3D Action/Health
End the Healthcare Protection Racket
A Call to Health Autonomy and Liberation
2026

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supporting the harms but also the concrete, physical infrastructure that allows it to move through time and space.

Act where and when you can, alone or with friends, but remember also that redundancy and interconnection will also make the structures we build more durable to repression. Immediate tasks can be distributed among trusted comrades in cells and affinity groups. Connections with other cells can distribute more general work while maintaining a security culture where only strictly needed details are shared. Eventually you can form a hub where individuals can come to build new connections.

Once you have a sense of the landscape, and enough trusted comrades to not only move once but move again, start building something new and tearing down the old.

After laying down some roots and taking immediate actions, send up a secure flare to help the front articulate more broadly. A blossom above to pollinate further and connections to the fungal network below.

Fundamental Questions

To answer the question of why the December 4th execution of UHC CEO Brian Thompson happened seems easy. Denials, price gouging, and the health insurance industry at large. However, as one unravels the outpouring of stories and symbolism in its wake, one finds it difficult to wrestle into a specific activist program. The questions one runs into are so urgent, but so foundational, that they resist easy answers.

Who lives and who dies?
Who is healed and who is hurt?
Who takes resources and who loses them?

There are no quick fixes to this system's problems. Even if you personally have good insurance coverage and good health, you have seen loved ones struggle to afford or access lifesaving care. You have seen the downstream effects of for-profit healthcare in rising costs, closed hospitals, under-staffing, wait times, bureaucratic obfuscation. You have seen people lose everything to cover cancer care, forced to choose between rescue inhalers and rent, while c-suites get rich off the blood in the streets. It is impossible to avoid the growing realization that there are no quick fixes to this system's problems because this system is the problem.

This is a part of the reason the events of December 4th resonated across the globe. While the "united states" is particularly bad in this regard, paying substantially more for worse care, other countries still struggle. "britain" has such lengthy wait lists for gender affirming care that the system forces trans people out of the country. "canada" may have universal healthcare that makes public hospitals and clinics available, but even still, has increasingly privatized some care, leading to 17.5% of the population to significant medical debt,[1] and the healthcare regime also pushes disabled people

[1] https://www.healthcoalition.ca/canadians-have-three-times-moremedical-debt-than-australians-poll/ 2. https://www.theguardian.com/world/2022/may/11/canada-cases-rightto-die-laws.

toward assisted suicide programs.[2] In Cuba, healthcare is free but US sanctions manufacture health scarcity by blocking the flow of technologies and medications both to punish Cuba for fighting western imperial capitalism and as propaganda against free healthcare.[2]

Within the "united states", attempts to revise policies for better health outcomes have met little success.4 This is because such attempts do not fundamentally change the power dynamic at play, so insurance companies and hospital corporations continue raising prices, deciding what care gets covered, and limiting available services regardless of what laws are passed or revoked. Reform is not the solution when the system kills for profit.

We do not want to simply renegotiate the terms of a hostage scenario. We want the power to no longer be hostages.

A Guiding Light — A Vision of Healthcare Possibility

We believe in healthcare that:

1. Provides access to all who need care.
2. The community directly runs and operates and that is accountable to the community at all levels.
3. Cultivates a vibrant community knowledge-base,

[2] Cuba's healthcare system was incredible, and, though it now suffers from severe shortages, this current state is due to sabotage and slow genocide via sanctions and retaliation from the "u.s" and other capitalist empires. For more, see "Creating the Irreversible: an Excerpt from First Revolutionary Measures," *Fight Like Hell For the Living: A Health Autonomy Reader*, 70–73. https://mutualaiddisasterrelief.org/wp-content/uploads/2022/07/FightLike-Hell-For-the-Living.pdf. For what sanctions have done, see https://www.aljazeera.com/features/2012/6/18/the-truths-and-tales-ofcuban-healthcare See also, Red Media, *The Red Deal*, 17–18.

struggles, but do not wait on some mythic dream of a "right time" to arrive before taking action.

Lights, Camera, Action – Immediate Steps

To start, we need to engage with the current landscape. This includes the autonomous, free, and pay-what-you-can health resources already on the ground. Share this zine with your local medical mutual aid orgs, street medics, harm reduction collectives, and comrades in care. People need to sit down together and consider what their communities have, and what they need. You cannot assume you know what your neighbors need until you ask. We need to share the knowledge we each hold. This can look like offering skill shares and trainings in first aid, basic trauma care, or CPR, but it can also look like sharing the knowledge you've learned from years of living with diabetes or allergies or arthritis so others don't have to start those journeys from scratch.

We all have something to share. When we pool our resources and knowledge, we can create the care landscape that we need.

Note that your evaluation of current resources does not need to be binary, recognizing aspects of both healing and harm. While we should hold ourselves to high standards, binary thinking can encourage us to ignore harm when done by people who we otherwise believe to be doing good or because we are scared that will result in cutting ourselves off from any good options. However, it is by being honest about the harm that we can elevate ourselves to those high standards, and help those for whom harm is pervasive get the help they need.

As you discover groups doing more harm than good, you have started the process of mapping the attack surface in your area. Pay attention to what specific things are harming the most vulnerable among you. Pay attention to both the abstract, social infrastructure

because you hold a line against killing or because you believe that resistance should be more organized), and still provide prison support for the accused, including but not limited to Luigi Mangione. Similarly, we should also support those facing repression, even when we view them as not radical enough. Supporting someone facing state repression does not mean we have to hold them up as a saint nor does it mean we have to invite them into our personal organizing circles. It means sustaining our connections with those who have fought for us before and encouraging courage through demonstrations of mutual support for the imperfect aspiring rebels who come after.

Together we must seize the means of health production.

Interlocking Fronts — A call to Solidarity with Other Movements

This is only one of many fronts in a broader network. Each front is a critical part of the movement. We must press on, on all fronts. We stand with our comrades against genocide and colonialism from Turtle Island and Abya Yala to Palestine. We stand against ICE, prisons, and the police. We stand against white supremacy and fascism everywhere. We stand with the proletariat, working dethrone the billionaires at the helm of this doomed ship we call "capitalism." Our focus on healthcare is a tactical choice to facilitate real concentrated disruption of the structures that kill us and creation of better healthcare structures from their bones. We also move to provide support for these other fronts in the form of autonomous medical resources as well as by further facilitating the globalized dismantling of the killing apparatus of the state. Just like our lives and deaths are interconnected, our struggle is, too. This is not an individual battle for healthcare, but one front of many in the interlocking fight for liberation. We view ourselves as a part of these larger

4. Values the autonomy and desires of the individual, while at the same time:
5. Acknowledging our interdependence.

1. Provides access to all who need care

Currently we have a system that denies access to crucial care along multiple axes. Insurance denials mean that unless one's employer pays extra for a premium plan (and sometimes in spite of that), one may often be barred from accessing needed care on monetary grounds. However, problems around access extend beyond the costs of care. For-profit healthcare disincentivizes research into treatments for rare illnesses, as well as preventative care, because the system profits most from a captive patient population, not from our survival or well being.

Currently, the healthcare system is especially a minefield for those targeted by the fascist imperial government. Not content to simply cannibalize the research, grants, and educational arms of the federal health infrastructure, they also continue to sacrifice disabled and chronically ill people by politicizing and attempting to ban basic personal protective equipment like masks and interfere with vaccine access, mainstays in infection control and pandemic prevention for generations. Black and brown people are ignored, or worse, criminalized for seeking even basic medical care. Gender affirming care is under threat from federal lawmakers as part of their ongoing genocide against trans people and gender dissidents. Pregnant people are criminalized and denied lifesaving care, surveilled and punished for miscarriages, and, especially if they are Black or brown, ignored until it is too late, or worse. What the state did to Adriana Smith and her family is unthinkably horrible. In the name of "healthcare" they let a Black woman die, then kept her corpse on artificial life support to use her as an experimental incubator,

despite her and her family's wishes.[3] Then they had the audacity to drop the costs of this abuse on her family as medical debt.[4] For what medicine?

Instead of paying (exorbitantly) for (insufficient) care, we envision a future where we just give each other the care we need. Everything material we need is already in these hospitals and pharmaceutical companies, we just need to take it instead of asking or paying for it, so we can give it to each other, as needed, directly. If payment absolutely must exchange hands, let it cover costs as needed rather than be directed toward profit with built in avenues for those who cannot otherwise afford it. These will expand and replicate as the needs of peoples and places shift, as circumstances demand, and as we build, through mutual aid, medical education, and resource liberation, the capacity to provide more and more specialized care in autonomous and self sustaining community settings. We start by organizing and fundraising for free clinics and skill shares, but we don't stop until every pharmaceutical corporation's resources and labs have been reclaimed and redirected towards the needs of the people instead of the pockets of billionaires.

We envision healthcare that provides care to all who need it, whether it be a band aid or a stem cell transplant, a pap-smear or immunotherapy for a rare disease, an abortion or safe labor and delivery, hormone therapy, top and bottom surgery, chemo and radiation. Regardless of disability, diagnosis, race, ethnicity, class, gender, religion, citizenship status, documents, whether you have a home, whatever language you speak, we all deserve medical care that comes from a place of love and respect for our humanity. Unshackled from capitalism and the current socially determined and biased healthcare infrastructure, healthcare can be run by us for us, where we deploy resources to meet the needs of our communities

[3] https://sparkrj.org/spark-news-messages/a-message-from-sparkreproductive-justice-now-the-case-of-adriana-smith/.

[4] https://www.gofundme.com/f/help-adrianas-family-during-thisheartbreaking-journey.

Embracing a creativity of tactics will allow new actionists to more easily climb the ladder of escalation. This includes not only practicing the "anarchist calisthenics" to help us overcome the mental blocks of rule breaking but also practicing specific concrete skills before they become load bearing. With a lot of different work needing to be done, people can find roles that accommodate their needs and skill sets, including disabled people who cannot hit the streets directly. Finally, staying creative will be important as the system we are attacking itself adapts to our movements.

This creativity and diversity in tactics is not to put choices above criticism. We can find a variety of attack surfaces, which may require different needs, and choices do come with an opportunity cost. Tactics always need to be evaluated in a larger strategic context, and just because a tactic makes sense in some contexts does not mean it will make sense in others.

While we do not propose everyone pick up a specific tactic let alone assassination, we emphasize the power of Propaganda of the Deed that marries direct and symbolic action. Symbols can provide legibility both to the public and our enemies, helping articulate the struggle into a front. But, without concrete material disruption that front may not end up doing anything, and symbols become more potent when attached to something real. A direct action carefully chosen also emphasizes its legibility with the act itself. A perfect marriage of symbolic and direct action isn't always possible, and we encourage people to prioritize getting away with a disruption over a flourish that may give them away.

By choosing targets and locations carefully, the political message of the assassination was already fairly legible on the morning of December 4th, while symbolic work such as the writing on the bullets or the monopoly money found in the discarded bag, cleared up any doubt that hung in the air.

And, it will still require further rhetorical and material work to support both those accused and their supposed acts, even through disagreement. One can disagree with murder as a tactic (whether

eration requires research to uncover an opportunity that not all would notice let alone be in a position to exploit.

Knowing the system well enough to identify points of intervention, let alone points of intervention local enough to make contact with, does not happen over night. This research is often the first step of an aspiring action cell.

We do not highlight this work to discourage action but in fact note that actions one takes now are important, as they serve as the foundation for further action. While we can embrace spontaneity when it happens, the action network should provide a space to nurture the soil from which that confrontation springs.

A gust of wind cannot alone propel us forward. It is work we do with each other when times are slow that builds resilient and powerful sails, able to take advantage of both a soft breeze and a storm.

Fortunately, confrontation itself can take on many forms, and the 3D action network supports people finding a variety of methods against our foes. As noted by the historical examples of the section "The Path Forward" there are a number of avenues of attack that go between marching with signs and assassination. We also add on these other options here, in case they broaden imagination:

- Unions striking to drop UHC contracts
- Occupying a gentrifying hospital to provide care that it will not
- Blockade insurance executives so that even if guarded they cannot move freely
- Wasting the time of those recruiting for predatory entities
- Destroying the computer servers used to algorithmically deny care
- Seizing technology of care that is currently being hoarded

and locales, and where our answer to lack of resources is to liberate, fund, build, or create more whenever and wherever possible, not to ration care based on who can pay what essentially amount to bribes, and where the people seeking care have a say in that care.

2. The community directly operates

Currently, "our" healthcare system is owned by health insurance, pharmaceutical and hospital corporations. These corporations structure care decisions around profit margins, and manufacture rising costs for this reason. Hospitals overcharge for some procedures to pay for others.[5] This is not a problem in the abstract, it can be a component of mutual aid/crowdfunding. The problem is that, while we are effectively struggling to afford crowdfunding each other's care, hospital, pharmaceutical and insurance executives take a cut of the funds. This can happen because without community ownership there is a distinct imbalance between the corporation gatekeeping care and the patient seeking care.

Currently, our healthcare system avoids accountability by answering to abstract legal malpractice proceedings, governmental rule passed by antiscience and anti-human politicians with no context for what the needs of the people actually are. The state dictates what care we can access legally, the insurance system dictates what we can afford, and the hospital dictates what it's willing to offer based on those limitations and the biases it has internalized and reaffirmed against those of us who are not rich, white, cis-het men. And while researchers, healthcare workers, and advocates have continuously fought from within and without to change this system and to create accountability to patients and communities, the government has responded by cutting their grant funding and outlawing their work under inane "anti-woke" legislation. These

[5] Krupar, Shiloh. Health Colonialism, 65.

bureaucrats and fascists neither know nor care what we need to live, and they would rather we die than stand in their way.

Even when people try to tackle healthcare giants directly in order to sidestep legal proceedings stacked in their favor, these giants have much bigger warchests that they can use to recapture the arena. Doctors sharing complaints to tiktok or journalists working for small papers have had fewer resources to spare when UHC decides it does not like what they have to share.[6]

Instead we envision care networks built out of our communities wherein those with resources, time, skills, knowledge, or other forms of care to share do so, coming together to create autonomous community spaces that carry out the function our current system fails to actually deliver. Crowdfunding is already the cornerstone of the care we manage to get under this system. But, unshackled from capitalist healthcare industrial complex, it can become genuine mutual aid.

We envision a system where we all acknowledge our dual roles as both people who need healthcare and people who can provide it, in different ways according to our knowledge, interest, and capacity. Those seeking care have a direct stake in the process of providing care and can shape the process according to their needs.

With power distributed within the community allowing for us all to support each other according to our needs and skills, we are all, consequently, accountable to ourselves and to each other. This will not remove conflict nor will it erase the need to address the power imbalances that remain, as the structures of oppression run deep. However, some of the current danger posed by institutionalized hierarchical medicine, medical misogyny, gaslighting, and racism can be mitigated. Exact protocols for accountability and protection will vary by community according to the needs of the community, but at the very least, dismantling the hierarchies that sep-

[6] https://democracynow.org/2025/7/16/ nyt_unitedhealth_campaign to quiet critics

3D-Action Network

As the confrontational wing of this struggle, the 3D Action Network has a simple goal — disrupt the healthcare industrial complex and support autonomous healing work by us for us. This is our orientation to the future and the now — destroy the cancer of profit based medicine, help liberate supplies and resources for 3D Health Network and protect the seeds it plants so that they blossom into a truly autonomous network of health resources, clinics, hospitals, and embedded ways of caring for each other, keeping each other safe.

In the wake of December 4th, we saw various people energized by the action but confused as to why revolution did not spontaneously emerge in its wake and their imaginations for action lacked the middle rungs to reach their higher aspirations. Note in discussing December 4th, we use the Adjuster as a folk name for the assassin so as to avoid speculation given Luigi Mangione's ongoing trial.

First, we would like to emphasize that a lot of actions that at first glance seem spontaneous may still require a lot of planning or cultural pre-work to set the stage. If you want a crowd to erupt into a riot, you first need a crowd gathered at a particular location and time, which itself often requires publicizing. If protest occurs over time such as ICE centers in the Whipple Building, Broadview, Dilley, and elsewhere this can happen organically with on the ground reporting, but this still requires an initial nucleus of a legible target and group of people willing to take sustained action. This process is aided in cultures that routinely riot, as it makes the prisoner's dilemma less risky if you have historical precedent that you won't be alone.

Even smaller groups committing vandalism often go better with trusted peers that serve different roles including look outs, and not everyone automatically has those relationships to leverage. Regardless of whether the Adjuster worked alone or with others, the op-

- Plans to use local and regional resources to fix the lack of redundancy in the current medical manufacturing system which causes so many shortages, like the IV saline shortages following severe hurricanes in recent years.

In collectively organizing such resources, the Health Network will have to contend with some granular concerns, such as how to minimize the reproduction of harmful structures from our current healthcare system, and how to navigate risks inherent to building autonomous modes of care while the dumpster fire still rages around us:

- The licensing question. There is of course legal risk to operating clinics without licenses, or performing medical care without a license. But also, there are countless ways in which the licensing and for-profit medical training system manufactures the scarcity that creates our current healthcare worker shortage.
- Hierarchy and power dynamics. The patient/caregiver dynamic. We need to reckon not just with costs and priorities, or whose lives are judged worth saving in service of the economy, but also with the way we see ourselves as patients and caregivers. The passivity of patienthood isn't working.
- Ensuring that these spaces are not limited to or subscribe to a hierarchy centering on western medicine. Many medicines work, and different people and communities may need different meds, kinds of care, or approaches from each other. This space is coalitional and western frameworks are not exclusively valid, nor superior, to the vast world of medicines out there.

arate clinicians and patients will start to break down the material bases on which such injustices feed.

With this in mind, we can create another world of care.

3. Cultivates a vibrant community knowledge base

Currently we have a system that creates artificial scarcity through gatekept knowledge. We hear about the doctor shortage as if students aren't turned away from medical education every year, especially those without the funding to pay for it, those with backgrounds that may make it hard to have the perfect resume, those who don't come from privilege already. There is a constantly reinforced binary between healthcare workers and patients, despite the fact that we all perform care work in our own circles, and despite the fact that all healthcare workers are also patients. When we perform first aid on our friends, splint a sprained ankle, take insulin, or use an epipen, we are performing healthcare work. Only the necessity of these everyday acts of care is obfuscated while the privileged space of the clinic is reified as synonymous with healthcare itself, rather than the legitimized side of something much broader and deeper. This goes hand in hand not only with the denigration of the necessary and lifesaving but often gendered and racialized care work we perform as underpaid nurses or unpaid family members and friends.

Meanwhile even the most simple and straightforward clinical tasks are described as things that take special aptitude, when in reality, we all have the capacity to care. We might not all have the skill or drive for brain surgery, or the desire to perform it, but basic wound care, injections, and administering various diagnostic tests are all things we can learn from and teach each other. Phlebotomy, for example, the practice of drawing blood for analysis takes only one day to learn. One day's training will get you a cer-

tification. Why are we not all phlebotomists? Or CPR-trained? For more complex or highly specialized knowledge, such as that integral to nursing, primary care, critical care, and specialist care, we can take the nonracist, non-classist educational resources from existing medical education settings, open them up to the kinds of voices and knowledge and bodies they have historically rejected and ignored, and make such training programs freely accessible to those with interest and aptitude.

We instead envision an autonomous medical education system that builds off existing medic and trauma certification programs from in-depth medical school coursework and residency trainings to the basic care skills useful in everyday circumstances, like Stop the Bleed, CPR, and similar, along with the tradition of anarchist skill shares which make space for the kinds of knowledge that certifications and formal medical educational structures rarely consider important, despite its crucial nature, such as the gathered knowledge that comes from living with a chronic illness or disability, needing to memorize the landscape of resources in your area, and such survival tactics and skills. This can form the ground, give breadth to, and direct passionate medics towards further trainings and specializations of a broad multifaceted medical education program built not around prestige, competition, and profits, but instead on training by and for us to reproduce the knowledge and skills of nurses and doctors in our ranks. Such an approach is only as strong as its commitments to hearing and sharing what the current system ignores. Therefore, at its core, this kind of medical education necessitates a careful attention to critiques of medical education's built-in biases, from clinical models to data collection, a rejection of racialized diagnosis and care planning and a commitment to bodies of all kinds. Similarly, it only works when it holds space to listen to and learn from people who hold deep knowledge of forms of healing and medicine that rarely make it to the lectern of colonial medical schools, like Traditional Ecological Knowledge and other non-western sciences and medicines.

Maybe you can access IV supplies to liberate. Maybe you can teach CPR. Maybe you have a lot of unused medications. All of this is needed. We propose a network connecting street medics, underground autonomous clinics and resources, and aboveground but sympathetic free or low cost health centers. These each do their part in the work to build autonomous medical capacity and get care and resources into the hands of those who need it.

The more we build such capacity for care, the more we disrupt the structures of medical violence. Starting with extant resources on the ground, we can then move on to address and meet what needs in our communities aren't currently being met and working to address those needs.

The specifics of what each community needs will depend on the community itself, but some general categories include:

- Autonomous primary, preventative, and specialty outpatient care clinics.
- More highly specialized, inpatient care settings for things like complex or life-threatening illnesses, injuries, surgery and recovery, and similar critical interventions.
- Community medical education, from casual capacity building via skill shares to more long-term specialized training and education with an eye to creating new generations of nurses, doctors, pharmacists, technicians, and researchers, to ensure that we have the people in place to provide care for each other on every level from primary or urgent care to higher level medical intervention.
- Autonomous research infrastructures that repurpose current facilities and resources to reprioritize drug development and manufacturing to provide open source medications that meet the actual needs of the people from managing common conditions to orphan diseases.

3D-Health Network

Direct action is when we stop asking for those in power to change our fates and rise up to do it ourselves. While this is often associated with militant confrontation, what is more direct than seeing someone in need of care and providing aid yourself?

RFK doesn't keep us safe. The government doesn't keep us safe.

Your local hospital isn't there to protect you or heal you. It is there to make money.

But the medicines inside it work all the same. Liberate them. The nurses and doctors and techs can diagnose, treat, and prevent illness. And the patients have vital insight that can help better provide care based on lived experience. Liberate each other!

The sterile supplies and the autoclaves, the labs and the imaging tech, from the MRI and PET scanners in the basement to the mobile x ray truck, all of these are held hostage for ransom when they could be comrades in our struggle to keep each other safe. Let's change that.

The goal is autonomy, but this is a long-haul. Work with who you can, where you can. Let the aboveground clinics with licenses and funding be comrades on the inside of the machine, sites for research and resource gathering. Try to orient them to the cause. Everything we need is on the ground already. We just need to seize it. We have the skills and knowledge to educate ourselves and each other. Both in the basics and in autonomous medical education. We have the spaces in our towns and cities that can become free clinics, hospitals, and labs. We have the specialists and techs among us who know how to carry us through different sicknesses, and the facilities to produce the medications and supplies we need. It is up to us to fix the potholes in the healthcare landscape — nobody is coming to save us.

This work is already happening, autonomous medical mutual aid operating under the radar. Think about what you and your neighbors, friends, or affinity group need and what you know.

Crucially, we propose a collectivist and collaborative healthcare system in which no one voice can speak for the many. This is critical to ensure that care is truly equitable and prioritizing the needs of the group, as well as to protecting the community from misinformed but charismatic rhetoric from anti-vaxxers and others like them who view their own opinions as more important than the safety of the community.

4. Values the autonomy and desires of the individual

Currently our healthcare system shortchanges those that deviate from what it believes the individual should want or desire from their body. Women's bodily autonomy around reproductive care is under attack, and even outside of state restrictions on abortion care, women without any intention to bear children have operations turned down over the possibility that they may one day change their mind. Trans people are facing genocide through state restrictions on everything from gender affirming care to suicide prevention resources, while intersex people have surgeries forced upon them in service of the false notion that sex is binary. These same controlling norms are deployed against autistic people, especially children, who are treated in a way that benefits the parent's vision of the ideal child rather than the child's actual needs.

We instead envision a healthcare system that prioritizes our needs and desires for our bodies over the desires of the state to mold our bodies into compliant re-producers of labor value under capital. Healthcare should help us flourish and thrive in our differences, not forcibly homogenize us according to the norms of a state designed to oppress us. Healthcare should respond to our own dreams and aspirations for our bodies and minds, not just what it dreams for us.

5. Acknowledges our Interdependence

At the same time our health care system currently atomizes individuals, de-prioritizing the health of the community writ large and especially the health of the most vulnerable. We see this in the abandonment of long-established public health practices like mass vaccination campaigns and masking around immunocompromised people in highly vulnerable settings like ICUs and NICUs, cancer centers, let alone general masking in daily life. We see this in the austerity measures taken by federal and local governments alike that strip funding from Medicaid, SNAP and other survival mechanisms and redirect it to military infrastructure, measures which are expected to kill millions. And we see this in the targeted grant cuts that are being used to halt research into the healthcare priorities of oppressed communities, ensuring Black, Brown, Native, and queer communities continue to face manufactured medical disparities and data genocide for decades to come.

We instead envision a healthcare system committed not just to the well being of individuals, but to doing what we can as a community for our community, especially the most vulnerable among us. A system that commits to masking as community care integrated into our daily lives, that doesn't just treat sick people but helps us all stay well, and that refuses to abandon us, no matter what. A system that provides care regardless of personal payoff, and recognizes that a shared physical, social, economic, and political environment means that health risks are often shared across the community while also recognizing the ways in which particular communities continue to face violence in the forms of inequitably distributed risks and harms, from toxic exposures to the weathering effects of racism to lack of access to safe food and water sources, to generational trauma and structural violence have lasting health consequences which necessitate particular care to mitigate and treat equitably. A system that prioritizes community based participatory research led by those facing particular healthcare needs and supported by those who recognize our health and wellbeing is shared.

As the Action Network disrupts, the Health Network rises to put the means of production already on the ground to better use, not only providing the care we already have access to, but working to address the intentional gaps in the current system, becoming the better world we know is possible. And, as the Health Network grows from isolated clinics and street medics to autonomous preventative, primary, and hospitalist medicine, as we rise up to take control of pharmaceutical research and production, medical education and trainings, and use these resources to shift our model of care from western individualism to community collaborative thriving, the Action Network continues to liberate more and more supplies, clinic sites, medications, protective equipment, hospital buildings and works to protect the medics that work to protect the bodies and minds of its people.

Note that the distinction between these portions of the network (discussed individually in the following sections) is not one of risk nor one of the underground/aboveground divide. Both sides can include a range of risk and visibility. Instead the health network focuses primarily on proactive work to meet the community's health needs on its own terms. The action network meanwhile focuses on confronting the entities in healthcare currently causing harm.

We aim to be weeds — everywhere, beautiful though often overlooked, key pieces of local ecosystem health (it is the native weeds, the wildflowers, to which the pollinators return). Not profitable. Not for sale. Thriving in spite of efforts to eradicate us or box us in.

Like the trees and grasses, our roots connect with a deep fungal network, nourishing us, informing us, and rooting us in place when others try and destroy us.

mechanisms for referral to a cell that may better address their needs. A cell that acquires medical supplies it does not directly need should have a structure through which it can hand off those supplies to those who would find them useful. Someone who wants to form an affinity group may not have immediate trusted friends who also want to tackle the same issues, but through a hub they may be able to meet like minded people. They then develop trust through lower risk activities before branching off into their own cell.

These hubs also specifically bridge the above ground and below ground worlds. Above ground entities are lights that cast shadows in which the below ground entities can prosper. For example, spaces and events that include both above ground entities, interested patients, and curious community members can also provide some plausible deniability for underground entities to meet new people who may also need their services.

We also specifically emphasize the importance that information sharing can have in building our vision. Having a good sense of the current local landscape, both abstractly and physically, is important to actually find points of intervention and holes that need addressing. While some research will need to be done for individual projects, working together and communicating on broad issues will help us not each start from scratch. At the same time, in order to maintain the integrity of the connection and not burn those engaged in riskier activities, individual cells should be able to have discretion on how much they share (and how much they engage with hubs more broadly).

We must destroy to create, and create to destroy. As such we envision our work as having two branches a 3D Health Network that builds alternatives and a 3D Action Network to confront the harmful status quo.

However, while each side can engage in work independently, the hubs provide infrastructure through which 3D Health Network and 3D Action Network inextricably link and support each other.

An injury to one is an injury to all. We are better when we take care of each other.

An Unfortunate Dead End — On Universal Healthcare

For-profit health insurance spells disaster. Many people have proposed universal healthcare as one immediate and direct solution, and it is not one we totally discount. Many countries with universal healthcare have significantly better health outcomes than we do, and while we believe in the power of local mutual aid networks and local community based care, a move across the country or break in your social circle should not disrupt your ability to receive care. Additionally, under universal healthcare access is not dependent on employment, as is currently the case.

However, we are not proposing universal healthcare as our strategic goal for two reasons. First, it does not fundamentally remove the hostage scenario of modern healthcare, instead replacing the captor of the company with the captor of the state. Second, we cannot wait on the state to take action to save us.

Though it does remove the incentive for corporations to profit by raising direct pricing, universal healthcare does not rid the health landscape of capitalist interests-it obfuscates them. Now, it is the state trying to maximize profits, by paying as little as possible to keep the working class alive and well enough to raise the GDP. Even then, one still must beg for a bureaucratic body to approve medical care of which it often lacks the context to understand the necessity, and which faces no consequences for denial, regardless of how many die as a result of this stinginess. This continues to be felt most acutely by those without resources and those excluded from the body politic, as we see play out in “britain” and “canada”, where disabled people face decades-long wait times for accessible housing, and health programs that are

unwilling to fund medical or social support and care but happy to pay for euthanasia.[7]

The ability to ration healthcare funding in fact becomes one of the methods of policing the borders of the nation. With transphobia so intense in "britain", it shouldn't be a surprise that "british" trans people seeking gender affirming care often wait years for the resources they need, to the point of being pushed outside the state.[8] However, one of the best examples of this phenomena is homegrown in the "united states" with the Indian Health Services. Although the IHS isn't technically an insurance program, as a free clinic network, it is the closest thing the "united states" has to universal healthcare. However, the IHS is extremely underfunded to the point that it refers out to approved other providers for most critical services.[11] This forces Native people to travel long distances to access out of network care without cultural resources, adding further barriers to a system that already too frequently denies Indigenous people the care they need based on racist and colo-

[7] https://www.habinteg.org.uk/latest-news/wheelchair-users-subjected-todecadeslong-wait-for-new-accessible-housing-2004/ https://www.cbc.ca/news/canada/british-columbia/disabilityaccessible-housing-bc-1.6567378. https://www.cbc.ca/news/canada/windsor/supportive-housing-delayscontinue-1.5241574. Same as 2: https://www.theguardian.com/world/2022/may/11/canadacases-right-to-die-laws.

[8] In Britain, waiting lists for gender affirmative care are extremely long. For example, London's Tavistock and Portman Clinic has a 79 month waiting list, Sheffield Health and Social Care has a wait of 71 months, and, per their own websites, in 2025 both are still scheduling initial consults with people referred back in 2019. In summer 2024, Vice published an excellent interview with trans people caught in NHS limbo: https://www.vice.com/en/article/nhs-transgender-waiting-listcrisis/. For gender care wait times across the UK, see: https://transactual.org.uk/medical-transition/gender-dysphoria-clinics/. 11. https://www.npr.org/sections/health-shots/2017/12/12/569910574/ native-americans-feel-invisible-in-u-s-health-care-system. https://centerforhealthjournalism.org/our-work/reporting/people-dienative-americans-face-serious-barriers-accessing-care.

To make this happen, we need avenues of communication for critique and empowerment, and sharing information and materials. We also hope that by articulating various individual battles together as a part of the same revolution, we may see new opportunities for coordinated action and encourage each other to dream bigger with an army of comrades at our side.

Casting Call

Who do we aspire to be? We are people with bodies. We are your neighbors, your friends, your relatives, your patients, your nurses, your doctors, your baristas, your retail workers. We welcome all. We are looking for comrades everywhere.

We are an informal cell-based collective comprised of autonomous groups, working on their own projects but articulating each group's battle into a larger front. These cells do not need to be cells in the classic sense (though they could be). They can be affinity groups, organizations, clinics, or other forms of collective organization tackling a specific need in the community. The fight for healthcare is multifaceted and groups will need to organize around specific goals, which will in turn inform the structure these groups use to organize. We do not pretend that an aboveground clinic, an underground distro, an educational team, nighttime vandals, and workers pushing for a say in their insurance should organize themselves in precisely the same way.

We are also local hubs which provide space, for those with interest to find each other, to encourage the formation of such autonomous cells, and for cells to share ideas, tactics, strategies, rhetoric, news from the front lines, resources, and relevant analysis. We hope to connect those already doing this work with each other as well as encourage more to get involved. For example, someone who needs care may not be a good fit for the first autonomous health group they encounter, but a hub may provide

gether fought UChicago for 30 years until they brought back their trauma center.[23] And intersex advocates protesting outside Lurie Children's got the hospital to stop performing nonconsensual surgeries on intersex children.[30]

Disrupting the functioning of the government that segregates the sick from healthy, disabled from abled, is confrontational. The whole reason we have the legal protections that grant disabled people equal access to hospitals and schools like the ADA and Section 504 is because disabled activists including disabled Black Panthers took over a federal building in San Francisco for 26 days in 1977.40

But sometimes, when lives are on the line, more direct, violent confrontation sparks. We are past that point. That is why December 4th is such a rallying cry. Whether or not you valorize the assassination, it should drive us to confront these issues head on and not shy away from what must be done, however we define the task. The structures killing us are not invincible. They die like the rest of us.

Single confrontations can often be isolated and ignored. It takes a sustained effort and legibility for the message to not only be received but reckoned with. And, a revolution rarely happens in a single battle. A pattern requires persistence and similarities (even if symbolic) between instances even as individual perpetrators remain hard to pin down. And, a message carried across numerous different attack surfaces, leaving no quarter, becomes a genuine threat.

We hope to turn those individual battles into a coherent front of a larger war. Some of this work can be symbolic and rhetorical. But at its core, this fight is a material one, running on direct action against the cancer of the current system.

[23] For the history of the Trauma Center campaign, see https://www.southsidetogether.org/news/tcwon 30. For more on this, read *Nobody Needs To Know* by Pidgeon Pagonis.

nial assumptions.[9] While the IHS is supposed to pay for this out of system care, patients frequently get billed anyway, leading to debt harassment.[10] Given that it is run by an occupying settler colonial state that constantly breaks its treaty obligations, the IHS is always under threat of being shut down,[¹4] including during recent HHS purges.

Given we live under a state that disappears cancer patients,[11] sends ICE agents into hospitals,[12] where many vital healthcare workers are themselves immigrants,[13] how could we trust the state not to use healthcare access as a cudgel?

[9] On both sides of the medicine line (separating the so-called colonial states of the "u.s." and "canada"), far too many Indigenous people die from both medical negligence and overt racist violence, whether in the slow sense of shortened life expectancies or the quick, overt racist violent that took Joyce Echaquan (Atikamekw). We remember, mourn and honor you.

[10] http://ictnews.org/news/native-americans-face-higher-than-averagemedical-debt-report-finds-often-for-bills-that-arent-their-responsibility/

[11] ICE regularly disappears cancer patients, keeping people incarcerated without access to treatment for months, and deporting people away from their medical teams. Currently, several people are in danger of dying because ICE has denied them care during arbitrary detensions. Yari (Arbella) Rodríguez Márquez, who has leukemia, has been trapped in the Eloy Detention Center for months without medical care. She has lost 55 pounds as her cancer worsens and she will likely die without intervention. Similarly, Jose Angel Giron Rodas, imprisoned at Otay Mesa Detention Center for 13 months, has been getting sicker and sicker with what his doctors fear to be colon cancer. He was in the middle of getting diagnosed when ICE kidnapped him. Children have not been spared this brutality, either, including a 4 year old with metastatic cancer deported from Louisiana in April, a 10 year old with brain cancer deported from Texas in April, and a 6 year old with leukemia who was taken to a detention facility in June.

[12] ICE has raided various hospitals and clinics in 2025, including Avera Hospital in Marshall, MN, Riverside Community Hospital in Riverside, CA, Ontario Advanced Surgery Center in Ontario, CA, and Dignity Health in Glendale, CA, among others. For more information, as well as on how healthcare workers are fighting back, see http://lapublicpress.org/2025/06/ice-raids-families-too-scared-to-go-todoctor/ and https://www.emra.org/emresident/article/ice-in-the-ed/

[13] Immigrants are critical healthcare and hospital workers, without whom none of us would be able to access medical care. An average of 16% of hospi-

Universal healthcare also does little to address the other ways in which bureaucracy and algorithms turn healthcare into a site of exploitation. The insurance machine whether private or state run poses a massive barrier to those without the time and resources to fight for their care access. Any clinician can choose to based on their evidence informed judgment rather than external algorithms, but bureaucracy only approves what it can quantify and otherwise make legible.

This in turn ossifies anti-Black racism, algorithmically denying care to Black patients when it would approve the same for white patients. The algorithms used to gauge how sick our lungs, hearts, and kidneys are all have arbitrary factors included that artificially inflate the results for Black people's tests, making them seem healthier than white people with the same underlying illnesses and disease severity, even costing Black people life-saving organ transplants.[14] Similarly, while pulse oximeters are significantly more accurate at detecting hypoxia the less melanin you have, meaning that, in the early stages of the COVID-19 pandemic, white people's dangerously low oxygen would get diagnosed much earlier, increasing their access to limited supplies of ventilators and ICU beds.[15] Both cases lead to Black people receiving delayed care or being denied care entirely.

And, even if universal health care did solve all these problems, how could we trust the state to reform itself to help us?

This is especially true with Donald Trump and RFK in office actively destroying our public health infrastructure. They throttle NIH funding and attack confidence in vaccines, ban words from research and de-platform critical information from research data

tal workers across the "u.s." are immigrants: https://www.axios.com/2025/07/08/hospital-workers-immigrantsstates-map/.

[14] Braun, Lundy. *Breathing Race into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics*. 2021. https://apnews.com/article/kidney-transplant-race-black-inequity-biasd4fabf2f3a47aab2fe8e18b2a5432135

[15] https://publichealth.jhu.edu/2024/pulse-oximeters-racial-bias.

These sparks continue to spread: ongoing health autonomy work in the "united states" ranges from the biohackers behind Open Insulin Foundation, working to create local infrastructure for producing free insulin for all, to the work of street medics bringing direct care to unhoused communities and encampments across the country, to ACT UP and other community organizations in running health resource fairs that help ensure that we provide for each other what the health system denies us, and that our friends know where to turn when they need specific forms of care.[22]

These actions are critical examples because they not only prove the feasibility of seizing the means of care, they also show us that, when the community provides care for itself, outside the formal structures and licensing of the old system, that care is safe, effective, and catching. Each liberated, decentralized, autonomous clinic or network inspires others and spreads the cure to our diseased system.

However, even with the building of alternatives, the old system will not take its suffocation lying down, and as such, we cannot avoid confrontation forever. Additionally, confrontation can itself be a powerful tool in shaping narratives and weakening our enemies before they have the chance to strike.

Confrontation can take many forms.

Making a scene is confrontational. In addition to their work providing resources, ACT UP has a long history of confronting the structures responsible for the HIV pandemic from the CDC's complete disregard for queer life to the Trump administration's attack on funding, research, and resources. Disrupting the hospitals that harm you is confrontational. Protests outside hospitals interfere with their business, bring bad publicity, and have successfully forced hospitals to change harmful policies. Southside To-

[22] Open Insulin Foundation: https://openinsulin.org ACT UP: https://actupny.com (note website does not like vpns)

to clinical guidelines to public safety information. As the passage of deadly austerity measures like the "big bullshit bill" highlight state-run healthcare is not a safe, sustainable, or reliable structure when the state itself is a for-profit entity subject to fascist take over. Cuts made to social safety nets like state insurance will ripple through the health system, forcing clinics that treat those on state insurance to close due to the state's refusal to pay.[16] These hospital and clinic closures worsen the manufactured crisis in healthcare staffing, adding strain and unsafe wait times to already overtaxed health centers in metropolitan cores, forcing us all to travel farther, pay more, and wait longer for care, including in emergencies,[17] and further deepening divides between regional academic centers now tasked with treating wide swaths of the population and their local communities, who often see added costs but decreasing access to care as a result of the institutions in their midst.[18]

As austerity measures swallow up Medicare, more and more people are not only left without access to care, but also coverage that specifically was there to support those who cannot get coverage through employment under this system. Disabled, chronically or severely ill people, unhoused people, elderly people are going without coverage, and they are often those who need healthcare the most. But it gets worse. It's not a coincidence that these sweeping cuts to Medicare came right before pushing bills criminalizing being unhoused and changing how medical debt is counted in credit reports, which means that landlords would be able to deny lease applications based on you still being in the process of paying off surgery, or having had cancer (which bankrupts 50% of patients).

[16] https://protectourcare.org/wp-content/uploads/2025/06/ Report Hospital-Closures.pdf.

[17] Per health economists at Penn, the big bullshit bill will likely kill 51,000 annually. https://ldi.upenn.edu/our-work/research-updates/trump-senate-billseen-causing-51000-preventable-deaths-annually/.

[18] For more on this phenomenon, read Krupar's *Health Colonialism.*

cerns from asthma to epilepsy to diabetes.[19] But there is no reason why street clinics should be limited to emergency medicine. They may begin there by necessity, but as people build capacity and resource networks, more and more autonomous medicine becomes feasible.

Historically, some of the most revolutionary healthcare work has been efforts to bring primary and specialist care to the people rather than relying on the healthcare system. The Janes Collective brought means of performing abortions back into the hands of the people.[24] The Black Panther Party ran free clinics from Oakland to New York, providing primary, preventative, and sickle cell care.[20] The Young Lords Party, BPP, The Health Revolutionary Unity Movement at Gouverneur Hospital, and the revolutionary health workers at Lincoln Hospital collaboratively built mutual aid health networks throughout new york, ultimately liberating both an x-ray truck used to screen thousands for TB and Lincoln Hospital's sixth floor, which they turned into a harm reduction and addiction care clinic.[21] They redirected infrastructure already on the ground to provide care the community actually needed, free for all. And while most of the above are historical examples, the Zapatistas, who have run fully autonomous healthcare system in Chiapas for 30 years, are still going strong, providing everything from preventative medicine to surgeries.[27]

[19] On the 2019–20 Chilean uprisings, check out the documentary *Fell in Love with Fire.* On healthcare in the Student Intifada, consult your local SJP 24. For more info on The Janes, see *Fight Like Hell for The Living*, 16–25.

[20] For a quick summary of BPP health care, see https://blackpast.org/african-american-history/black-panther-partysfree-medical-clinics-1969-1975/. For a more detailed history, see *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* by Alondra Nelson and *Black Disability Politics* by Sami Schalk.

[21] For various communiqués from the Young Lords Party, see *Fight Like Hell for the Living*, 26–40 27. For a primer on Zapatista healthcare, see *Fight Like Hell for the Living*, 41–45

They don't want to keep us alive, let alone well. They want you sick and vulnerable to their gestapo raids, so they can disappear you into the prison-industrial complex and its slave labor force. Re-expanding Medicare would help, but it won't save us from a system that impoverishes, exploits, and incarcerates us for having the pre-existing condition of being human, of needing care.

However, Democrat politicians have also denied the need to update our healthcare system or gave lip service to the idea but delay implementation. They defend their ineptitude on the campaign trail as pragmatism and view being deposed electorally as another fundraising opportunity. Fundraising that very often hinges on wealthy donors and corporations, who see no issue with the system as it currently stands, because this system is functioning as designed — to enrich them. It is designed to turn sickness and death — especially of Black and brown, Indigenous, disabled, working class, queer and trans people and women — into money for corporate executives — mostly white men.

We do understand the appeal of universal healthcare and appreciate the labor of those seeking it, such as the Nonviolent Medicaid Army. Many of our concerns and goals are shared with these comrades in struggle, saving lives and keeping each other safe, and universal healthcare could save many lives. But, if we didn't have to justify that our health matters, or beg bureaucrats to consult obscure black box algorithms and instead just treated ourselves and each other by seizing the means of medical care, we would save a hell of a lot more.

The Path Forward — Creation and Disruption

As a compass that will orient us in action toward our healthcare vision we propose an emphasis on actions, projects, and campaigns that:

1. Seize or build healthcare infrastructure in line with our vision, making us less reliant on the current system;
2. Nurture the knowledge and education base in our communities so that people are empowered to use said infrastructure;
3. Disrupt the existing entities that produce healthcare inaccessibility, creating room for our creative enterprises to flourish;
4. Articulate local healthcare struggles into a broader legible front, allowing us to be more than the sum of our parts.

We cannot wait for a better world to be born, we must both clear its path and bring it into being. Disrupting the systems that sicken and kill us is not enough. We have to create networks of care in their place.

These steps do not happen sequentially but in tandem. Tearing down the old system will likely not happen overnight, and without building nourishing alternatives, after each strike our enemies will regenerate themselves on our own exploitation. In fact, directing people toward alternatives can be one way we attack our enemies by starving them out of existence. Since December 4th the idea of a health insurance boycott has occasionally surfaced, but it will fail to gain traction until those who need care see other ways to access it.

There is a long track record of autonomous emergency healthcare working to support other efforts to confront the state and institutional power. Recent examples from the front lines include street clinics in the 2019–20 chilean uprising and health tents in the 2024 student intifada encampments. These spaces were mostly first aid, urgent care and triage, treating inflammation and preventing further harm caused by tear gas, pepper spray and other chemical agents as well as managing other emergency care for common con-