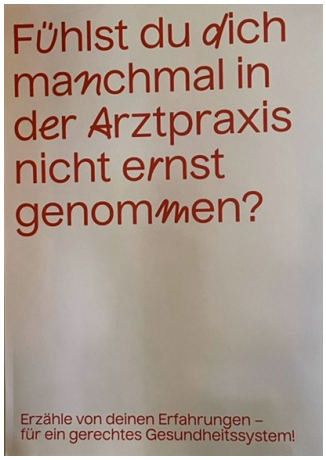

Figure 9 - Picture of a poster at GEKO Berlin acknowledging discrimination experience in health care, copy right: Luisa Gerstgrasser

I observed many small efforts to achieve low language and mobility barriers. For instance, at Geko Berlin, I heard many different languages spoken by the members and visitors and I saw different languages such as Turkish and Arabic written on signs in the space or on flyers for health promotion and group offers. Furthermore, the building was accessible with a wheelchair. In terms of language requirements, many of the policlinic groups included the option to have the website content written in other languages than German or in simple language (Geko Bonn, n.d.-b). For policlinics, this fight against inequalities and for free access is based on the universal right to access to health(care) and the idea that health as a basic need that needs to be ensured (RM1)(inosc, 2024).

4.2.4. Health care as Verhältnisprävention

Tying together the politicized model of care and health, the social determinants of health mentioned earlier and the awareness and practices to reduce discriminations and inequalities in health care (and beyond), I now describe how policlinics develop their model of 'Verhältnisprävention' as counter-model to individualized health promotion and disease prevention.

For policlinics, instead of (only) focusing on individuals, health prevention (and health care) should (also) aim for non-individual conditions such as social, environmental or economic factors. In contrast to behavioral prevention (Verhaltensprävention), Policlinics call this Verhältnisprävention or conditions-based prevention (Poliklinik Veddel, 2019). This central practice means that the burden of health and prevention is not put on the individual (alone) but understood and addressed in terms of social context. Thus, in policlinics behavioral tendencies of patients or communities "*are always discussed in the context of social living conditions"* (Poliklinik-Syndikat, 2020). For policlinic members, communicating to their incomers and patients their anti-individualizing understanding of health is essential. Lukas explains this to me as:

> *"We keep saying [sighs] … from our point of view, it's mainly the structures and not you. That's what's (making you) sick"* (I1)

Policlinics understand health promotion and prevention as a *"a contested process that is never complete"* – thus here again we have this processual notion of health and the idea that it is essentially **a** continuous social and political fight (Poliklinik-Syndikat, 2020). For policlinics, doing community work next to primary care is a necessity – or at least the alternative is deemed inefficient and insufficient. Lukas describes this as:

> *"And I don't think it's enough to just offer one-on-one, individual help. It's about changing circumstances so that people can simply be healthier. (…) And as long as I don't do that, I'm just tilting at windmills"* (I1)

Policlinic members criticize that social determinants stay *"in theory"* but never get translated into practice (I1, I3). For them, the concept of social determinants is well-established in research (I1,I3), with a range of social epidemiological evidence underscoring the importance of social relationships in

producing health disparities (Poliklinik-Syndikat, 2020). Additionally, it is not taught (enough) in medical sciences – which is why Niko organized student-led seminars on social determinants before joining the policlinic movement. However, even this left Niko unsatisfied because it *"remains very theoretical and somehow lacks something concrete"* (I3). This aspect of translating a critique into practice was mentioned on several occasions and can be tied to the second influence in the emergence of policlinics, the interventionalist Left (IL), a political group dedicated to take *"action outside [left-wing]* subcutures*"* instead of *"getting lost in pure criticism"* to overcome *"the powerlessness of the left" (Interventionistische Linke, n.d.)*. According to Lukas and Mathias, people from IL were active in the founding process of the policlinic movement (I1, I3). This also reflects in the political aspirations of the policlinics which is to *"put left-wing transformative health policy into practice"* (RM1).

I will quote from my fieldnotes to illustrate how policlinics visualize and spread their conceptualization of health:

> *Whenever you visit a website of a policlinic project or when you walk through the policlinic, you will find the picture of the rainbow with the social determinants by Dahlgren & Whitehead (1991) in many places. Each bow has stands for a category of social determinants, such as living and working conditions (green) or factors related to individual lifestyles (orange). The policlinics even integrate this in their health education materials. In the Geko Berlin, one of the members proudly shows me their newest visualization strategy: a large homemade intestine pillow with small laminated and self-drawn pictures hanging from it (*Figure 10*). The pictures represent different social determinants categories and are thus in the same color as the respective bow. For instance, there is a picture of a two hands pressing against a clock, representing time pressure and stress, against a green background: or a picture of a glass of milk with an orange background. This helps them to visualize how digestion is related to environmental factors and thereby explain the idea of social determinants of health (*Figure 11*). I have to think of the examples of craftivism once discussed in a seminar, thus the practice of using crafting or creative practices for activist or political aims. Here, policlinics use crafting to produce their own health promotion materials.*

Figure 10 - Picture of the intestine pillow visualizing social determinants of health at GEKO Berlin, copyright: Luisa Gerstgrasser

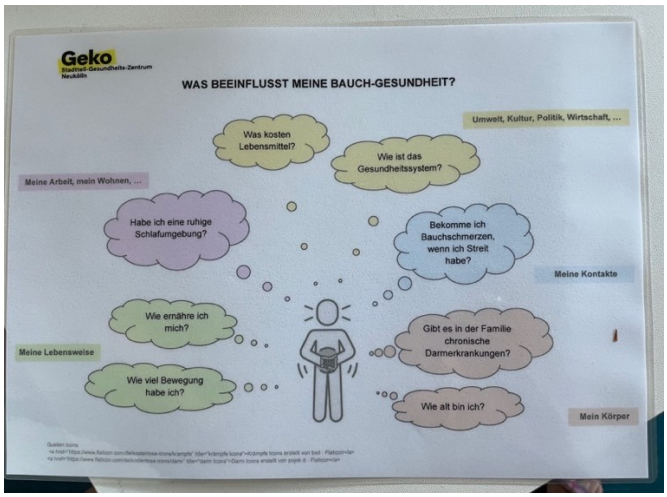

Figure 11 - Picture of how to explain social determinants based on gut health & digestion, from GEKO Berlin, copy right: Luisa Gerstgrasser

Another example of the policlinics' practices to communicate and realizes their 'Verhältnisprävention' are their open group offers. I already mentioned the Textilrezeptur above (cross ref), but another example can be found in the group called 'Mental stress in capitalism' (Geko Berlin, n.d.-b). This monthly meeting is open for everyone, and visitors can discuss, e.g.: *"What do our fears, depression, and other mental stresses have to do with society? How do high rents, unemployment, or poor working conditions affect us?"* (Geko Berlin, n.d.-b). According to Geko Berlin, people individuals are often expected to take responsibility for their own life circumstances and to manage them independently, but their meetings are a space *"to exchange ideas, support each other, and offer tips"* (Geko Berlin, n.d.-b). These regular open groups can be joined without registering and span over a variety of topics such as *"getting out of a personal crisis";* a regular meeting called "Roots Table" for POCs, the 'financial worries' group, but also an informational event on navigating in the healthcare

system for non-Germans or an event series on the challenge of finding a psychotherapy place or a regular group for *"more movement in your everyday"* (Geko Berlin, n.d.-b) (Figure 12). These group offers are different from other courses offered by e.g. insurances, focusing individuals changing their diet, and instead foregrounds societal structures, factors *"affecting everyday life"*, community-building and *"find[ing] ways together"* to deal with problems (I1)(Poliklinik Veddel, n.d.-c).

Figure 12 – Flyer (front &back) by Geko Berlin for the Open Group 'Mental stress in times of capitalism'

An important aspect is the outreach, thus extending the health care, health promotion and community work into the *"Lebenswelt/ lived world"* of people (Gerlof, 2024). In the podcast, Patricia reports how the Geko Berlin's social workers and health workers are going to playgrounds and youth clubs *"to talk to people and offer our services there as well"* (Gerlof, 2024). Here again, I was able to experience this myself when I visited the street festival in the Rollbergkiez where the Geko Berlin was having an information booth. This is an excerpt from my fieldnotes:

> *On my bike, I roll over lots of cobblestones, shaking me up, and the heat is stifling. Sweat is running down my forehead as I arrive at Sasarsteig at the Geko Berlin booth. I take a look around first, reading the notes hanging on the information board there. The topic is heat. And it couldn't be more fitting on this first day of July. The headlines these days are dominated by heat warnings for various European cities. Geko Berlin provides information in various languages (Arabic, Turkish, Romanian, German, etc.). and with pictures about heat, health risks caused by heat, the influence of heat on medication and metabolism as well as about cooling measures. A young woman, who later introduces herself as Selina, dressed in sportswear and wearing a Geko button on her T-shirt, and an older woman wearing a headscarf are sitting on a beer bench. Between and next to them are two little girls who are making fans out of wooden sticks and paper. Two other women, both wearing Geko buttons, are also nearby and talking to other non-Geko people. I approach the table and introduce myself. Selina welcomes me, invites me to sit down and offers me a glass of water. Unfortunately, I'm sitting partly in the sun, so I take one*

of the fans and start using it. We strike up a conversation about the heat, comparing Berlin and Vienna. I ask what they have with them today besides the information material on the pinboard and the flyers. The Geko women tell me about the wet wipes, which you can also take with you. If you wet them and even drip peppermint oil on them, they cool you down nicely. They also have a hot water bottle with them – they say that was what they learned that day: that you can also use a hot water bottle to cool yourself down. You fill it with cold water and put it in the refrigerator overnight (...). The older woman with the headscarf also shows me her cooling bracelet, which works nicely as well. While the children are doing crafts, I slowly start to cool down. The fan, the water, and the cooling bracelet are doing their job.

Two things stuck with me from this street festival experience. As illustrated by this excerpt, Geko Berlin aimed to provide cooling measures against the heat which are accessible and not too complicated, like the wet wipes or the hot water bottle. Thus, the aim is to have low-key tools or easily graspable measures against health risks for visitors. Interestingly, even the Geko members learned something new that day – illustrating their approach of seeing knowledge as disseminated.

The other aspect I took from this, also from conversations with Selina after this situation, is that policlinics' health promotion activities are not about teaching individuals but rather about reaching them, about being present and establishing relationships and networks in the neighborhood (RM2). Selina tells me she had to unlearn this, as with a background in health communication her idea of success was to talk to as many people as possible and to convey as much information as possible (RM2). After this street festival, she says she is happy with the outcome because she had a few meaningful conversations with local inhabitants and made new connections with existing actors in the area, such as a teacher interested in Geko Berlin's health promotion offers for their school (RM2). Additionally, Selina explains that although the focus of the booth was heat, she was not strictly speaking about this with visitors. Within health outreach work, you have to be flexible and *"it is a balancing act"* (RM2): whether to approach people with a specific topic, like heat, or in a more general way. While the latter can be too broad and overwhelming, not all topics are equally relevant to all visitors. Thus, the policlinics aim to follow a need-based approach rather than presupposing topics or deciding on them top-down. According to Selina, Geko Berlin's approach differs from classic health promotion in that it focuses on quality over quantity, foregrounds taking time and establishing relationships and trust, and acknowledges the different health problems and health promotion needs of its various target groups (RM2).

Another important point for the health outreach in policlinics is the attitude of solidarity. For Patricia, this outreach also connects to an understanding for the problems of potential incomers. She argues that this is what sets the policlinics health work apart from other classical health counselling offers and explains this based on nutrition:

"Often, people have completely different problems to worry about than what they eat. (...) That's why our approach is to first establish contact and build trust and relationships through activities

such as sports, and then very carefully and slowly, not right away at the first, second, or third meeting, not say 'you can't drink Coke anymore' but 'here's some water'. (...) And when they [the social & health workers] bring apples and water for the picnic, the young people take a look at that and say, hm, maybe it's not so bad after all. In other words, we also act as role models. (...) You can't just point your finger and say, 'You can't do that anymore, and you have to do this instead.' It has to happen slowly. And that takes time. But then it's successful." (Gerlof, 2024)

This quote by Patricia shows an important aspect already mentioned before: that it takes time, relationship work and trust building for health prevention projects to be successful. Additionally, as with the need-assessment and networking before establishing their center, the policlinics community work and health promotion practices try to avoid a condensing or patronizing tone.

4.2.5. Health care as community work

The community plays an important role in policlinic's understanding of health and healthcare but also in their idea of social transformation. Involving patients and local inhabitants in the planning and organizing of policlinic activities is crucial both for their participatory claim but also for the local inhabitant's sense of self-efficacy and agency. Therefore, policlinics' community work support and facilitates self-empowerment and collective action:

"People are also experiencing more self-empowerment, self-efficacy, and active participation in city life [as they] join forces and also realize what they might have, share with each other, and come together to tackle bigger problems collectively" (I4).

For policlinics, empowerment through community work is a form of health care and prevention. As Verhältnisprävention, the community work addresses socio-economic and environmental conditions for illnesses such as, the already mentioned moldy apartments. Another example for this, which was often mentioned during my fieldwork, is the policlinic in Hamburg where incomers got together to prevent the demolition of a residential building, where many of them lived (I1, I4). Instead, the building got renovated and *"people were not displaced"* (I1). This threat of losing their home and the ongoing struggle with the landlords was a shared problem and stress factor for many of the local inhabitants. This example illustrates how to combine primary care, prevention and community work.

However, it is not always direct political action that policlinics aim to do with their community work. First and foremost, there is the idea of policlinics being a meeting place. I experienced this firsthand when I visited the Get-together-event at the Geko Berlin in July (RM3). At this get-together event, I observed different people meeting and connecting: the local POCs meeting for their Roots Regular Table, employees at pediatrics' practice, regular guests at the Café Praxis and people from the

neighborhood who seemed to know the place[30]. The Bingo game illustrates this idea of policlinics being a meeting place beyond health care and the practice of fostering existing or helping to build new relationships and communities in the neighborhood.

> *When we arrive at Geko, there are a few people sitting on benches and chairs in front of Café Praxis under some colorful parasols. The transition between the two events happening on this evening are fluid—some of the visitors sitting outside are here for the Black Roots Table, others for the Get-together. (...) Back outside and now equipped with a cool beverage, I sit down between Selina [community work & management of the pediatric practice], Marco [the pediatrician's nurse] and Konstantin [the pediatrician]. (...) Nina [manager of Café Praxis] comes by and hands out bingo cards which she prepared for this get-together. The idea is to go around and find a person for each box who fits the description – so you are motivated to speak to one another. New visitors keep arriving. Some of them already seem to know each other and greet each other warmly. Motivated by one of the older ladies, Johannes, his friend who joined, and I also join in the bingo game. We quickly get a row crossed off because we find people around us who can tick the boxes. In general, people here move around relatively freely, as if they are here often. They don't shy away from entering the rooms of Café Praxis to get a drink or technical equipment. A handful of middle-aged male POCs are setting up a DJ booth. Dancehall music is filling the courtyard in front of Cafe Praxis* (RM3)

Figure 13 - Picture of the Bingo at the Get-together at GEKO Berlin

This idea of the policlinic being the meeting place in a neighborhood is also described by Ida and Laura:

> *"I would love it if we had a permanent meeting place for people in the neighborhood (...) where events could be held and people could just come together, not necessarily to seek healthcare, but simply to have a place for community, (...) for networking. That's also a goal for me, that*

[30] They could also be patients, but at this event and as an outsider I could not tell.

people, especially in times like these, when there is more uncertainty, can simply meet each other again and support each other, regardless of professional help" (I4)

Feeling connected and part of a network, to feel comfortable in your neighborhood, *"that's also part of being healthy"* (I4). And thus, for policlinics, *"community work is health work"* (Poliklinik-Syndikat, 2020).

Policlinics also want to contribute to community-building and to the political empowerment of these communities (I3)(Behrmann & Ihßen, 2023; inosc, 2024). In the inosc manifesto, it says that social clinics and their emergent practices are *"fostering communities of care"* –contributing to the creation of more just societal structures (inosc). Mathias explains this to me as trying *"to bring together people who are affected by some kind of injustice using certain methods so that they can become politically active"* (I3). This is also called *"community-organizing"* (I3). Thus, policlinics aim to strengthen such grassroot democratic processes and empowerment of local, often marginalized communities (I3)(inosc, 2024).

Members tell me that they also see the politicization of their visitor as an aim (I1, I3). Members hope that policlinics contribute to politicization and spreading of ideas like anti-racism or their political critique of economic inequalities in the local neighborhood, thus expanding also their political critique (I1, I3). Lukas speculates, with a little pride, that due to policlinic's engagement on the neighborhood in Hamburg, the voting for parties like the Left or Greens increased (I1). Other members see that policlinics could spread socialization ideas – as discussed in 4.3.4 (I2). Policlinics are connected to broader societal movements, to initiatives for fostering democracy and against racism and right-wing ideologies organized in a "against the right" working group within the syndicate (I1, RM1). Lukas also wishes for policlinics to be *"a bulwark against the right wing"* and by maintaining structures of solidarity strengthening *"a counter-model and perhaps also (...) left-wing politics, a kind of counterpoint"*, even more so as polarization is growing (I1). However, members also tell me that most visitors cannot grasp their concept and probably see the policlinic primarily as a medical practice or counselling center (RM2). The aims of politicizing and empowering mirror what Sanchez also described from their fieldwork in Greece (ref).

Moreover, the excerpt from my fieldwork shows the centrality of a space within policlinics not designated to counseling or medical treatments per se. A space, like the Café Praxis, works as an open meeting place, embodying the idea that health care extends the medical realm. In Café Praxis, *"you can wait for your doctor's appointment or obtain information, e.g., about a consultation",* you can talk to people, have *"brief conversations"* or "*you can also just sit there—without buying anything and without talking" (Geko Berlin, n.d.-a).* You pass through the Café Praxis to get to the practice or the counselling rooms, and you find all the information about events and about the regular open groups in the shop window (RM3).

Such personal relations together with the policlinics primary care, health prevention and community work is what makes them so special and transformative according to Lukas: When people

notice *„that there are people who are concerned about such issues, (...) that keeps you healthy too"* (I1). Thus, it is about feeling and knowing that you are not alone with the problems you face, but also the positive experience of feeling cared for (I1). When being asked to describe what makes policlinics transformative, he describes it as follows:

> *"It's a mixture of feeling and knowing that people simply experience what it means (...) to be part of structures of solidarity and such holistic thinking and thinking that is far removed from the market, such thinking that is not profit-oriented, but rather needs-oriented thinking. (...) And that people simply feel comfortable and well cared for (...), so that at some point, hopefully, this connection will develop, like, ah yes, it feels good and that is why or what feels good: (...) these core characteristics, and this view and this attitude"* (I1)

4.2.6. Conclusion

This subchapter shows that from their critique of current health care system, the activists not only develop counter-imaginaries or radical imaginaries, but they also try to realize parts of it in concrete alternative ways of doing and organizing health care in the present. Thus, different to other political activist groups, policlinics do not only criticize the current health care system, but, in line with radical imaginaries as prefiguration, they try to establish and work towards an alternative (Asara, 2025; Haiven & Khasnabish, 2014). With the way they envision, plan and do their projects, they want to show that it *is* possible to have a different health care system and thereby also to do things differently as a society. I argue that policlinics can be understood as health care commons, because it serves as a space to resist and invert the discriminating, fragmented, hierarchical and individualizing dynamics in health care and society (Dawney et al., 2015).In line with commons, the practices described in this subchapter show the centrality of grassroot decision making, equality, participation, empowerment, relational work, community building, care and awareness for power imbalances, hierarchies and discrimination in the policlinics' alternative practices.

The first two chapters also show that the separation into 'medical/ public health' versus 'political' within imaginaries or practices of policlinics does not hold. Sometimes members try to draw boundaries of political and non-political. However, in line with the theoretical scholarship on alternative imaginaries in activism, the political values and the health (care) related arguments are interwoven – both in imaginaries and in practices (Lehtiniemi & Ruckenstein, 2019).

The example of collective ownership being only possible in theory already showed that these alternative health care practices and imaginaries are not without tensions, frictions and challenges – as already discussed as inherent feature to commons (De Angelis & Harvie, 2014; Schikowitz & Pohler, 2024). Therefore, I look at challenges and tensions policlinic members identify, and I analyze two strategies of dealing with these challenges and working towards realizing their vision in the future.

4.3. Challenges and how to deal with them

4.3.1. Paying for policlinics - from volunteer work to salary models

When realizing their counter-imaginary and establishing their alternative practices, policlinics face challenges, mostly around finances. In this subchapter I will describe the problems which younger policlinic projects and older ones with a medical practice face and the overall challenge of creating the working conditions envisioned.

Young Projects

Most projects start with a health counselling, or with health promotion offers, like information events or a free sports class (Geko Dresden, n.d.-a). Additionally, they try to connect with stakeholders in the area and establish their idea of a primary care center (I4). For projects in this phase, most of their work is done on a volunteering basis as they have limited financial resources, either from donations or funding from foundations or municipalities (I4).

For instance, one rather short-term way of getting money is through the Fusion festival, one of the biggest festivals in Germany. However, Ida tells me that she is the only member from Dresden to take on this fundraising work. This is because they are a relatively young group—meaning that many of them are just starting their careers in the healthcare system. She tells me, that *"they don't feel like taking vacation time just to work at a festival so that the collective can earn money, but they want to take vacation time to recover from their strenuous work"* which she understands well (RM4).

This short impression shows how smaller policlinics struggle to find funding possibilities and the general challenge of doing this volunteering or activist work next to a job. On top of that working conditions in the health care system are strenuous, making the combination of paid work, especially in shift work, and political work more difficult (I4, RM4). This is also illustrated by the fact that not many members from the founding generation are still involved (I4).

With the limited time and personal resources, they have, Ida and Laura tell me how it is a struggle to split it up between their two main tasks: offering services to establish themselves in the neighborhood and acquiring money with writing project proposals. The Geko Dresden recently got funding for two mini-job positions, representing an improvement to the mostly non-paid volunteering work (I4). Applying for funding requires much of the group's time and capacities. Ida and Laura share with me how they are afraid of *"somehow get bogged down in these bureaucratic traps"* when they write proposals or talk to representatives of the municipality, because it makes it hard to keep *"being on site and doing what we're actually in this project for"* (I4). This shows a fear of becoming distracted or even disconnected from the work on the ground and with the people in the process of gaining financial sustainability as a project.

For Ida and Laura, the financial situation is the biggest challenge–since their funding is always short-term. This insecurity and instability are making the establishing of trust and relationship with local inhabitants difficult. Both Ida and Laura say they would wish for a registered practice where people could be employed because then *"the project can or could be self-sustaining"* (I4). Ideally for them,

municipal funding could cover the *"other work"* like community work or health promotion (I4). This idea of opening a practice is also *"the ultimate wish"* and *"the next step"* for Niko from Geko Bonn who is annoyed with applying for funding repeatedly (I2). However, usually one must buy the license from the previous owner and most probably take out a loan from the bank. Therefore, the ideal case would be:

> *"It would be cool if some practice came along and said, hey, your approach is so cool, I'll give you my license here in this neighborhood for free, which really needs something like this"* (I2)

However, Niko admits that getting a practice for free or for very little money is unrealistic. He tells me it would have to be "*idealistic people who are willing to get involved in a project like this"* but even then, he acknowledges that *"it could work, but it's still very expensive"* to start a practice (I2).

Older projects with a medical practice

However, in projects owning a practice like Berlin and Hamburg, the struggle of financing continues. I observed three main problems when policlinics become official health care providers. First, problem is that policlinics want to establish medical practices in medical areas which are not known for creating surplus, such as orthopedics or ophthalmology, but instead they establish a rather low-profit specialty practice like general practitioner's practice and a pediatric practice (I3) (see 3.3.2). On top of that, the way policlinics want to practice health care, it requires higher personnel costs because of the case meetings, taking time to talk to patients and regular team meetings. As Mathias puts it:

> *"Of course, this poses the problem that personnel costs are simply much higher than in regular practice. (…) And that makes it difficult to operate them economically, yes, so they are not cash cows for the other areas. That would be nice, but it's not the case"* (I3)

Policlinics want to run their practice differently but are confronted with the problem that personnel costs are *"the most valuable resource"* (I3). As policlinic practices are not *"cash cows",* there is not much surplus to be made. The practices rarely make profits, they are merely financing their running costs or paying back the loans. As already explained above, policlinics work on a non-profit basis. Thus, if there are any profits made, they try *"to distribute the money as fairly as possible among the employees and invest in the practice structure"* (Gerlof, 2024).

This points to the other two problems within policlinics that have a practice: namely the problem of how to finance *"the other work"* or the nonmedical work and the challenge of being two separate legal units – medical practice and NGO. Under current legal conditions, it is difficult to perform financial transaction between these two units (I1, I3). The only money that flows e.g. within in Geko Berlin is the rent paid by the practice to the NGO, renting the whole building (Gerlof, 2024). The following quote by Mathias describes this:

"The major issue is that we would need to operate independently, both organizationally and financially. This means that there are essentially separate budgets, and we cannot combine everything to cover shortfalls in one area with surpluses in another" (I3)

Members wish to break up this separation, thus having a primary care center *"which can be financed from a single source under one roof with one budget"* (I3). Policlinics want to decide themselves how money is distributed among the different professions and offers. They perceive this separated financing structure as countering their vision and values and as *"it is a burden",* not only financially but also practically (I1). For instance, Lukas complains that within the public relations or outreach, they always have to be careful to state that they are two different units (I1).

To cover the nonmedical offers, such as the self-help groups, the counselling, the health promotion offers or the community work, the older policlinics also apply for funding from foundations or municipalities. Together with insurances paying for the health benefits, this creates a *"mosaic of funding sources"* with *"five, six, or eight funding programs running at the same time"* leading to *"an enormous amount of bureaucratic effort"* (Gerlof, 2024). Thus, also older projects face the continuity problem and the workload of applying for funding. A member from Geko Berlin jokingly says that in fact they need *"an extra position to take care of the reapplication process all the time"* (Schunke, 2022).

Besides wishing for a common legal structure and shared budget, members envision a basic, long-term funding for their NGO. Then, one could still apply for funding but for *"experiments"*. If the basic offers were covered, then *"writing applications would be more fun again"* because even in such an ideal future scenario, *"experiments would not be paid for by health insurance"* (Gerlof, 2024). For instance, community health nurses cannot be paid through insurance benefits and to enable this, policlinic members must apply for external and temporal funding (RM1). This aspect of only being covered by insurance benefits when there is evidence and thus not for 'experimental' health care approaches, as discussed in 4.3.3.. For the work not covered by funding, policlinics rely on *"extra effort"*, thus volunteering or employees doing more than they are being paid for (I1). Lukas describes as *"commitment beyond the norm"* which they need to "*establish new structures"* (I1).

Working conditions & Salary models

From these three problems arising when policlinics establish a practice – the lack of surplus made, the separate units and the mosaic of funding to cover nonmedical offers – I will now turn to another challenge relating to the working conditions at policlinics, particularly the topic of salary models. Based on the idea of equal interdisciplinary, policlinics strive for wage equality within their project (I1, I4). This issue of fair salaries was mentioned several times as a potential topic of conflict, as something which needs to be changed structurally and legally and as a limitation for the policlinics potential scaling-up (I1, I3)(Gerlof, 2024). Although members were carful in sharing details about how exactly they align their salaries – I learned that there are essentially three approaches. There is the uniform wage where everyone, regardless of profession, receives the same wage, the subgroup wage

where everyone in a group receives the same wage or the needs-based wage where wages depend on the needs of individuals in the collective (RM1). Each local groups in the syndicate decides among themselves how they want to do it – which often *"leads to arguments and discussions every six months"* and decisions are revisited regularly (Gerlof, 2024). Several factors make this salary alignment difficult for policlinics. The separation into practice and organization is a challenge here again. Members explain, that even if the employees of the practice give up parts of their salary, it cannot be transferred to employees at the organization that easily (I1, I3) (Gerlof, 2024). This is why, for Mathias, *"the big idea, the fair salary model is simply not possible"* because:

> *"This separate management also means that you don't really come together in your day-to-day work, because the first level with the practices is always somehow a bit separated from the NGO's structures and the NGO's offerings on the ground floor. So, there are always (...) perceived differences and conflicts, which are then reflected, for example, in (...) very different salary models in the various institutions"* (I3)

However, other factors make the salary alignment difficult as well. For instance, a member explains to me that for doctors, this might be difficult due to the medical association's guidelines (I1). Generally, it is difficult to pay less or more salary, because certain professions have binding collective agreements.

Another reason making this billing difficult is the billing through insurances. Because policlinics are restricted in what offers and services can be billed at insurances, the salary for certain professions can be covered by billing through insurances, whereas others cannot. Additionally, when professions or offers are paid through e.g. municipal funding, there might be regional differences. At the event, a member from Freiburg tells me that they received funding for two part-time positions which are paid in an E13 pay scale for the public sector, which *"[they] can be very happy about"* (RM1). But she acknowledges that *"this only works in wealthy cities"* (RM1).

Generally, at policlinics, Patricia explains that doctors' earnings are *"worse than on the general market"* often because positions are shared thus only part-time, but the actual working hours might be more (Gerlof, 2024). However, other professions, such as social workers or nurses might earn more than elsewhere. Patricia says, if doctors want to work at the policlinic but also want to earn more, they might *"even work an extra shift at the weekend to get the money"* they need (Gerlof, 2024). Such working conditions are not something for ordinary people:

> *"A few idealists like us will certainly do that. But if we want to scale it up, which is our idea, then it has to be accessible to ordinary people"* (Gerlof, 2024)

Niko sees this like Patricia – as he explains to me that *"of course there's a lot of idealism involved"* for the policlinic members (Gerlof, 2024). Together with the financing challenge, this might lead to self-exploitation and members might be at risk for burn-out (RM1)(Behrmann & Ihßen, 2023).

Overall members have raised about the projects' sustainability. This and the risk of self-exploitation urge policlinics to professionalize. Similarly, Niko also sees these problems and the urge to become professional because they *"can't all continue working like this"* (I2). For Patricia, to become an attractive, accessible and professional working place, also for non-idealists, they need "*structural changes"* (Gerlof, 2024). For instance, an additional digit in the insurance billing system allowing for more policlinic activities such as interprofessional team meetings to be paid through insurance (I1, I3). This example of team meetings illustrates the contrast of their counter-imaginary and practice of interprofessional meetings (which are pivotal), and the reality, where it is a financial struggle to set time aside for these meetings.

Thus, although equal pay is an aim, it is hard to realize in policlinic projects and a challenge for the upscaling of policlinics (Gerlof, 2024). These problems have described been described as constantly being faced with "*little obstacles in our way",* thus mainly *"outside"* challenges which prevent them to *"to do things differently"* (Schunke, 2022). This disconnect between what policlinic members envision as ideal and the actual non-ideal working conditions is described by Lukas as well:

> *"Well, I would say that the working conditions we have created so far do not reflect what we would like to see in society. (...) So we work in very precarious conditions"* (I1)

Coming back to the risk of self-exploitation, I will give one more example from my fieldwork which already illustrates how policlinics handle the challenge of different salaries and the precarious working conditions. At the vdää event, one older vdää member commented, rather provocatively, that their project seems like *"classic left-wing self-exploitation"* because individuals are being underpaid for their work which he as a union man would criticize (RM1). The syndicate members presenting took this with question seriously and acknowledged the problem of unpaid and underpaid work needed to establish a policlinic. One syndicate member replies that there are also union members in some of the local groups, and that they are *"aware of the issue of wages and self-exploitation"*, saying this in an almost appeasing or defensive manner (RM1). Another member calmly replied with a smile:

> *"Yes, we know that there is no such thing as a good life in the wrong. No model is ideal. Some people earn more than usual at Geko [Berlin], others less than elsewhere"* (RM1)

Lastly, when members acknowledge the difficult working conditions, they mention the meaningfulness and the group's good communication as compensating for it (Gerlof, 2024). The following quote, illustrates how having a job position at policlinics is seen as political (work):

> *"The first doctors who participated truly saw it as a passion project. They also saw it as a political imperative, and as an investment in the future, hoping that the model could be replicated."* (Gerlof, 2024)

It shows that members might also value their work in policlinics differently because it is more than a job to them. For instance, Laura told me that when she finished her medical degree and started

working as a doctor, she realized she would have less time for political activism, and when she found the Geko Dresden, she thought that would be ideal for her as she would have been able to combine working as a doctor and political work[31]. This idea of being an activist and political project is also what distinguished policlinics from other primary care center projects (I1)(Schunke, 2022). However, this idea of working in policlinics as being a way of realizing one's desire for activism or political volunteering is not shared by all members. Mathias, for instance, tells me he never wanted the policlinic projects to become his job, but consciously remained *„one of the only activists left"*(I3). These quotes, referring to idealists who started the project, and Mathias, being the only activist left, show how this activist nature of the policlinic groups is changing as projects grow into professional health care providers.

4.3.2. Growing up - from cozy political groups to being a business

In professional or providing policlinics like in Berlin or Hamburg, due to the time and capacities being bound in health care provisioning, policlinic members discuss the loss of activism, political work, or simply time for internal discussions. This leads to members demanding more internal work within the groups and the syndicate, a reduced growth and again, more structural changes to make their work easier and more aligned with their vision.

Mathias tells me that since Geko Berlin has scaled up, there are fewer people working in the project as activists or volunteers:

> *"Those who are activists, who don't work there, have basically become fewer in number (...), those who are active here, politically active, let's say, don't show up at all in everyday business. So, they can take a shift in the café or something, or offer a group, but, that's drifting further and further apart. (...)"* (I3)

Thus, Mathias explains that those who used to be activists in the policlinic projects, are now employed and have obligations in provisioning or project-based tasks (I3). Political work is less done by employees – *"simply due to a lack of resources, not a lack of will"* (I3). Mathias does not sees this change as a problem per se but more as *"a development"* although *"many people view very critically"* (I3). For some policlinic members their activist structure as something that *"also sets us apart, probably from conventional health care centers"* (Schunke, 2022).

This loss of political activists is often described as becoming a business. Mathias emphasizes that the Geko Berlin has evolved, from *"a political activist project (...) into a medium-sized company"* (I3). Lukas also compares the professionalization of the policlinic Veddel to a change from "*a cozy political group"* to *"a business"* (I1). The question is whether they lost the coziness or the political or both. The coziness might refer to the fact of being a smaller group, of having an overview over the

[31] However, Geko Dresden does not have a practice yet, so she does not work as a doctor but still does activism besides her paid work.

processes and people and having closer personal relationship among each other – aspects that have been mentioned as potential losses by policlinic members (I1, RM1). A member at the vdää event says, that after all the work and the stress, is it the personal relationships among each other in the collective that fall behind (RM1). This is why other projects would take extra time and, for example, cook together once a month before the plenary session (RM1). In older policlinics, making time for internal meetings becomes more difficult. For instance, at the get-together, one of the volunteers tells me that plenaries where all groups, from the two practices, from the Café, from the organization and the community work come together used to be every two weeks, but *"this is not possible anymore"* due to the growth and professionalization (RM3). There had been attempts to organize regular monthly get-togethers, but somehow few members had been attending over the years and now they are trying every three months, in the hope that more people will come (RM3).

Beyond cozy, for some members, it is clear that *"the more professional we become, the less politically activist we are"* (RM1). And there is simply never enough capacity after providing care even if people would like to do more political activism and networking. Interestingly, intimate personal relations in the collective are tied to being a political activist group and both become more difficult to realize when becoming professionals. This also applies to Lukas, who speaks about the beginning of the project with a certain nostalgic notion, even comparing it to a family or shared flat:

> *"In the beginning, of course, everything was so cozy, and we were like a little shared flat, slash family, I don't know what, and everything was so gut-driven and stuff, and then, we grew more and more, and then other people joined us, which is also totally great (...)"* (I1)

Thus, being a small group has its advantages, such as being *"gut-driven"* (I1). Now, he struggles with *"a loss of orientation",* in the sense of knowing *"who is responsible for what"* (I1) and he complains about growing number of bureaucratic and organizational tasks. But as the collective grew, for Lukas it becomes increasingly difficult to say, *"I'm part of a collective and we all take care of everything*", like they used to do (I1).

Also doing plenary sessions which make policlinics different, are also what falls behind when projects scale up. Tying back to the 'cozy political group', I will share another impression from my fieldwork. At the street festival in Berlin, Elin, who does pharmaceutical counselling on a volunteering basis at Geko, tells me that plenaries where all groups, from the two practices, from the Café, from the organization and the community work come together have become rarer over the years. According to her, there used to be general meetings every two weeks, but *"this is not possible anymore"* (RM3). There had been attempts to organize regular get-togethers, but somehow as the project grew, fewer people had been attending. Now they are trying every three months, in the hope that more people will come.

Notably, younger projects, see the comparison to a business more critical and as something they want to avoid. At Geko Dresden, where they are less professional in the sense of not having a practice

yet, it is important to keep a collective responsibility and although they now have small job positions. They emphasized that they do not want to end up becoming a business-like structure, when they tell me:

> *"So, for example, now that we have become employers (...), well that has been accompanied by a significant increase in responsibility, but that is being handled quite well by the group. That is perhaps also a big difference from companies, right, which are very hierarchical, where individual people bear a great deal of responsibility"* (I4)

Thus, even though Geko Dresden has become an employer and more professional, the members do not want to become like a company because it is too hierarchical, reflecting the anti-hierarchical value in policlinics' counter-imaginaries. As with the salary models, the importance of having internal discussions is highlighted (I1, I4). Ida and Laura also tell me that to manage this transition to an employer, their group has done supervision, because it was important to avoid overload for both employees and volunteers, to discuss together how these positions now change group dynamics and how they want to organize their work. The supervision helped them to talk about *"worries and doubts"* and about how employees *"feel now with this special role"* (I4). Thus, focusing on emotions was useful because the group could reflect on *"processes [that] run automatically that we are not even aware of"* (I4). This was also the case in Hamburg, where the group has also done supervision, to support the professionalization process and reflect on how to emotionally handle the difficult situations of patients they are confronted with (I1).

The shift from activists to providers also affects the policlinics' self-understanding as political (activists). Selina tells me, that she thinks it's interesting that I talk to *"younger projects",* who are not providers yet. With a smile, she says that she is also a little envious of such groups because they still have the freedom to be a little more idealistic and are not primarily concerned with providing. I quote from my fieldnotes:

> *Then she says that there is always one concern that hangs over everything like a cloud: "what if we simply become a doctor's office? Without any idealistic or political aspirations?" She herself doesn't really believe that this is a danger at the moment or that it will happen in the future. We walk for a moment in silence. Then she adds: "But it does hang over everything a little"* (RM2)

Taking the loss of political aspirations or idealism seriously, describing it as hanging *"over everything a little",* Selina is still not greatly concerned about it. However, she takes this seriously, when she describes the risk of losing the political as hanging 'over everything a little'. Similarly to Lukas, she speaks with a nostalgic tone about younger projects without provision responsibilities. Mathias tried to answer this question of losing the political in the professionalization process with nuance and simultaneously a bit contradicting. For him, there is no *"significant weakening of (...) [their] political,*

health political stance" and he insists that they *"haven't softened (...) [their] stance"* (I3). At the same time, he constitutes that there has been a shift among the members**:**

> *"What is always a problem, of course, is the political, let's say, developments toward a more just society, toward, more equality, more equality of property…(...) getting the political ideas to align with the concrete, rather narrow requirements of the projects. (...) Especially because now, there are people working there who simply want to work there. They think it's a good place to work (...) but they don't necessarily always share the political and health policy ideas of the founders, the founding generations. In other words, they don't necessarily support those ideas. They don't drive them forward"* (I3)

Right after saying this, he tells me that this is not a problem, but more of a challenge and that overall, he does not think that they have *"lost (...) [their] edge"* (I3). Still, it is important for him, to not get lost in providing at policlinics, but to keep on doing political work guided by the question: *"Is there a right life in the wrong context?"* (I3)

Another dimension to professionalization and politics is the responsibility towards the employees. Mathias tells me, that hanging a banner from Deutsche Wohnen und Co. enteignen from their window at Geko Berlin, is something they need to seriously. They need to *"always ensure that our project funds continue to flow so that we can provide for the employees there"* (I3). If they *"attract inappropriate political attention"* or if their *"non-profit status were revoked because of political activities"* this would mean less money and having to lay employee off (I3).

Thus, engaging in political action as an NGO and health care provider is a balancing act. Policlinics depend on their status as non-profit, and several members have mentioned fearing what could happen to their project with growing right-wing political parties and conservative governments (I1, I3)(Behrmann & Ihßen, 2023). For Mathias, however, this fear does not mean that *"let ourselves be silenced, nor should we feel conflicted internally"* (I3). Later in the interview, when Mathias talks about policlinics conveying *"the idea of justice and equal treatment beyond the concept of health (...), of a more social, more socialist society"*, he tells me that *"you can't always say that out loud because of the non-profit status"* – again giving me conflicting or ambivalent information but also illustrating the carefulness of policlinics regarding politics (I3).

This question of keeping their political edge also concerns cooperations with conservative municipal governments. For Beatrice, the question is *"what we can do without compromising ourselves and still work with them"* (RM1). Their strategy would be to always refer to public health research, i.e., facts and scientific terms and arguments on the topic of social determinants of health, because *"that way, we feel less vulnerable"*. Some people might see this strategy as being *"going soft",* but Beatrice disagrees:

> *"If one is sitting opposite these politicians, you could argue quite clearly that these factors make people ill – even if they might not call it capitalism" (RM1)*

A member from the syndicate adds that how pragmatic or idealistic policlinics are or should be, is discussed differently in the various local groups. Having represented policlinics at inosc, she reports how German policlinics seen as more opportunistic or pragmatic. At projects in Thessaloniki, Greece, for example, *"it's completely different there, and everything is organized on a solidarity basis"* with attempts to get by entirely *"without external funding"* by insurance or state (RM1). For Lukas, it remains clear that policlinics are political projects and fundamentally different to state initiatives (I1). This self-understanding as political, even as activists, and even as they become providers, is different from other providers. I noted this when Lukas talks about new health centers being built in Hamburg based to certain degree on the policlinic model and the difference being something one can feel:

> *"This is an (...) imposed program by the authorities (...), these aren't left-wing activists who then hold a plenary session in the evening and so on, yes, so it simply has a different feel"* (I1)

Becoming professionals is accompanied by a lack of time. Lukas tells me how provisioning or the *"outer work (...) eats up"* most of the capacities (I1). The 'inner work' of policlinics would be to foster internal communication, their collective organization structures and maybe even reflection on development options. Syndicate members also talked about the need to conduct *"internal alignment work"* within the syndicate and to examine their own professionalization, their organizational development, ways to shape the growth and new memberships to improve work processes and capacities (RM1). For Lukas, the need for *"inner work"* is very clear and "*it naturally comes back to haunt us"*, causing uncertainty. This is why, he prefers a *"limited"* or *"completed"* growth to cope with *"growth risks"* (I1).

One of the problems tied into this priority of outer work is that the need for provision is growing, illustrated by the fact that Geko Berlin does accept new patients (I3). Members explain that their offers do not cover the growing needs – and that this should not be the aim (I1, RM1). Beatrice explains that they cannot *"always meet the demand with more services, with more and more consultation hours",* as this is not their *"task"* but *"a long-term political solution is needed"* (RM1).

However, what this political solution could be remains to be decided, as there are different schools of thought within the syndicate on what development options are. Mathias adds that this discussion on the best option in the near and far future is often neglected. It also ties into bigger questions of how to relate to state infrastructure, like Sanchez's work (2023). For Beatrice, it would be ideal if there were something that wasn't completely parastatal, but still integrated in some way, to remain independent of the government's political orientation. Jonas even spins ideas of policlinics becoming a future *"infrastructure for left-wing movements"* outside the state to circumvent possible repressions. For him, with the escalation of social struggles and the recent criminalization of the climate movement or anti-fascist activists, thus the increase in state repression against activists, this might *"be entirely beneficial, necessary, and sensible"* (Behrmann & Ihßen, 2023). Thus, we can see that members relate

differently to the overall health care system, and to the state as actor, seeing the future cooperation sometimes more pessimistic (I1)(Behrmann & Ihßen, 2023), other times optimistic (I3)(Gerlof, 2024).

For Mathias, to reach political solutions, political work such as lobbying, organizing political events and campaigns, trying "*to get more involved in committees"* and trying to connect with other political actors needs to be enhanced (I3). This ties into the problem of missing political activists and the political work falling behind in professionalisation and the political work being difficult to be fund (I3). To solve this, Mathias suggests that policlinics could outsource the political work to the syndicate. The provision should take place locally, but the political work and interfering into the public debate is something the syndicate could take on. Mathias tells me, he knows from his other activism at the vdää:

> *"If you do it long enough and develop enough expertise, you'll be heard in the scene. And then the discussion, the political discussion, takes place with you"* (I3)

This idea of the syndicate strengthening the political work was also discussed as current priority at the last syndicate's general meeting where members decided that the syndicate understands itself as *"political actor"* (RM1). However, as in the local projects, the capacities of the syndicate are limited as well. Struggling with finding financial resources as an NGO, they recently got funding for two mini-job positions. The problem is that these newly employed people struggle with the amount of work and most work is still being done on a volunteering basis (RM1). This is described by Mathias as:

> *"It's a tricky situation: Either you exploit yourself even more [when doing political work as provider], or you hand it over to the umbrella organization, but then there's no money. That's why there's also the Strategy and Utopia Working Group in the syndicate"* (I3)

This quote shows that the syndicate also struggles with financial and personal capacities. For instance, Mathias explains how the syndicate is busy with the organization of general meetings twice each year for all members where they are "*constantly introducing, integrating, and aligning the new groups, providing them with the necessary knowledge"* (I3). With these 'growing pains' other discussions sometimes take *"a bit of a back seat"* both locally and in the syndicate (I1).

Despite this, members proudly told me about they recently successfully finished the project of establishing a statute (I3, I4, RM1), where they clarify *"which tasks the syndicate should take on"* and define *"the shared value basis"* (RM1). According to Mathias the previous problem was a lack of a formally established political consensus among the different projects (I3). At the last general meeting in Göttingen in Mai 2025, they voted on the statute, which now gets discussed within the local groups and each group can bring discussion points for the next general meeting (RM1)(Poliklinik Syndikat, n.d.)[32]. Overall, the statute was described as this shift towards prioritizing more inner work in the policlinic

[32] Which is not public yet

movement (RM1). Although the statute is still in the editing process and not public yet, they shared a quote from it in the Zoom chat at the vdää event:

> *"We see a constant conflict between the demand for emancipatory healthcare and the financial and systemic conditions. This conflict requires ongoing debate about the tension between aspiration and reality"* (RM1)

This constant conflict for Mathias means that "*there can be a discrepancy*" between "*what you demand externally"* and what you *"follow internally"* (I3). However, and fitting to the statute quote, how big this discrepancy is and where it lies, is something groups need to discuss internally and be generally aware of.

Thus, overall members agree that structural changes are needed to respond to the challenges policlinics are currently facing and make them more sustainable. As projects are growing and becoming professional providers, the question of *"what is going to happen next"* arise (Schunke, 2022). Similarly, Jonas argues, that policlinics cannot continue with limited financial and personal capacities and to become a countermodel, they need to organize their work legally and financially in a more efficient and less self-exploitative way (Behrmann & Ihßen, 2023). Within the policlinics, there are different ideas about how exactly to realize or how to best work towards their vision of health care. Some members see the research working group's efforts of collecting evidence in the framework of the Navigation project, to ultimately become part of standard care as an important next step and potential structural solution (I3, RM1). For others, the solution is developing ideas of socialization in the utopia working group. The next two chapter will focus on these two projects which members see as addressing these challenges or the problem of policlinic's work being unsustainable[33]. Analyzing these two approaches will help me to illustrate the different strategies of policlinics to deal with inherent tensions of commons and how they, despite this, work on realizing their (radical) counter-imaginaries in the future.

4.3.3. The Navigation research project – becoming part of standard care

For some policlinics members, science needs to be included in restructuring health care (I3)(Behrmann & Ihßen, 2023). Research plays an important part for policlinics, as already described in 4.2.2. Here, the Primärversorgungsreform in Austria is mentioned as positive example because here, progressive public health politics were realized based on scientific insights (Behrmann & Ihßen, 2023). Members argue that having scientific evidence and evaluation for their solidarity-based community health center as they envision it, would be pivotal. They need *"to prove that what we do works"* (I3). Without the evidence, their ideas will not have enough credibility. Mathias puts it like this:

[33] It is important to mention here that these two projects or priorities are not mutually exclusive as they work on different timelines and levels.

"We can, well, we can say for a long time that we're doing this and that, and it all sounds great, that our social workers are going to the soccer fields and trying to pick up young people who might eventually come to the center with their parents when they have problems. Yes, but we have to prove it. Then it has power" (I3)

Their counter-imaginaries and alternative community practices are not enough, but policlinics also need to collect scientific evidence for their whole model to gain 'power'. In this context, members tell me that the Navigation research project has this potential (I1, I3, I4, RM1) [34]. This project called Navigation or 'Sustainable care in community health centers – health at the center' is funded by the Innovationsfond and spends from April 2025 until March 2027. In total 580 patients will be followed as they undergo *"a novel care pathway"* (Poliklinik Veddel, n.d.-c). The policlinics in Hamburg and Berlin represent *"best practice model"* which potentially *"set new standards in interprofessional, community-based primary care"* (Poliklinik Veddel, n.d.-c).

The Innovationsfond is the financing body of the joint federal committee, which sets standards for what is funded by insurances and consists of insurances, providers and patients[35]. The fond is responsible for promoting projects on new forms of care and health services research. The main idea of Navigation is to improve the care pathways (see Figure 14Figure 1414). This means that patients can receive interprofessional care, getting support by the community health nurse, who holds a coordinating position. Thereby, the evidence for this concept is also strengthened. Overall, Navigation claims to establish better accessibility because *"everything [being] under one roof" (Poliklinik Veddel, n.d.-c)*. The project is targeted for patients with chronic diseases (Poliklinik Veddel, n.d.-c)[36].

[34] whose start in April 2025 was by the time of my fieldwork recent

[35] The latter cannot vote but only put items on the agenda (Gemeinsamer Bundesausschuss, n.d.) – fitting the criticism of existing participation described in 4.2.2.

[36] but according to Patricia this will be easy to find in the neighborhoods of the policlinics in Berlin and Hamburg, as – saying this jokingly - these criteria apply to many local inhabitants there (RM1).

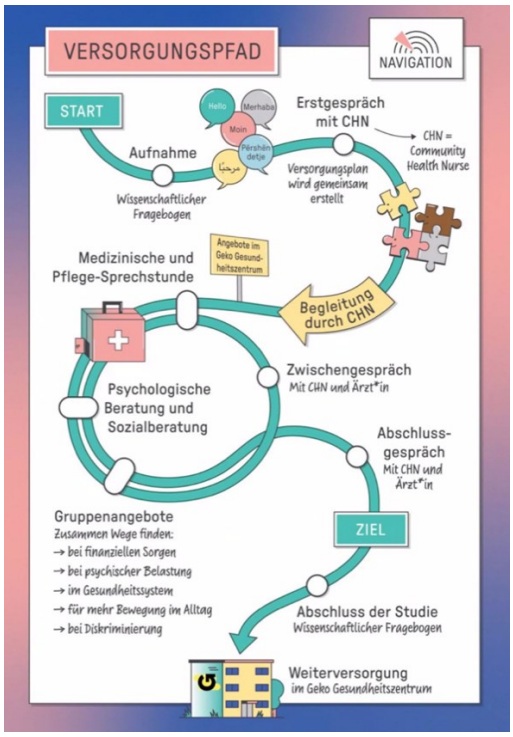

Figure 1414 - Picture of the care pathway in the Navigation project

Within the intervention phase of the project Navigation, data about patient activation, improved health literacy as well as quality of life and life satisfaction are collected to then evaluate *"whether the model improves the quality of care in Germany and how costs develop in comparison to standard care"* (Poliklinik Veddel, n.d.-c). This evaluation will be performed by the Charité – Berlin University Hospital and the result is expected in October 2027. Different insurance companies are supporting the project as the concept of primary care centers as laid out by the WHO and as realized in policlinics, is one of their political demands (Poliklinik Veddel, n.d.-c).

Many members are happy about this project as it is important and because it is the first research project of this size for policlinics (I4, I3) (Poliklinik Veddel, n.d.-c). Notably, it is not only the size of the project but the fact that it represents the possibility to collect evidence for the policlinic's alternative model of primary health care (I1, RM1). The goal is *"to test an interprofessional care model for primary care centers"* and the outcome will decide whether such primary care model becomes part of the standard care covered by insurances (Poliklinik Veddel, n.d.-c)[37]. This hope becomes clear when Lukas tells me about the project:

> *"So, the greatest hope is, of course, that this innovation fund project will be successful. And that this will actually change the financing situation, because in the best-case scenario, certain services that we currently cross-finance, do on a voluntary basis, and so on, will become part of standard care, especially when it comes to this whole interdisciplinary aspect. (...) That would*

[37] Primärversorgungszentrum, PVZ

definitely be great and is also extremely important, because otherwise, I don't know if it will be sustainable in the long term" (I1)

Lukas hopes that the success of Navigation project leads to an integration into standard care which is needed to make policlinics sustainable as otherwise he does not know "*know if [the projects] will last in the long run"* (I3). Thus, Navigation is an answer to the frustration with the health care system and the policlinic members' struggle with how their projects are currently running.

Beatrice also describes Navigation as *„an important step toward establishing a sustainable model"* making follow-up policlinic projects much easier (RM1). Thus, making Navigation is an important factor for the upscaling of policlinics (RM1). As a positive example, which previously got Innovationsfond funding and due to the project's success became categorized a potential new candidate for standard care in one of the GVSG drafts, are health kiosks. However, in the final legislative proposal they were not included anymore, leaving this idea in a certain limbo state (RM1). This example shows the importance of having evidence to get *"incorporated into the legislative process"* and maybe achieve a legislative change. Mathias uses the picture of seeds and plants to illustrate this:

"And where, using the example of health kiosks, multi-professional work was recognized as an idea (...). In outpatient care in Germany, that was new, those were very small seeds, but in healthcare, as long as I've been following it, it's always been the case that the seeds of one law have a chance to blossom in the subsequent law. Well, these seeds have not yet taken the form of legislation, but we need that" (I3)

However, what also becomes clear is that policlinics had to adjust their model to fit the criteria of Innovationsfond. Because policlinic models already exist in Berlin and Hamburg, they needed to *"do things differently"* and focus more on the supply chain to ensure that their application met the criteria (RM1). This means that some of the community work activities at the Geko Berlin, like the arts and culture program cannot be supported by Navigation. The focus is more on health promotion offers, like the swimming lessons for Muslim women (RM1). At the same time, Beatrice proudly explains that through the Navigation funding, two new positions for interdisciplinary collaboration could be funded (RM1).

When Beatrice talks about this reframing of the policlinic as new and innovative, she rolls her eyes. In a similar way, Mathias tells me about the necessity for evidence*: "That's the logic (...) That's part of the game"* (I3). Thus, although this subtle questioning or annoyance, both Mathias and Beatrice acknowledge that these are the rules they have to adhere to achieve the aim of becoming standard care and to reach their political aim of establishing the concept of primary care centers, resembling value pragmatics of data activists (Mager, 2023).

For Beatrice, becoming part of standard care paid by health insurance as policlinics, would mean to be finally independent from political budget planning by the municipalities – thus also a solution to what has been described before as a fear of a political shift and the resulting political headwinds by

many members (RM1, I1, I2, I3). When Beatrice presented the Navigation project at the vdää event, my impression was that she did this in a slightly defensive manner, as if she had to justify this 'unradical' move by the policlinics (RM1).

Lastly, I just want to mention that this need for evidence for their model is not shared by all members. Niko tells me that there is already consensus in research about such primary care centers because the WHO is demanding them for years (I2). However, he also acknowledges that Navigation still is important, because *"there the interventions are happening"* – and you need scientific evidence on the efficacy of these interventions as well (I2). Furthermore, policlinics are more than the WHO primary care centers – because they do not only address social determinants but actively contribute to the empowerment of patients *"not only in terms of healthcare services, but also in other areas of life relevant to health"* (Poliklinik Veddel, n.d.-c). This refers to the open groups within the Navigation project which are *"tailored to patients' social and cultural needs"* and *"provide space to collectively address social determinants"* (Poliklinik Veddel, n.d.-c). Thus, instead of 'only' empowering patients in their health or disease management, the policlinics aim to offer collective spaces and approaches to tackle the underlying social, political and economic problems that patients share, such as financial worries or discrimination experience (Figure 14).

4.3.4. The utopia working group - socializing health care

For other members, like Niko, the challenges are frustrating and the current stage of policlinics does not fit his utopia:

> *"So it can't be the utopia… (…) the way we currently lift these things, and we close the supply gaps, it includes so much idealism, voluntary work, care work, unpaid work and so on"* (I2)

Thus, for Niko growing is good – but it will always stay within structural limitations and thus he wishes for more utopian thinking. In his eyes, policlinics should not stop at what they can achieve under current conditions – but instead should engage in criticizing and rethinking these conditions. This utopian thinking for Niko means to develop ideas of democratic public ownership of primary or all of health care. How exactly this would look like is still unclear – but this is where the Utopia working group of the policlinic syndicate, co-founded by Niko, is working on. This working group has recently finished a concept paper[38]. This paper has three levels for democratizing primary health care.

The first level would be orientation towards the public good meaning that *"all production means, [which means] all practices, infrastructure, equipment, and so on should not belong to a private individual but should belong to the community"* (I2). This criterion is part of the counter-imaginary of policlinics, but as discussed in 4.1.2, is challenging to realize. Other members are concerned with this as well (I1), although not seeing this as necessarily connected to the socialization/democratic public

[38] which is not public yet, but which Niko summarized to me in the interview

ownership debate nor to the need of developing a utopia (I1). For instance, for Lukas utopian are those *"easily euphoric"* who want to establish more policlinics or expand the existing policlinics but care less about consolidating or making the practices of policlinics more sustainable (I1). Thus, what is meant with utopian thinking is not the same for all members (or contributors in the debate on how to restructure health care).

The second criterion is the democratic or grassroot structure, meaning a board overseeing all primary care facilities within a certain area with "*the authority to make all decisions"* and *"composed of the employees of the public institution, i.e., healthcare workers, and (…) patients"* (I2). This takes the participation in the counter-imaginaries and practices of policlinics further, expanding them to all od primary health care. It is not clear who else exactly should be part of this board. As Niko answers that *"this hasn't been fully discussed yet"* (I2). Asking about insurances, Niko answers that in the utopia, there would be only one global insurance. But he immediately tells me that *"the working group has not yet approved the inclusion of this, because it is very, well, it's a long shot, so to speak"* and laughs (I2). If this is not possible, there would be a citizen insurance in Germany represented those boards. But overall, he tells me, these are still *"open questions"* (I2).

The third point concerns financing. Important is that healthcare *"must be far from the market"* and decisions on and distribution of health care services should not be influenced by market dynamics (I2). One toll for this that Niko deems promising is the per-capita flat rate, which has been tested in community health centers in Belgium. This concept, for Niko, could replace the market-like competition and structure of health care institutions and exceeds medical care:

> *"This means that for every person registered at a health center, there is money available to cover prevention, social work, legal advice, medical intervention, psychotherapeutic support, and everything else, potentially, regardless of how often the person visits the center. So, there are no incentives to call them in more often than necessary or to cross-finance anything"* (I2)

It is not clear how this per capita flat rate option should be funded. Another option discussed in the working group is the idea of a local index. In this scenario, the policlinic's real estate and equipment would be paid by the municipality and *"the basic costs would be covered by insurance and curative work"* (I2). Then the other work, Verhältnisprävention and community work, could be financed through an index which *"indicates the social determinants of health"* for the district health center. However, Niko acknowledges that *"municipalities have different amounts of money, and some can do nothing, some can do everything"* – which is why the different indexes would need to be cross-financed between municipalities (I2). Here, for Niko, research is needed to clarify the *"fairness aspects, financial advantages, transparency advantages"* (I2). Niko concludes that the topic of financing of the utopia is the crucial point and they are *"not quite there yet"* (I2). The last criterion for the policlinic's utopia is scalability - thus whatever the group comes up with, must be something that *"can be transferred and*

can be copied, (...) which works elsewhere as well" (I2) – fitting to scaling strategies described by Ribera-Almandoz and Clua-Losada (2021).

The idea of the state paying for community and prevention work through an index is different to what other members envision with insurance-paid health prevention work. For instance, for Lukas "*if community work were somehow financed by health insurance companies—that would be awesome"* (I1). Thus, Niko describes this an "*an exciting discussion*" which needs to be revisited regularly. Niko emphasized repeatedly throughout the interview that these ideas are not finished and the discussions around them are still on-going. This is why the concept paper circulates in the syndicate so *"everybody can discuss it"* (I2). For Niko, it would be ideal if these discussion around the utopia could be *"enjoyed together"* (I2). Furthermore, Niko hopes the concept paper spreads to *"a political level"* where it *"could be used as a discourse intervention (...) eventually moving toward a campaign"* (I2).

The idea of a campaign is inspired by a housing commoning campaign from Berlin, the 'Deutsche Wohnen und Co enteignen' (DWE). Throughout the interview, Niko often compares the socialization demands of policlinics to the DWE, who campaigned for a referendum for the socialisation of housing in Berlin[39]. Niko also tells me how he and other members got inspired by the success of DWE and they *"wanted to transfer [these demands] to the healthcare system"* (I2). However, he also sees this critical because the housing sector is different to health care[40]. Despite this difference, DWEs conceptual work is an inspiration and model for himself and the utopia group. For instance, about barriers and access to participation, *"it's great that [DWE] has already done so much groundwork, and we would like to do it the way they say is best"* (I2).

Apart from the connection with DWE, Niko and the utopia working group also connect with other important actors in the German socialization debate, such as Communia or the activist group system change not climate change (SC) (I2). Communia and the syndicate also co-hosted a workshop on 'Socialising health' at the SC camp in August 2025 where policlinic members presented their work and invited people to discuss ideas for the democratic ownership of (primary) health care (I2)[41]. This debate "*"really grabbed [Niko]"* and in Niko's words *"excited us all"* and convinced them that socialization is a good strategy for their own projects (I2):

[39] based on the Article 15 of the constitution, allowing "Land, natural resources, and means of production may be transferred to public ownership or other forms of public enterprise for the purpose of socialization (...)" (DWE, n.d.). Since the realization of the referendum is blocked in city parliament, the organization now finished a policy draft to realize it (DWE, n.d.).

[40] For instance, since there is already existing, party public infrastructures, expropriation would not always be necessary, making *„the healthcare sector (...) so suitable"* for socialization (I2). However, as policlinics also criticize, many infrastructures such as practices or laboratories are increasingly owned by private actors (as described in 3.3.2), thus maybe expropriation becomes necessary.

[41] I sometimes use socialization and sometimes democratic planning and ownership, as I am not sure which is the correct translation of the German word 'vergesellschaften'.

"This is also something where we are still, aiming for, to be part of the answer and also taking the first small steps out of capitalist structures, and then we really wanted to transfer that to the policlinic syndicate" (I2)

This aiming for democratic public ownership is one of these *"small steps out of capitalism"* and thus fits to the policlinics' overall aims of societal transformation and anti-capitalist values (I2). For Niko, it would be ideal if the socialization of policlinics could feed back into and inform broader democratic public ownership debates and they could discuss it in a *"synergistic way"* – then they *"would have made it"* (I2).

The idea of socialization is the main way to achieve the policlinic vision for Niko, seeing *"no other alternatives to the socialization"* (I2). Similarly, developing a utopia is a necessity for Niko "*so that people still want to work in this field"*. And ideally, the working on a utopia and the working on concrete projects should not be separated but interconnected so that *"what we are all building in concrete terms should take utopia into account"* (I2). Interestingly, for Niko 'the utopia' is not a concrete moment in time:

"Well, I don't think there's a moment when we establish utopian or socialized centers, but rather we're moving toward that step by step, and I believe that we need these aspects that are required there as a horizon, a utopian horizon, so to speak, so that we know in which direction we can take steps that contribute to that" (I2)

Working towards socialization both in healthcare and beyond, is necessary *"so that we can get out of these distribution struggles"* in times of a shift to the right in Germany (I2). Here, Niko connects the problem of under provisioning, (financial) access barriers in primary care, with other areas such as poverty and social struggles highlighting the interconnectedness of these different political fights. For Niko, if we had democratic public ownership over different areas of life, it would mean *"a secure livelihood for everyone, so that we no longer have to kick downwards"* because "*fears are taken seriously [and met] with concrete offers"* (I2).

From my impression**, the enthusiasm** that Niko has for working on a utopia is not shared by all members. For instance, Lukas sees about the ideas of socializing primary care, as one of the options but marked by unresolved questions. For him, policlinics rather needs to ask "*what tools are available to achieve"* non-profit orientation or orientation towards the public good more broadly (I1).

Even before Niko and his colleague founded the Utopia working group within the syndicate – the idea of socializing primary care was already discussed within the movement. In 2024, the policlinic in Hamburg started an event series called "Socialize outpatient care!" together with the Rosa Luxemburg Foundation and the Hamburg Agency for political education (Poliklinik Veddel, n.d.-a). The goal was to host events where *"strategies for a solidarity-based, democratic, and gender-equitable healthcare system"* could be discussed (Poliklinik Veddel, n.d.-a). The policlinic Veddel invited known German scholars, who are part of the debate on commons, care and socialization like Barbara Fried or Silke van

Dyck, but also people who are organized in political groups and share their practical experiences, such as the vdää or a neighborhood union initiative from Bremen. Within this series, the policlinic Veddel wanted to *"highlight current developments in outpatient healthcare, clarify key terms, and discuss the outlines for a new socialized primary care system"* (Poliklinik Veddel, n.d.-a). Lukas tells me, he appreciates how the event series has increased his knowledge on democratic public ownership. There are different levels of knowledge about democratic public ownership among policlinic members, like Lukas who tells me he is not an expert in comparison to others. For policlinics need to discuss whether and how democratic public ownership could work for them. For Lukas it remains unclear whether *"this [can] be a tool that is somehow useful and realistic for us"* (I1).

I got the impression that this idea of socialization is not as promising or exhilarating for Lukas than it is for Niko. Maybe this arises due to the fact that Geko Bonn is still in the beginning and policlinic Veddel is concerned with everyday struggles of running the clinic ('outer work') and doing other big projects like Navigation. This impression also ties into Selina's comment on smaller policlinic groups being more idealistic because they are not yet health care providers. In contrast, Lukas talked much more about the research happening in the Navigation project – whose success for him would be *"the greatest hope"* (I1). Also, when I asked him about socialization, he tells me that this topic and these debates are less important for him and to some degree for the policlinic Veddel as well:

"The most honest answer is that it simply takes a back seat to many other issues right now" (I1)

What is interesting is that Lukas told me that the policlinic Veddel member who initiated and hosted the event series is also the one who now is site manager in the Navigation research project, which is why *"this topic is now somewhat on hold again for the time being"* (I1). This shows how there is personal overlap between different visions (e.g. political work/ education versus research to become part of regular care) and policlinics also adapt different strategies depending on what is needed and what is getting funding (I1).

4.3.5. Conclusion

Overall, this subchapter shows how the policlinics' imaginary and practices are challenging to realize. For instance, one central challenge is that policlinics cannot bill their complete health care provisioning through insurance, making their practice of e.g. doing multiprofessional case discussions difficult. Another problem is that when policlinics apply for funding to realize such 'experiments', this requires time, work and sometimes carefulness in their political expressions. Additionally, as policlinics professionalize, there is a risk of losing time for social relations, 'internal work', debates as well as political work. This chapter also demonstrates how members are negotiating aspects of the policlinics' radical counter-imaginaries of health care – such as the question of whether to be integrated into state-driven structures or whether to work on alternatives.

The importance of internal discussions and "inner work" became clear throughout the first two subchapters (4.3.1. & 4.3.2). This inner work does not only apply to internal organizations and decisions, but I would argue also to emotional work within yourself, such as critically self-reflecting as a doctor. With this, policlinics illustrate the importance of relational – and I would add *emotional work within commons* (Schikowitz & Pohler, 2024; Smits, 2024*)*. Interestingly, the difference of health care commons like policlinics to regular health care is something patients or people generally 'feel' (4.2.5).

The challenges discussed in this subchapter, illustrate the general tension of activism and commons working with or against existing structures. It reminds of Schikowitz and Pohler's (2024) description of housing commons having different degrees of political radicalness and the tension of commoning against and with markets and state but also of Geiger's (2021) typology of more radical or 'deviant' activists and invited and less radical activists [42].

Moreover, this chapter pointed at different views and an ongoing debate within the policlinic movement on how to advance, exemplified by the Navigation project and the utopia or socialization working group. These two working groups can be described, somewhat schematically, as a more radical political strategy and a less radical political one. I overstate this distinction intentionally for analytical purposes because rather than representing two fixed positions, they mark the ends of a spectrum. The analysis thus highlights the diversity of imaginaries and practices within commons and the presence of constant internal debate. While this is clearly the case for policlinics in Germany, it is likely also applicable for transnational networks such as inosc, where pragmatist and idealist groups come together. Thus, in contrast to Schikowitz (2025) and Geiger's (2021) categorization of invited and uninvited activists, the policlinics may in fact support both approaches at the same time.

The debate around professionalization and growth 'risks', or the question what steps (at which moment) help to realize policlinics' radical counter-imaginaries exemplifies the challenge of finding common ground while upscaling (Ribera-Almandoz & Clua-Losada, 2021). Building trans-local networks like the syndicate or inosc to "gain visibility and influence" also means finding commonality in the activists demands and risking over fragmentation (2021, p. 184).

Additionally, the analysis has shown how the boundaries between political and medical visions—or more broadly between different aspects of the policlinics' imaginaries—are continuously drawn, dissolved, and renegotiated. For instance, the policlinics position themselves as political actor and contributing to socialization debates, while keeping the option of cooperating with more conservative politicians and keeping their NGO status to be credible receiver of funding. Policlinics deal with these tensions by prioritized or foregrounding different (radical, political, medical) aspects of their radical counter-imaginaries and practices depending on the context or the current moment.

[42] in this case insurances representing the health care markets and the state representing funding through municipalities and federal states.

This reminds of the housing commons, trying to infrastructure themselves as resistant and opposed to current urban planning while at the same time as inevitable actors worth including in urban planning (Schikowitz, 2025). I would argue that policlinics try establishing themselves as fundable and professional actor, while at the same time trying to keep their activist nature and political radicalness opposing the general structure of primary health care. Additionally, by blending technical or methodological and political arguments, such as the lack of small-scale data on healthcare access with the aggravated inequalities due to socioeconomic inequalities and private ownership, policlinics resemble the housing commons described in Schikowitz and Pohler (2024) but also Epstein's (1995) description of AIDS activists' strategies.

The findings show how even in these two projects, some of the challenges persists, such as the question of how radical political one can or should be: questions of being more political or activist versus focused on health care provisioning, and overall, the dilemma of working with or against existing structures. This suggests that these tensions may not be resolvable, as seen in the statute describing the contrast of emancipation and financial conditions. This suggests that policlinics view these tensions as to some degree unresolvable and inherent to the challenge of wanting to change the system while simultaneously working within it.

5. Discussion

Against the background of these empirical findings, I come back to my research questions of how policlinics reimagine and develop their radical counter-imaginaries of health care commons and develop their practices as counter-model to the current German health system. Additionally, I will formulate some insights from the policlinic case for the broader debates on (healthcare) activism and commons as response to neoliberalization of healthcare (and society).

5.1. How policlinics reimagine health, care and community

With my first sub-question I wanted to look at *how policlinics reimagine health, care and community.* Their broader and politicized understanding of health as a process, intertwined with social and economic conditions is central. To achieve health for all, policlinics envision primary health care centers, focused on the community in the local neighborhood and addressing and incorporating social, economic, environmental factors. Doing health care centered around a local community and space echoes both the downscaling approach in health care activism, but also medical anthropology's calls for understanding humans' health not as isolated but embedded in their environment and society (Bůžek et al., 2022; Ribera-Almandoz & Clua-Losada, 2021). Thereby, policlinics are "addressing health disparities that are not framed explicitly in terms of biomedicine or bioinformatics" as mentioned by Clarke et al., and I agree with them that those are needed in times of personalized public and techno-solutionist approaches focusing on digital health (2023, p. 103).

Moreover, policlinics envision a different organization of healthcare, where other types of knowledge and expertise are heard and valued. In the policlinics' reimaginations, health is not solely a medical matter and requires multiprofessional care and different types of expertise. Thus, policlinics envision a multiprofessional and equal cooperation among doctors, nurses, therapists and social workers, leading to better working conditions and quality of care as alternative to the current doctor-centralized and hierarchical health care. Furthermore, policlinics reimagine health care and prevention as empowering individuals and strengthening communities through participation. However, as opposed to current paradigms of patient empowerment focusing on informed patients taking responsibility for their health, or participation without power, policlinics counter-imagine that the patient's expertise, knowledge and their general life situation, including problems and capacities are acknowledged and addressed. In policlinics, patients can participate in decisions about health care treatment and about local prevention projects.

In policlinics' radical counter-imaginaries, health care services and infrastructures are a public good and therefore not compatible with marketization or financialization. The activists see problems such as discriminations, inequalities or under- and oversupply as intertwined with neoliberal politics of marketization and austerity politics, in line with Deppe, Geiger or Nandi et al. (2010; 2021; 2020). Because health care is a public good, it should be planned according to needs in a participative and

democratic manner. With their critiques and alternative visions, policlinics fit to Kazansky and Milan's (2021) counter-imaginaries, against a hegemonial health care paradigm, serving as a sense-making and mobilizing tool for activists, enabling them to critically engage with existing public health data and narratives (Kazansky & Milan, 2021; Lehtiniemi & Ruckenstein, 2019).

Additionally, policlinics demand that the caring for one another needs to be enabled and strengthened and that care work needs to be valued more to achieve better health care (and a better society). Thus, policlinics envision care and community as tool to achieve better health *and* social change. This mirrors feminist demands for recognition of care or reproduction work and calls for transforming societies to overcome the gendered and hierarchical dimensions of care work (Aulenbacher, 2020; Fried & Wischnewski, 2022; Winker, 2015).

Notably, policlinics' imaginaries extend the medical realm by criticizing health care and the overall society. Thus, as argued, their project is not only understood as counter-imaginaries, where activists want to achieve social aims like participation regarding their topic like data or health, (Lehtiniemi & Ruckenstein, 2019); but to fully capture policlinics, this should be complemented with the concept of radical imaginaries. In line with this concept, policlinics base their critique of healthcare on structural hierarchies, oppression and inequalities (Haiven & Khasnabish, 2014). Furthermore, like radical imaginaries focusing on alternative worlds, policlinics serve as prefigurative experiment of establishing health care commons (Haiven & Khasnabish, 2014). Thereby policlinics, like other social movements studied through the lens of radical imaginaries, understand themselves as part of a societal transformation. Like other radical imaginaries-driven activists, policlinics reconceptualize health care but also individuals, communities and society in a post-neoliberal way (Asara, 2025; Haiven & Khasnabish, 2014). Hence, I describe policlinics as establishing *radical counter-imaginaries*, combining these two concepts to better capture such critical, oppositional but also prefigurative and transformative imaginaries of (health care) activists.

5.2. How policlinics' imaginaries are put into practice to develop health care commons

Secondly, this thesis asks *how the policlinics' imaginaries modified, negotiated and put into practice as they develop their health care commons.* Policlinics aim to empower patients and invite participation through need-assessments and inclusion of local groups into the planning of their prevention projects and community work. One central practice of policlinics is the 'Verhältnisprävention', based on their understanding of health and their critique of individualizing neoliberal public health. Thereby, policlinics counter-act hegemonial prevention approaches by addressing societal conditions in their treatments, health education, prevention programs and group offers. Their offers aim to alleviate the individuals' feeling of loneliness and overburdening but also politicize them towards socio-economic inequalities as substantial factor for how health and disease are distributed. For policlinics, strengthening social relations and empowering the community is a form of health care prevention. The policlinics' Verhältnisprävention and community work illustrate my

argument of policlinics being health care commons, representing "ways of living together [or doing health care] that resist the privatization and individualization of life" and the commons' focus on communities (Dawney et al., 2015, p. 2; Sanchez, 2023; Smits, 2024).

In line with their anti-hierarchical stance and their understanding of health, interprofessional team meetings are part of policlinics counter-practices. Additionally, the policlinics' internal organization is characterized by democratic structures and regular internal meetings – fitting commons' characteristic of horizontal decision making and management (Dawney et al., 2015; Sanchez, 2023). In the spirit of collective organization and dialogue, they hold regular plenaries for all members to negotiate and re-discuss topics. Although their medical practices cannot be run as a collective, the NGO of each policlinic project is run collectively – already illustrating the challenge of commoning against existing structures (Schikowitz & Pohler, 2024).

Another important practice within policlinics is the acknowledgment of and fight against discrimination and their attempt at creating an accessible space by e.g. treating patients without insurance. Mirroring policlinics' radical counter-imaginaries of free and equally accessible healthcare, this also shows how parts of the policlinics' radical counter-imaginaries can be realized and put into practice. The solidarity attitude of policlinic members guiding their offers, is like Deppe's argument, that solidarity figures as alternative to neoliberal and privatized healthcare.

5.3. Policlinics' challenges and tensions and how they deal with them

My third research question asked *what the challenges and tensions of the policlinic are and how they deal with these.* The main challenge, for young or old policlinics, is how to finance their counter-model. Young projects struggle with relying on volunteers and the lack of time and capacities, mirroring van Dyck's (2019) warning about precarious working conditions and self-exploitation in community and volunteering-based provisioning. Facing these problems, policlinics argue that they need to professionalize to make their work more sustainable. However, as professional providers and employers, financial struggles persist. To pay fair salaries is difficult to realize when medical practice and the NGO are two separate legal entities, forcing policlinics to make compromises and have an 'ideological' cooperation. Thus, policlinics' radical counter-imaginaries cannot be fully realized, especially since billing through insurances is difficult, but this also fosters hope activists' hope placed in the Navigation project.

Additionally, policlinics want to prioritize social care within collective with e.g. supervision and emotional plenaries. This resembles Sanchez's (2023) descriptions of care commons in Greece. However, caring (outside of official roles) and taking times for extensive patient communication, internal meetings and social care comes under pressure when policlinics become employers and there is an external pressure of only getting paid for health care provisioning. This reminds of common's value practices clashing against others (De Angelis & Harvie, 2014). Thus, even though they want to do and value care differently – the time for care is still not economically valued. This is a great example why I

argue that valuation studies of care could be complemented with feminist-economic theories to acknowledge the problem of care not fitting into market logics. Even if alternative valuations are more diverse than in economic regards, there is external restrictions to alternative practices of valuing such as collective care, making them hard to upheld or enact continuously. Still, my findings support the valuation studies argument that alternative valuations are important and partly already enacted, such as when policlinics members perceive their work as valuable even if they are not paid for it. The question is simply how sustainable it is to do such alternative practices and work without the economic valuation. These examples thus illustrate the limited applicability of care within market logics – because caring for your patients, for your colleagues and team, for the material infrastructure, for the local neighborhood or the community takes time, emotional and relational work – which does not fit in economic calculations. This shows that even if you do things differently, certain (economic) limits to the radical counter-imaginaries and commoning practices prevail.

When older projects become professional practices, or 'like a business', members discuss both advantages and disadvantages, such as losing the coziness or political activist spirit. The question is who takes on the political work to spread the policlinics' counter-model in policymaking. Additionally, members try to be careful with political positions to not lose their fundability while keeping their 'edge', resembling Schikowitz's findings (2025) and illustrating that activism does not only relate differently to markets but also states or municipalities, as argued in 2.3.2. Again here, economic pressures, namely individual employees depending on their jobs, and policlinics depending on funding, restricts the full realization of policlinics' radical counter-imaginaries.

Lastly, what my findings show is that there is not one coherent imaginary within the syndicate and partly diverging strategies or priorities for the next steps. This ties into the second part of the third sub-question, namely *how policlinics deal with tensions and challenges.* One answer is the increased pursue of professionalization or institutionalization. If, through the Navigation research project, policlinics' interprofessional primary care model gets enough or the right kind of evidence, this might be 'small seeds', enabling the billing through insurance in future legislation. This would not only help policlinics' everyday work but also increase their legitimacy and the power of their political demands of primary care models for every neighborhood. Thus, this 'Realpolitik' option for financial stability gives them hope, even if it still would mean adjusting their radical counter-imaginaries to the current legal situation because financing would still be through insurance, not covering all their activities and continue the separation into medical practice and NGO, as private ownership remains the norm.

The Navigation project shows the importance of gaining evidence for the policlinics' primary health care model, sharing overlap with other types of medical evidence-based activism (EBA) (2.3.1). However, policlinics do not focus on one disease like (Rabeharisoa et al., 2014), but take more of a social political movement shape as described in Cornish and Campell (2021). Different to clinician-led-evidence-based-activism, policlinics are not reinforcing clinician/doctor authority, but actively decenter doctors in primary care, questioning health care hierarchies and higher power position of doctors by

foregrounding multiprofessional care in Navigation (Pushkar & Tomkow, 2021). Simultaneously policlinics or inosc question neoliberal (bio)medical science and raise doubts about science being too influenced my markets and companies. Although engaging in the same epistemic practices foregrounding clinical evidence and health-economic valuations, policlinics also employ different methods through which knowledge is produced by e.g. collecting their own small-scale data through 'doorstep conversations' to assess health care needs in their neighborhood. This data is then also used to highlight unequal access and undersupply in primary health care, again reminding of EBA. In contrast to hegemonial public health approaches, policlinics reconceptualize health as social process, and health-related knowledge as distributed among doctors, patients, nurses, social workers and other professions, Jewson's (2009) medical cosmologies. Besides this emerging way of knowing about health and socially interacting in medicine their understanding of health as socially situated is fundamentally opposed to current (and past) medical cosmologies. However, policlinics' imaginaries concern society beyond medicine, thus differing from Jewson's (2009) ideas.

The second approach of dealing with challenges is developing utopian imaginaries and working on socialization of health care. Having discussion about their utopia(s) and dreaming big might also make people enjoy their work more. This approach, I argue, is important because it reminds policlinics of their political aspirations, activist nature and radical imaginaries. Moreover, this work helps policlinics to (re)gain hope, as Pötz (2019) describes with utopian imaginaries. Furthermore, the concepts from the utopia working group represent occasions to have debates about developments options, which takes a backseat when policlinics professionalize. Furthermore, with these debates about socialization, policlinics connect to other political actors and debates. As a form of scaling to the sides, complementing the already mentioned downscaling in local communities and upscaling in the syndicate and inosc, policlinics connect health care with other political fights such as climate change, housing crisis, fights and against right-wing politics and for democracy. This is in line with their understanding of health as socially, economically and ecologically embedded.

The two projects in the syndicate, conducting research to secure insurance funding and developing a utopia and connecting to socialization debates, represent two beacons of hope for members. These two were also compared to taking little steps but looking at utopia as horizon. I argue that this dual strategy of policlinics is a way of not giving up on the utopia or radical ideas of primary care socialization, while at the same time not neglecting evidence-based projects leading to small improvements and fostering institutionalization. Thus, it is not that only one strategy is sustainable or transformative, but activists might pursue diverging strategies as well – and time will tell if this is contributing to the activism's sustainability.

Furthermore, what makes policlinics special is bridging the political topics or social inequalities in society and health care. Thus, it is neither 'just' medical activism nor 'just' a political movement against marketization and privatization, but they connect these two in their imaginaries and practice to show that it can be done differently. Therefore, I argue policlinics represent a special type of public

health activism, better captured with the concept of care commons due to the foregrounding of communities and care as answers to neoliberalism. To capture new emerging types of commoning imaginaries and practices such as policlinics, this thesis is an attempt to bridge the STS scholarship on activism in health(care) and counter-imaginaries with the work on radical imaginaries, the commons debate and the related Feminist-Marxist scholarship on care and socialization.

5.4. Relating and contributing to existing debates

Tying this observation back to my theoretical sensibilities, I argue that policlinics are switching between medicine/public health centered imaginaries, e.g. multiprofessional primary care, to counter-imaginaries, like non-private and community centered primary care, to radical imaginaries of socializing all of health care. Depending on the context, policlinics change which imaginary is in the foreground or on the 'outside' – but in the background or 'inside' all of these exist and vary between members and local groups. Thus, going back to STS, this illustrates, how not only STIs are diverging and multiple, but this also applies to activists' imaginaries (Lehtiniemi & Ruckenstein, 2019; Mager & Katzenbach, 2021), as this combination of maintaining different imaginaries is what characterizes policlinics. I argue that policlinics are playing both sides – of invited and uninvited forms of engagement, of deviant and conventional activism and of commoning with and against markets (Geiger, 2021; Schikowitz, 2025; Schikowitz & Pohler, 2024). Additionally, policlinics may change their strategies and imaginaries depending on the political climate.

The policlinics are aware of this switching and are discussing the value tensions openly. My findings show that policlinics see discussions and tensions not as necessarily counterproductive or avoidable. Difficult decisions can be renegotiated and revisited and notably, policlinics view conflicts not per se as negative. Thus, policlinics, to some degree acknowledge the inherent tension of their work as unsolvable, in line with scholar's assessment of commons (De Angelis & Harvie, 2014; Schikowitz & Pohler, 2024). This also echoes the call to look at the uncommons in commons – and to understand them as inherently ambivalent and sites of contestation (Asara, 2025; Dawney et al., 2015; Smits, 2024). Taking this further and adding to the common scholarship, I argue thath to deal with these tensions and commons, collectives need to take the time and do the 'inner work', meaning relational work, emotional work and taking time to talk with one another, echoing van Dyck's (2019) call to address emotions in community projects.

For policlinics, there is not ideal model or perfect solution, but one should keep hope and aim to achieve small changes. They are aware that this requires constant work and the risks of commons, like only filling provisioning gaps, are acknowledged. Besides this acknowledgment, policlinics pursue a common (political) ground with their statute and as they become a political actor, a political consensus seems to develop. The question is whether this also means the radical counter-imaginaries and strategies within the policlinic syndicate will align more or whether the dual strategy will be kept.

What might be perceived from the outside as an internal contradiction (Navigation vs. Utopia) is the strategy of polyclinics, defying the categorization into radical or conventional. In that sense, I would suggest, this strategy is perhaps more sustainable or transformative than only being deviant or invited activists (Geiger, 2021; Schikowitz & Pohler, 2024). Of course, it comes with its challenges. Hence, I would disagree with Geiger's (2019) argument that it is more realistic to work with markets and become invited activists. The policlinics are an example that doing both might be possible. The debates within the policlinic also show that losing the radical stance is not an inevitable option for (healthcare) activism and that precisely imagining a future for healthcare outside markets and alternative economies is an important task of activists. For instance, with their concept of Verhältnisprävention policlinics refuse the market endogenesis of activism and its alternative understandings of the collective goods in health care and by not falling into the trap of understanding prevention simply in individualized terms as other health care activists do (Geiger, 2021). Thus, agreeing with Geiger (2021), policlinics illustrates the importance of resisting marketized understandings of the collective good, thus of deviant activists in health care.

This brings me to this thesis' two contribution to STS. Firstly, the policlinics case shows that civil society does play an important role in questions of collective good, as argued by Geiger (2021) and Prainsack and Wagenaar (2021). However, I would argue not as 'incubators' of creative (technoscientific) innovations (Prainsack & Wagenaar, 2021), partly because we already have enough technosolutionism and narrow conceptualizations of innovation, but because an alternative solution for health care in crisis might come from radical counter-imaginaries and commons like policlinics. Thus, STS scholars should focus on already existing social innovation(s). Projects like policlinics this might inspire to politicize health care, its inequalities and problems even more, to dare to criticize more radically and zoom out to question the framework conditions of health care, such as devalued care and private ownership of provisioning infrastructure. Thus, this study contributes to STS and social sciences discussions on commoning, the role of social movements and activism in neoliberal and biomedical health care, and the politics of health care transformation.

Secondly, based on the policlinics case, I argue that STS studies on health care activism, alternative valuations and caring communities might profit from theoretical debates on radical imaginaries of commons, their challenges and ambivalences. Moreover, on the nexus of STS and health care policy, regarding the question of how to restructure health care and its valuations or how to understand current health care crisis, it makes sense to leave the comfortable frames of reference, such as calls for more participation to have other valuations in marketized health care as suggested by Zuiderent-Jerak et al. (2015) or Datta-Burton (2022), and to study radical alternatives such as policlinics to learn about the restrictions of alternative valuations and contradictions of care and capital as formulated in feminist theory (2.2.3.).

To conclude, the policlinics case suggests that activism and in particular commons cannot happen without tensions and outside of market or capital's logics – else it would not happen at all. The

dual strategy of policlinics illustrates the argument of critically examining commons or other experiments considered as real utopias, as they are never without ambivalences (De Angelis & Harvie, 2014; Wright, 2011). The idea of taking small steps with Navigation but still look at utopias as horizon reminds me of Geiger's (2019) metaphor of activists walking a moral tightrope: to keep balance it is important to look ahead, have a strong focus and take small steps – to avoid falling. After all: to walk on a tightrope, there needs to be tension.

To illustrate this, I will turn back to the syndicate's logo depicting the impossible object from the introduction. To simply say, you can build this and not acknowledge the impossibility or hardship of doing so, is naïve. But to stop drawing the object just because you cannot build it (now), is hard to do if you are convinced that this object is better than others. I believe that it is not a coincidence that the policlinics chose this impossible object as their logo: They know that realizing their vision or building the cube is almost not possible, but the utopia or their drawing of the impossible cube serves as their horizon towards which they walk with small steps in the present.

6. Conclusion

This thesis examined how policlinics both counter-imagine and counter-act hegemonic biomedical and neoliberal health care by combining the concepts of counter-imaginaries from STS with the ideas of radical imaginaries and commons from the scholarship on social movements and societal transformation. Thereby I analyzed this specific health care counter-model in practice and from different theoretical perspectives.

The policlinics' multiprofessional case discussions and their participatory planning processes demonstrate how policlinics see relevant knowledge and expertise as distributed among patients, doctors, nurses, psychologists and social workers. Practices such as the community work illustrate the policlinics' understanding of health care as enacted, collective endeavor, requiring relationships and trust, and as exceeding the medical realm, encompassing the environment and communities. Different to other health activists, policlinics go beyond criticizing and reconceptualizing patient-medical staff relations, prevention paradigms, or medical cooperation but also demand non-private ownership of and more participation in social provisioning infrastructures.

Policlinics resemble Milan and Kazensky's (2021) counter-imaginaries of data activists, because they allow activists to make sense of and rally-up against problems and hegemonic conceptualizations in healthcare. However, policlinics can also be understood as radical imaginaries as they connect health care problems with structural inequalities and power imbalances in capitalist and neoliberal societies (Haiven & Khasnabish, 2014). Combining these two concepts into radical counter-imaginaries captures both the policlinics' opposition towards biomedical and neoliberal health care but also their prefiguration of alternative health. As policlinics resist individualizing narratives of health care prevention, but also prefigure a counter-model, challenging market and state, I further categorized them as health care commons. Their practice of democratic decision-making and foregrounding of relational work, further strengthens this categorization as commons. Furthermore, the internal debates and contestations within policlinics are also in line with both scholarship on commons and imaginaries in activism describing them as diverging and inherently ambivalent or contested (De Angelis & Harvie, 2014; Lehtiniemi & Ruckenstein, 2019). Hence, my thesis shows how policlinics' activism should be understood as more than a counter-imaginary to biomedicalized and neoliberal health care, namely as *radical counter-imaginaries* of *health care commons*. Still, policlinics are marked by diverging imaginaries and it is not always their radical imaginaries they foreground but sometimes also more pragmatic visions.

This thesis acknowledges that policlinics are open spaces for collective experimentation, but they remain embedded in broader economic and regulatory frameworks that shape what is possible. My thesis confirms that commons are not per se outside of markets. Policlinics operate in a context marked by the retreating welfare state and the crisis of neoliberal governance. Thus, their emergence cannot be detached from structural conditions of austerity and privatization. Therefore, they must be situated

within broader debates on community capitalism and the ambivalences of volunteerism instead of becoming a prime example for the transformative potential of care commons (van Dyck, 2019).

Furthermore, I found that within activist groups and commons, diverging imaginaries and both deviant and invited forms of engagement are at play. Policlinics show that there is not only potential in invited forms of activism – but that these can be paired with uninvited forms of engagement and more radical imaginaries. By analyzing the policlinics' practices, challenges and ways of dealing with challenges, this thesis illustrates how radical counter-imaginaries and commons are continuously negotiated, contested and stabilized. In doing so, I attempted to move beyond idealized narratives of community-based care or and (health care) commons by foregrounding the seemingly inevitable tensions they experience. On the one hand, I wanted to avoid the risk of romanticizing commons or neglecting negative side-effects of community- and volunteering-based activism in social provisioning (van Dyck, 2019). On the other hand, I did not want to describe the policlinics as inherently transformative, as other scholars do with commons (Sanchez, 2023; Schikowitz & Pohler, 2024). I believe transformative potential is hard to assess as commons are marked by ambivalences and as my findings show, even policlinics have internal debates about what they consider as transformative.

The policlinics' divergences and tensions should not necessarily be understood as a disadvantage or challenge but could also figure as a strength of policlinics. My findings show that these tensions are known to activists. Thus, I argue it is not the task of researchers to educate them about this and neither to celebrate them for this, but simply to examine commons and their specific radical counter-imaginaries, and the corresponding tensions and negotiations - in contrast to Haiven and Khasnabish (2014), in line with van Dyck (2019) and Wright (2011). This might inspire other activists to not attempt to resolve any tensions but instead find ways to deal with them. Furthermore, this suggests that the emancipatory potential of projects does not lie in their mere existence, but in their capacity to reflect upon and negotiate their tensions. As Dawney et al. (2015) and van Dyck (2019) suggest, projects of commoning must confront their problems, contexts of emergence, and structural constraints. Only by situating commons activism like policlinics within its material and structural conditions can its transformative possibilities - and limits- be adequately understood. In conclusion, this thesis shows that policlinics are neither simply utopian counter-models nor endogenized into and reproducing market's logics as other 'invited' health care activists (Geiger, 2021). Instead, they are, in line with scholarship on radical imaginaries and commons, ambivalent spaces where prefiguration happens but is still limited by societal structures.

Now moving from policlinics to STS, I want to reflect on the role of social movements and their radical counter-imaginaries for technoscientific fields and in particular for medical cosmologies. As Jewson (2009) describes these frameworks of understanding, seeing and talking about medicine have changed throughout centuries due to multiple influences. For instance, STS teaches us that technological change is (partly) responsible for new medical cosmologies, but as argued in the beginning so are social movements and their political contestations. Public health is and remains more than just science, and

this case illustrates the entanglement of science and politics in public health (as described in 2.1). Thus, neither medical cosmologies, nor medicine, nor public health are fixed but instead continuously changing. The question remains, in how far social movements can establish new paradigms or how(far) radical counter-imaginaries can become medical cosmologies. This ties into the question *in how far medical cosmologies can be established in a bottom-up manner or whether they can only be established through structures like state institutions, centralized education and technoscientific infrastructures? How could activists successfully influence or change medical cosmologies – and what role do prefigurative experiments like commons play in this? How can radical counter-imaginaries spread beyond small-scale projects and how could this be foster in health care politics?* Answering all these questions will be beyond the scope of this thesis but seem like fruitful avenues for further STS-guided works on health care activism and social movements, especially in times of a growing health care crisis.

In the future the tensions and challenges for policlinics will probably grow. With the latest cuts in health care, reducing the budget of Innovationsfond projects, it becomes clear that current health care politics are not about radically reconceptualizing health care but rather about reducing public spending (Deutsches Ärzteblatt, 2025). The question arises, already hinted at by policlinics members, *how policlinics will manage the increased challenges and tensions in the future*. The examples from care cities initiatives from Spain show how radical and feminist approaches become institutionalized and hegemonial – although not without ambivalences and compromises, such as the lack of changes in the privatized (health) care sector (Fried & Wischnewski, 2022). *Do grassroot initiatives with radical (counter-)imaginaries always either end up as invited and adapted forms of activism or end up being too fragmented by internal discussions? How can radical counter-imaginaries be sustained and how can health care commons continue to exist despite tensions, challenges and ambivalences of commoning with and against markets and states?* This thesis cannot give a definitive answer to these questions – but the case of policlinics suggests that critiques and alternatives to current medical cosmologies are growing. The current health care crisis might represent a turning point for bottom-up counter-models, or maybe it will make formulating such radical counter-imaginaries to our current biomedicalized and neoliberal medical cosmologies increasingly difficult.

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8. Materials

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9. List of Figures

10. Appendix

10.1. Overview interviews

No	Interviewee[43]	Gender	Project	Years of involvement	Working group in PKS
1	Lukas	m	Poliklinik Veddel	> 5	unknown
2	Niko	unknown	Geko Bonn	< 5	Utopia
3	Mathias	m	Geko Berlin / PKS	> 5	Lobby
4	Laura	f	Geko Dresden	< 5	unknown
4	Ida	f	Geko Dresden	< 5	Delegate in steering committee

10.2. Overview Participant observation & research memos

Event	Abbreviation Research Memo
vdää event	RM1
Information booth Geko Berlin	RM2
Get-together event Geko Berlin	RM3
Fusion Festival	RM4

10.3. AI usage table

AI Tool	Work Phase	Task/How was the AI used?	Reason for Usage	Comment and Reflection on the Results
Chat GPT (v.4)	Editing & drafting an abstract	Shortening & making paragraph more concise, e.g. Can you tell me where and how you would shorten this paragraph? Abstract drafting, e.g. can you write me an abstract based on my introduction & conclusion and using my phrasing/ wording	Saves time	This is very useful as I am a person who tends to write too much. And after several rounds of editing and reading, you do not see where to cut anymore or where you repeat yourself. Abstract is something ChatGPT is good at and this function also saved me a substantial amount of time
noScribe, Vers 0.6.1.	Transcribing	Transcribing interviews	Saves times	This worked well. I especially like that this software complies with privacy guidelines. The transcription of German worked well.

[43] These are pseudonyms