Daniela Krüger, Angela Schuster, Beatriz Aragón Martín, Marta Pérez, Lucia Mair, Janina Kehr:

»Collective Care«

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cache 04

RADICAL HEALTH

intercomverlag, Zürich 2025

COMMUNITIES

COLLECTIVE CARE Glitch

What is made visible in moments of transition and crisis, and how can collective existence be upheld? In their 2016 essay *The Commons: Infrastructures for Troubling Times*, the late Lauren Berlant, literary and queer theorist, ruminates on the recognition of a "glitch" in times of crises. More precisely, Berlant considers what the glitch reveals about the infrastructural scaffolding, or "patterning" of our lives: where it is unstable, fraying, even perpetuating harm. Berlant's understanding of infrastructure is broad, encompassing roads, hospitals and schools as well as families and norms, as "the living mediation of what organizes life: the lifeworld of structure".[1] Published several years before the onset of the COVID-19 pandemic, Berlant's essay is taken up in this contribution as an invitation and entry point to re-think collective ways both of looking at and looking after infrastructures. To Berlant, crucially, the "glitch" opens up a window of opportunity for repair, in ways which encourage new forms "from within brokenness beyond the exigencies of the current crisis, and alternatively to it too".[2]

"All times are transitional. But at some crisis times like this one, politics is defined by a collectively held sense that a glitch has appeared in the reproduction of life [...] an interruption within a transition, a troubled transmission. A glitch is also the revelation of an infrastructural failure."

Lauren Berlant: "The Commons: Infrastructures for Troubling Times", in: *Environment and Planning D: Society and Space* 34/3 (2016), pp. 393–419, p. 393.

In the following conversation, anthropologists, physician-anthropologists, a sociologist and a physician-epidemiologist jointly reflect on how they each experienced broken healthcare infrastructures before, during and after the COVID-19 pandemic, how they imagine alternative futures of health and care and how these futures might be collectively realized. Together, we reflected on the layered, acute and chronic infrastructural failures of the last two-and-a-half pandemic years, while speaking from different regional and disciplinary perspectives as well as particular positions within healthcare systems. Marta Pérez, an anthropologist, and Beatriz Aragón Martín, a physician-anthropologist, both work in public health centers and activist health movements in Madrid. Angela Schuster is a physician, epidemiologist and part of the neighborhood community health center the Berlin Health Collective, while Daniela Krüger is an urban sociologist researching emergency medicine in a German metropolitan city. In this interview, Angela expresses her experiences and thoughts as a researcher and member of the Berlin Health Collective; however, her positions do not necessarily reflect those of the Collective. Both Lucia Mair, a physician-anthropologist, and Janina Kehr, a medical anthropologist, share a common research interest in novel forms of social medicine and the iterations of public healthcare today, respectively in Germany and Spain. Our conversation aimed for an exchange to share regional experiences and foster connections to think about the problems and possibilities of healthcare during the long pandemic moment.

How can one work within, alongside or against the system to reach transformation, repair and community in a troubled world?

But while the infrastructural failures and affordances we talked about were laid bare by the COVID-19 pandemic, in many cases, they also preceded it in the face of increasingly profit-oriented logics of and pressures on public health systems in the last thirty years. In this troubling context, though, not only failures, but also new collectivities, collaborations, networks of sharing and care emerged. Renewed appreciation for community-engaged healthcare as one potential arrangement to move past the "glitch" happened in Germany and Spain alike, as Marta, Bea, Angela and Daniela recount. The following conversation is thus testimony to how public healthcare is defended on the street in both countries, how the pandemic changed the relationship between providers and patients, and what radicality means in theory and practice. It is an invitation to reflect on how to work within, alongside or against the system to reach transformation, repair and community in a troubled world.



Photograph by Lucia Mair (2022).

Image of half torn off posters with political slogans, plastered on a wall in Berlin. The slogans are: "Health is a human right. It is denied to me", supporting access to healthcare for asylum seekers; "Who do I save first?", and "We save you. Who saves us?", both from the trade union ver.di in support of improvement of nurses' working conditions.

Lucia Mair: The projects you, Marta and Bea, are engaged in are part of a powerful movement in Spain, the *Marea Blanca*, which has protested against the privatization of hospitals and austerity policies in the healthcare sector since 2012. I would be interested to hear from you, Angela and Daniela: do you see anything comparable happening in Germany, in the past or future? Do you see particular topics of concern that could motivate both health professionals, but also the broader society, to become more aware of the problems regarding cuts and privatizations in healthcare that many of us here are worried about?

Angela Schuster: I think from a structural point of view, the German health system is very fragmented. This leads to a situation where change is enacted rather slowly and is probably also transferable to other aspects of the German welfare system. In the last years, I have had the impression that there is an increased collaboration and interest in community care in the context of primary healthcare centers. What the Health Collective[3] is doing (by opening a community health center), for example, also happens in other cities. Most of these initiatives were born from activism for undocumented migrants, who are excluded from formal healthcare in Germany. It thus seems to me that there are two different possibilities against fragmentation, to provide integrated care: one comes with a political impetus to create community-integrated care while considering social and economic determinants of health; the other one can be subsumed under a managed care approach, which might nevertheless amount to a similar form of care provision. From a historical point of view, then, there is a long history

of polyclinics in the former German Democratic Republic, which we, in Western Germany, have tended to forget and haven't re-implemented. Besides forms of healthcare provision, I also think that a driver for change could be the increasing awareness of health workers' stressful working conditions, and their increasing loudness in expressing their dissatisfaction about their working conditions. I am thinking for example of the *Berliner Krankenhausbewegung,* or Berlin Hospital Movement, which might be a pull factor for change. Because health workers – and I see that from my students as well – are not willing to work under these conditions anymore.

The *Berliner Krankenhausbewegung* (Berlin Hospital Movement) was founded in 2021 by healthcare workers from Berlin's two largest state-owned hospital groups, Charité and Vivantes, and Vivantes' subsidiaries, with the goal of improving working conditions. Almost 2'000 workers, including nurses, midwives, medical-technical assistants, kitchen staff and cleaners, went on strike for several weeks in the summer of 2021. One of the longest strikes in the history of the German healthcare system, it culminated in a collective bargaining agreement. In October 2022, more than 1'000 of Charité's physicians followed suit, going on strike for the first time in over ten years.

"Berliner Krankenhausbewegung", https://berliner-krankenhausbewegung.de.

Daniela Krüger: Berlin is very rich in NGOs and political activism, which is also something particular about the city – a very rich scene, like a movement. What I see from my case, emergency care, in Germany and other contexts, is that there's large motivation to improve the responsiveness of healthcare. Emergency care providers have been observing two changes: on the one hand, an increase in the overall number of patients; and on the other hand, an increasing number of patients who circulate between different service providers without receiving the social or medical care they would benefit from. These professions, and the decision makers and planners within the organizations, are increasingly moving towards approaches resembling community healthcare or holistic care, understanding their jurisdictions as too narrow, too specific. Some advocate for a paradigm shift of cooperating with other professions, even including them in their work or within their organizations. And I see this as a very interesting example of the motivation to change something within the system, from within regular care.

COLLECTIVE CARE System

Janina Kehr: System is a good keyword here, because Spain and Germany have quite different healthcare systems: Spain has a National Health Service (NHS), universal in access and free at the point of use, and Germany has a Social Security-based system with built-in healthcare exclusions for those who are not insured. In Spain, universal access exists only in theory, however, and has been continuously reduced through legal measures in the last decades. But at least there is an idea of universality of access, which partly translates into practice, and which is defended when it is attacked. So what we have seen in Spain in the last ten years are different forms of healthcare activism, which struggle against problems with access to care, particularly for undocumented immigrants and other marginalized or vulnerable groups. How did this come into being? What is your take on this, Marta and Bea?



Photograph by Janina Kehr (2013).

This picture stems from a large *Marea Blanca* demonstration in October 2013. Protesters chanted *"Sanidad Publica, no se vende, se defiende"* ("Public healthcare should not be for sale, but should be defended"). On the protesters' numerous signs, one could read *"Recortes en sanidad matan"* ("Cuts in public healthcare kill") and *"Se vende tu salud"* ("Your health is up for sale").

The *Marea Blanca*, in English *White Tide*, is an activist movement by citizens and healthcare sector employees. It emerged progressively in October 2012 in the Autonomous Community of Madrid to protest against the privatization of healthcare institutions in the region as well as budget cuts due to national and regional austerity measures. The movement assembled thousands of protesters in its first years of existence, sociologically cutting across society and activist organizations. Until today, *Marea Blanca* demonstrations are regularly organized by the *Mesa en Defensa de la Sanidad Publica de Madrid*.

"Mesa en Defensa de la Sanidad Pública de Madrid, MEDSAP - Marea Blanca", https://mesaendefensasanidadpublica.wordpress.com/about.

Marta Pérez: At that moment, in 2012, many things were coming together. The *White Tide* or *Marea Blanca*, for example, was partly a consequence of the mobilization of the *Indignados* movement. This context of popular uprisings made it possible for people to imagine actually organizing large demonstrations, occupying hospital halls, taking over the streets and the public institutions. It was a moment of possibility. At the same time, a very direct attack on public healthcare in Madrid – the so-called privatization plan – was being implemented by the regional government. This was so massive that it was too much for people to take. Thirdly, people were excluded from healthcare in Madrid, particularly undocumented or illegalized immigrants, although I think healthcare exclusion was not the main driving force behind the *Marea Blanca*.

The *15-M* or *Indignados* movement – in English movement of the enraged – was a vast, heterogeneous popular movement that emerged on May 15, 2011 in Spain. After large-scale demonstrations for more democracy across the country, several groups of people decided to camp out in the main squares of different cities, among them Puerta del Sol in Madrid, thereby consolidating the movement. Participants wanted more political participation, and also intended to collectively call attention to how people lived through the crisis after years of recession and precarization in Spain. The *Indignados* movement has profoundly transformed Spanish activism. It has also contributed to the politicization of parts of Spanish society, including portions of its healthcare workforce.

Bryan Cameron: "Spain in Crisis: 15-M and the Culture of Indignation", in: *Journal of Spanish Cultural Studies* 15/1–2 (2014), pp. 1–11.

was suffering from. People were not worried about healthcare exclusion as such, you know. It was more what it represented. The fear was: they are reducing healthcare for migrants, maybe they will also, after that, reduce it for us. Healthcare exclusions were proof that an attack was taking place. People were not demonstrating because of healthcare exclusion. They were demonstrating because, at that moment, they thought their healthcare system was going to become worse, also because of the privatizations that were going on at the same time.

Marta Pérez: I agree. There was a sense that they were taking something from us, they were taking away our healthcare. This sentiment was shared among people who were socially very different: a cardiologist working in a hospital, and a woman in her sixties from a very working-class neighborhood. That was unique. And it's not very common. The organization of the *Marea Blanca* was driven by the primary care sector, but hospital staff were strongly represented as well. It was a shared feeling that went beyond party politics. Just a sense of owning the public system, whatever the government was. And that was really special. This is not happening anymore, even though in this very moment we are actually worse off, also in comparison with what Angela and Daniela recount about Germany and Berlin. Particularly in the domain of primary care, people are so tired, and the pandemic was so hard on them, not only for their bodies and minds. Many feel that work has become unbearable – in the sense that work does not make sense anymore. It's a lot to take. Imagine: all of the hard work you do seems futile. It's a very difficult moment now for politicization. Because there is this feeling of: 'what I do has no value'. I dont know whether at any moment in the history of Spanish healthcare, or Madrid healthcare, that feeling has been so widespread.

Beatriz Aragón: Absolutely. I think that's one of the interesting things, the difference between Germany and Spain. In Spain, our public healthcare system is based on the idea of Alma-Ata, with primary healthcare as the basis of the healthcare system. In the end, it has never been truly like that, because most of the social factors that feed into health or disease are not well recognized. Plus, the budget for primary healthcare in Madrid has steadily decreased since 2012.

The Alma-Ata Declaration was the outcome of a 1978 summit on Primary Health Care hosted by the World Health Organization. Signifying a shift from traditionally curative approaches, the declaration's core recommendation was community-determined primary healthcare as the basis for attaining health for all. Disease prevention and health education were key components. The language introduced in the declaration was soon taken up by health planners and activists around the world.

World Health Organization: "International Conference on Primary Health Care: Declaration of Alma-Ata", https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata (1978).

Beatriz Aragón: I started my activism inside the institution, while I was doing my residency, because I had all this training about social determinants of health and how important they were. But what can you actually do from within the institution, from an institutional point of view? Since my initial training, I have seen all this deterioration, and this loss of a sense of our practice, even to the point that work has become completely unbearable in a way. Not everybody asked themselves: "What is your purpose as a general practitioner, in this idea about health inequalities?" In some of the health centers I worked in, some of us were actually trying to act on health inequalities from within the institution. But now you can't even find a way to do that. With the healthcare exclusions that we see now, work has become so frustrating.

People no longer understand what is going on. There is a lot of frustration, and a lot of clashes between the population and healthcare workers. This gap is very difficult to handle.

From 2012 onwards there was a bit of a rebellion against health exclusion, but it was mostly people coming from migrant health or primary care, not the rest. No cardiologists there. I mean, it's a joke, but it is also important: why does a cardiologist not care when healthcare exclusion has so much to do with all this? In 2012, we were defending public healthcare for us, but also for everybody else. And now it's clear that we have to defend it for us, in the sense of: try to save yourself first. This is causing a lot of rupture, because the workload is increasing. There are a lot of issues with the population because the quality of care has deteriorated. Also, if you feel that what you're doing doesn't make any sense, you don't do it, right?

COLLECTIVE CARE Radicalities

Janina Kehr: What you are saying is very moving, and it struck me that there seems to be so little hope for change. Both Marta and you have alluded to the loss of meaning, a futility in everyday work, which seems to have become structural, almost permanent. What place does radicality hold here? What kind of radicality can one even imagine in a system which is not only non-functional, but also nonsensical? What does radicality mean to all of you in your work?

Daniela Krüger: Bringing our cases together, we thought of radicality as an idea of challenging dominant positions or structures and processes. In my case, this becomes obvious when jurisdictions and professional boundaries are challenged. It sounds so simple and not very exciting, but it is a huge issue, as these professional boundaries and jurisdictions appear natural to us, yet determine so much: funding, practices, protocols, knowledge, self-identification of professionals. Changing protocols in emergency care, and including other professions or ways of responding to emergencies, is a paradigm shift that changes these permanent or historically grown structures. The same applies for Angela and the challenges that the Health Collective in Berlin and other cities in Germany have to confront: there are all these jurisdictions and funding schemes which prevent working easily, smoothly together (with other professions or organizations).

I'm still wondering how to consider this notion of radicality, because in what way is better-coordinated care, more responsive care really radical?

Is acknowledging that there are social determinants of health (by changing the set-up of teams and protocols), that they affect healthcare, and then letting this information travel into the policy and planning arena already a political act – albeit a small one, because this acknowledgment is not yet part of these structures? Becoming an advocate for people in this sense is also a part of radicality that challenges epistemologies and dominant structures.

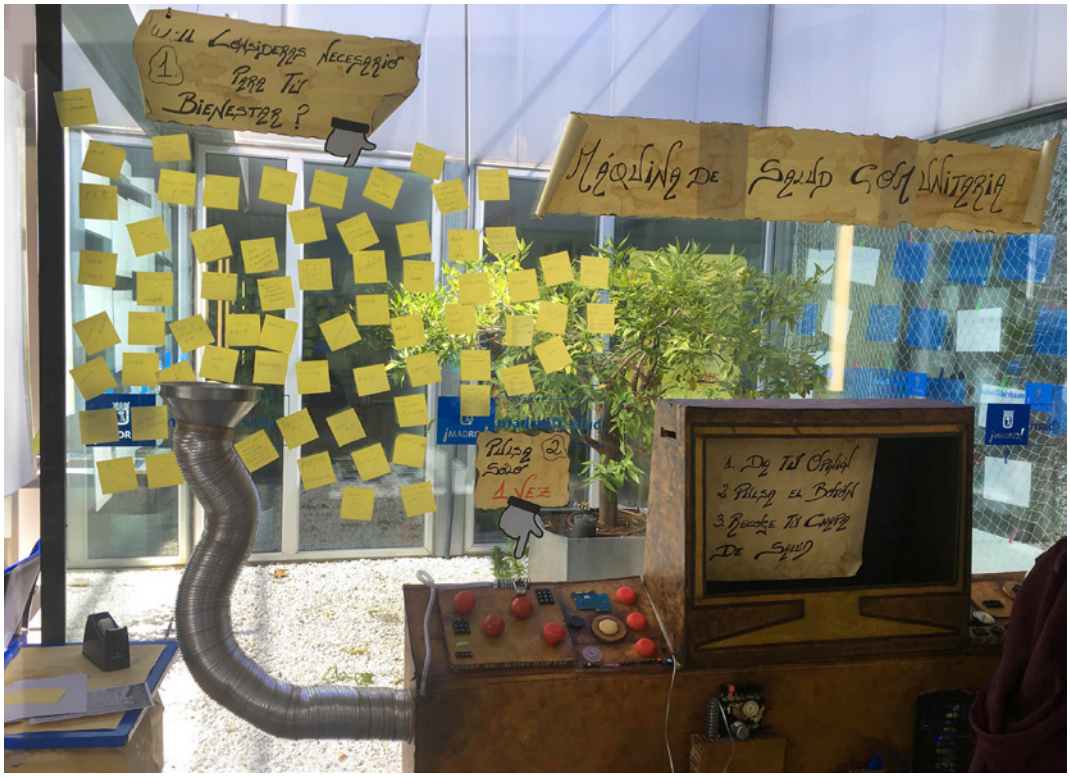
Angela Schuster: One point I would like to add is the need to start from a critical self-perception on how our professional identity has formed. We need to acknowledge that we, as medical doctors, have been formed to lead. To question this is something which I see as a continuous struggle when working in an interdisciplinary way. This includes, for example, how we as doctors are used to talking and discussing within a group. Overcoming these patterns requires a lot of critical reflection and discussion among interdisciplinary teams, which is not easy. It's also important to strengthen the therapeutic knowledge and self-identification of all professional groups in medical care, not only of doctors.

Maybe acknowledging social determinants of health is enough or at least a first step.

But it would also be a big step to include public health services in this, the *Gesundheitsämter*, which are the third column of our health system in Germany. There is a lot of unused potential there, because it is their duty to serve the most underprivileged populations and to facilitate access to healthcare services. The COVID-19 pandemic has underlined this point, that the third column of the healthcare system must be strengthened. The people working there are increasingly aware of what their potential role could be.

Beatriz Aragón: I completely agree with the point of questioning professional identity: from what position does each of us carry out their practice? We are still in a very hierarchical set-up, with patients, but also with colleagues and administrative staff. This was one of the goals when primary healthcare began here in Spain: to make it teamwork. This ideal – of taking care of the population as a team, as a part of and together with the population – only became true in rare situations. It's true that medical training is completely not about this but, instead, quite the opposite: it molds you into people who are specialists on just a tiny piece of someone's body. The other aspect are these fragmented, neoliberal logics of healthcare. It is both difficult to make sense of care in such a landscape, and to reconcile these configurations with care. It's one of the issues we are suffering from now in Spain. I mean, the general

practitioner gives you pills for high blood pressure, the nurse controls your weight, and the social worker asks for house aid. And between the three of them, nobody talks about the person: why have all these things happened? This is due to these institutional, fragmented logics. Radicality, for me, is going against this.



Photograph by Janina Kehr (2018).

The *Maquina de Salud Comunitaria,* or community health machine, was in use during an open house in a community health center in the south of Madrid in March 2018. It was a playful means to ask local residents what they needed for their well-being. Residents could write a Post-it note with their perspectives on well-being, then push a button on the machine and in return they would receive a badge with a community health slogan.

COLLECTIVE CARE Tension

The militant research collective, *Entrar Afuera* tries to re-think and imagine urban practices of care, reflecting and acting upon the bond among public institutions, territories and people. Some of them are located in Madrid (Spain) and others in Trieste (Italy) and get their practical inspiration from the rich genealogy of institutional critique and invention in Europe, especially in health and healthcare.

"Entrar Afuera - de lo público y lo común", https://entrarafuera.net.

Marta Pérez: In one of the militant research projects we are involved in (as part of the collective *Entrar Afuera*), we are working with people in Trieste, Italy. One of the questions we have learned from the Trieste system is to ask: who is responsible for this person? And that is a very difficult question because you can have a pack of services, with a list of tasks, but is there a professional responsible for what happens to a person, overall? If you want a system which holds responsibility for every person that comes in, this responsibility has to be clearly assigned. To me, that is one of the definitions of radicality: it's radical to organize a system around that, and difficult. The healthcare system now in Madrid is going in the other direction. Administrative staff screen your passport to know if you have access to healthcare services or not. In the minds of the doctors, this is a completely separate administrative problem, unrelated to the clinical, and the psychosocial part of healthcare. Even if you want to take responsibility for the overall process, you can't, because the work is organized in such a way that you can only do your part. That creates frustration.

Since the COVID-19 pandemic, there is a growing distance in healthcare relationships in Madrid which is not only physical.

We mostly provide primary care by phone now, and some patients say: "I won't ask for an in-person appointment because I know healthcare workers are overworked. I'm going to restrain myself, and not allow myself to see my doctor, to care for her or him". This distance between healthcare providers and patients sometimes comes from a place of care, but at the same time, it gets to a point where you don't feel that you are doing something together.

Beatriz Aragón: I think it's not only the loss of value or sense for healthcare workers, but also for the population: the realization that the general practitioner may not be able to help me. This was something that you were not thinking before COVID-19.



Still from Antonio Girón and Raquel Congosto, Los Cuidados (Taking care), Spain (2019) (licensed under CC-BY-3.0).
VIDEO ▸ cache.ch/1725

The film follows community healthcare workers in a working-class barrio in Madrid.

Marta Pérez: And if you don't feel that you are doing something together with your primary care physician, you're going to do it yourself, if you can, right? It's only logical. There is a lot of tension in healthcare centers because of the waiting list, because people are sick and they are worried. That tension escalates if it is not recognized and incorporated into (health) care.

Lucia Mair: You, Marta and Bea, described vividly how the situation of the COVID-19 pandemic changed your daily work in Spain, but also the interpersonal relationships that ground your work and drive it, in a way. Daniela and Angela, what of this resonates with you? And what do you do with this sense going forward?

Angela Schuster: I can respond to that from my perspective as a general practitioner: Taking care of these patients and vaccinating them was the absolute priority in the beginning of the COVID-19 pandemic, and everything else beyond it was not. This culmination of being overworked has also reached German practitioners. There was a lot of unhappiness and frustration among primary healthcare providers when political decisions were made which were not transparent, and not congruent. We (providers) didn't really know what to do about them, but we were the ones who needed to take care of our patients. In France, a lot of people who were against COVID-19 measures were distributed along political lines, including the left wing. In Germany, however, most of these movements came from the right-wing political parties. There was not such a fragmentation of political positioning towards the COVID-19 measures in Germany as in other European countries. My impression is that many in the politically active population have maybe not agreed with all measures, but were not completely against them, sometimes to avoid being put on the right-wing spectrum. The situation after COVID-19 will be a new start, to see how we are going to deal with the fact that many aspects of the social determinants of health have been not addressed for at least two years.

What is interesting is that for the first time during the COVID-19 pandemic, we asked doctors and patients alike to look at health not only from the individual perspective, but also the public health perspective.

Health workers are usually not trained for this task, and patients are not used to seeing this perspective. That was what we asked them when we prompted them to get vaccinated, although they might not perceive the individual risk. I think this shift in perspective is something we saw which challenges our health systems and our perspective on health.

Daniela Krüger: I might add some insight on pre-COVID times from my fieldwork on this tense relation between practitioners and patients. People working in emergency rooms and the rescue service were naming this as a very significant shift they encountered, and which they could not really grasp. They used this term, that people were more 'demanding' of services which they perceived as a right, in a sense. I think there is this notion that people are more engaged in their healthcare. In the field of emergency care during COVID, we saw a great recognition of the work that people do (in hospitals, practices or the rescue service). In addition, whether it was thankfulness, reservation or the fear of contracting COVID-19, the numbers of people using emergency rooms and the rescue service initially declined dramatically. Providers understood this at least partially as a recognition of medical care as a public good, not merely as a service. I talked to a doctor working in an emergency room, and she said they experienced this as people re-evaluating their situation more again and not using their services so easily. There are problems behind these notions as well. But some initially experienced declining numbers at least in part as an acknowledgment.

COLLECTIVE CARE Dis/Connection

Lucia Mair: Most of you are in the double role of social scientists and medical professionals. Where do you see the role of the social sciences, specifically, in responding to this shift in the ways patients and medical professionals are thinking about health and healthcare, when and how to use health services, and how to navigate them?

Marta Pérez: There is something inherent to the social sciences that really engages with discussion. You don't have to be a militant researcher to do that. There is a huge need for everybody to discuss the moment we are in. For healthcare professionals, this need may be even greater.

There is a lot of disconnection between the theory of community healthcare, family medicine and primary care, and the practice of it.

This disconnection has been going on for a long time now, but it became more visible with the pandemic and the crisis of primary care. It's difficult to make peace with this. There is a sense of possibility, however, among the younger medical residents, and social science is very keen to explore that: How do we make sense of this disconnection and what do we imagine going forward? Maybe we have to abandon some theories and create new ones to have that discussion. The problem is that its very difficult because people are afraid, they are tired and busy, and it hurts to talk about this. I think it's a very good moment to have these discussions, and at the same time, emotionally and practically, very difficult.

Angela Schuster: Meeting Daniela and her team was very fruitful for me. I'm a health scientist and general practitioner, and Daniela is a social scientist. In the last year we have been working on different projects and it has been very interesting, because I am from a pragmatic science where we directly go into action.

Scientific medicine has a positivist approach, you always focus on doing. It was very interesting and healing for me to spend so much time discussing and thinking.

Lucia Mair: If you could ask each other any questions, as a final round, what would they be?

Beatriz Aragón: I have a question for Angela, coming from an ambivalent position about institutional healthcare myself. I wonder if it's possible to build a different practice from within the public healthcare system, or whether it is necessary, as you have done, to create something from the outside?

Angela Schuster: When I see your project, I see it has a future, but I don't see it as scalable. You need well-intentioned and engaged people who are also politicized, and there are not that many, as I realized during our process. If scalability is there, then maybe it's okay to have health systems or primary health care centers which may be efficient, but not so political.

I see the risk of this political approach getting lost on the way somewhere, at least partly.

I would also have a question for you. I was very intrigued by the fact that you endorse primary healthcare, because I always have the impression that the principles of the 1978 Alma-Ata Declaration are something we talk about, but we don't really live them. What are the determinants for endorsing Alma-Ata in your health system?

Beatriz Aragón: This is done arbitrarily. Most of the medical training units try to incorporate it, but it is not very popular. If 2'000 general practitioners finish their residency every year, only one-third of them end up working in primary healthcare. Despite the training around the idea of primary healthcare as the base of the healthcare system, at the end of the day, this

does not apply in practice. And the COVID-19 pandemic changed everything so quickly, while beforehand, privatization in the healthcare sector happened gradually.

Marta Pérez: Maybe it's a crystallizing moment.

It's not like all of this happened because of the pandemic, but it was the perfect context for everything to collapse in a certain way.

Beatriz Aragón: There is so much frustration among healthcare workers. Before, people who were quitting were the people who didn't care about primary healthcare, who were there because it was just a job. But now, those quitting are those that believed in primary healthcare, who wanted to build another kind of primary healthcare, little by little. Because we feel that it is not possible to do it from inside the institution. The question is: where do you find the value in your practice, in the daily things that you do? Because if you do not find it, then you end completely in cynicism in a way, you know?

Notes

1 Lauren Berlant: "The Commons: Infrastructures for Troubling Times", in: *Environment and Planning D: Society and Space* 34/3 (2016), pp. 393–419, p. 393.
2 Lauren Berlant: "The Commons: Infrastructures for Troubling Times", in: *Environment and Planning D: Society and Space* 34/3 (2016), pp. 393–419, p. 393.
3 "Geko - Stadtteil-Gesundheits-Zentrum in Neukölln", https://geko-berlin.de.