Richard Bůžek, Iris Dzudzek, Andreas Exner, Bettina Franke, Susanne Hübl, Lisa Kamphaus, Jonas Löwenberg, Vasilis Tsapas, Anke Strüver:

»Right to the City«

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RIGHT TO THE CITY Foreword

How is the right to the city relevant for health for all and how does it already unfold in concrete practices of urban grassroots movements? How do the diverse structures of health inequalities unfold on the urban scale? How do urban movements address these inequalities through collective action and political struggles?
This polylogue presents insights from a roundtable discussion with critical urban scholars and health activists on health as right to the city. The discussion took place at the Radical Health Conference 2021 in Berlin. From the perspective of critical urban theory, Anke Strüver from the University of Graz explains the urban roots of health inequalities and their unequal embodiments. Vasilis Tsapas provides an activist account of how (health) inequalities are addressed in the everyday work of the Solidarity Clinic in Thessaloniki, a radical democratic and anti-hierarchical urban health collective. Andreas Exner as an activist scholar stresses the importance of radical democratic collaborations of right-to-the-city movements and grassroots health initiatives for health equality. Bettina Franke and Jonas Löwenberg from the community healthcare center *Poliklinik Leipzig* highlight the role of interdisciplinary work and the empowerment of local communities in approaching people's health from the bottom-up. Following this, the Critical Urban Research Group Münster emphasizes the role of urban space as an important scale for collective transformations of structural health inequalities in the sense of health as a right to the city. The session was moderated by Richard Bůžek and organized by Critical Urban Research Group (Iris Dzudzek, Richard Bůžek, Susanne Hübl, Lisa Kamphaus) from the University of Münster.

RIGHT TO THE CITY Collectivizing Health

Richard Bůžek: Anke Strüver, in your work you are investigating how health inequalities are unequally embodied in cities. Can you explain the roots of health inequalities on the urban scale in more detail? Where are the possibilities to transform health inequalities and how is this related to the right to the city?

Anke Strüver: As an urban geographer, I start with a very traditional introduction to answer this question. That is, what do we mean by "the right to the city"? Key thinkers here are David Harvey[1] and Henri Lefebvre. In the following, I refer to Henri Lefebvre. Henri Lefebvre defined the right to the city as it cannot be conceived of as a simple visiting right or as a return to traditional, pre-industrialized cities. Instead, the right to the city can only be formulated as a transformed and renewed right to urban life.[2]

"The right to the city manifests itself as a superior form of rights: right to freedom, to individualization in socialization, to habitat and to inhabit. The right to the œuvre, to participation and appropriation (clearly distinct from the right to [capitalist] property), is implied in the right to the city."

Henri Lefebvre: *Writings on Cities,* Oxford: Wiley-Blackwell (1996), pp. 173–174.

So, the emphasis for me is defining the right to the city as a right to 'just' urban life. Consequently, the question remains, what is 'just urban life'? I refer to 'just' in the sense of parity of participation,[3] i.e. justice relying on the connections between three dimensions of justice, namely distribution, recognition, and political representation. Urban life has always been characterized by social and spatial divides. Embodied health inequalities are but one example of these divides. They refer to the embodiment of both environmental exposure and social

processes, and how these two elements come together. There are obvious connections between socioeconomic differences along class lines, which we can label as outcomes of capitalism. Also, there are connections between socioeconomic conditions and socio-cultural contexts including resulting racism and environmental degradation in or close to particular urban neighborhoods, which are often labeled as so-called 'poor neighborhoods'. Those labels go back either to their location, e.g. when they are close to waste incinerators, noisy infrastructures such as main stations or airports, or in the proximity of high-emission factories and alike. They also might be labeled as 'poor' neighborhoods, due to insufficient quality of housing or their population composition along economic and cultural lines or all of them. This is a scenario where all three stereotypes of poor neighborhoods come together and we can find them in every city. However, people in poor neighborhoods neither are generally nor automatically less healthy than in different neighborhoods nor are they deprived of a good life, due to their place of residence or individual misbehavior, especially not in Central Europe. Yet, health inequalities within cities are strikingly apparent.[4] Negative health outcomes, then, are rather an effect of socially mediated processes of the entire urban or even national society. These processes are rooted in the dominant social structures, and neither in people's individual behavior nor in the built urban environment as such.

Health is not only affected by individual behavior or built urban environments but mainly determined by dominant social structures such as gendered, classed or racialized inequalities.

The dominant social structures such as gendered, classed, and racialized distinctions result in spatial and social inequalities. For us as geographers, the relation between social and spatial inequalities is particularly important. What is very interesting for me in particular is the embodiment of these social and spatial inequalities, including the embodiment of environmental bads, but not in a clear cause-and-relation-logic. That means people's physical bodies are the place where social, spatial, and ecological or biological impacts materialize and result in better or worse health conditions. Thus, the environmental quality of places deeply affects bodies, but if we consider embodied health inequalities we need to look beyond individual bodies and individual people and rather concentrate on the structural relations within a given society. That is, we need to look beyond the individual and the social and environmental quality of places, and instead foreground the urban and societal structure that results in socio-spatial inequalities and qualities of places. The material self, the body, and the embodiment thus cannot be disentangled from processes that are simultaneously economic, cultural, and environmental. Therefore, a perspective on human health should be 'bio-social'. A bio-social perspective on human health includes an understanding of human and environmental exposure as well as human and environmental nature beyond biological determinism and also beyond both socio-cultural essentialism and (failed) individual behavior and responsibility for one's health. If we ask, how social differences become physically or biologically effective in terms of health inequality, we need to point to the fact, that the reasons for exposure to environmental stresses are socio-economic and/or socio-cultural injustice, especially racism, and yet always related to capitalism as institutionalized social order. But the consequences of injustice are still health-related and that is why health is very important. Returning to Lefebvre and the right to the city in the sense of the right to urban life and the quality of just urban life, he also made a plea for real and active participation in cities.[5] This includes participation in education and healthcare, in the collective appropriation of public and green spaces, and so on. These rights are considered collective rights, including the rights to be different and to have different spatial visions and demands.



Photograph by Severin Halder and Lisa Kamphaus (2022).

Participatory intervention to learn collectively about health in the city and how to shape it structurally on the urban scale.

Health as a right to the city and fundamental part of social justice needs collectivization and de-individualization.

Against this background, I argue that health as a right to the city needs to be approached as a collective social process, but includes perspectives on individual yet social forms of discrimination. Integrating health into the right to the city thus depends on de-individualizing health and focusing on health as a fundamental part of social justice.

RIGHT TO THE CITY Solidarity, Not Charity

Richard Bůžek: Vasilis Tsapas, the Social Clinic of Solidarity in Thessaloniki has established the provision of primary health care to all following an egalitarian approach through practices of radical democracy.[6] How do you address inequalities in your everyday work and how are practices of solidarity in the clinic related to other struggles and movements?

Vasilis Tsapas: The Solidarity Clinic in Thessaloniki was founded in 2011. This happened against the background of the beginning of a health crisis in Greece when people without health insurance were excluded from the public health system. That is, they had to effect out-of-pocket payments for visiting public doctors, the medicines they needed, and hospital treatments. The Solidarity Clinic is based on the principles of direct democracy and the absence of authority and hierarchy in itself. Everybody comes to the Solidarity Clinic as a person and everybody is volunteering there. All decisions are being taken in general assemblies where everybody can participate based on equality, all opinions count as equal to prevent any hierarchy. All decisions are usually taken with consensus or with very big and clear majorities. If we cannot meet these requirements, then decisions are postponed, re-discussed, etc. In the general assembly, we also discuss medical matters. Hence, the way how people are treated in the clinic is not a matter of the medical professionals only, but everybody participating in the Solidarity Clinic. We invite people, who have been treated in the clinic earlier, to participate in the assemblies and the decision-making procedures. We are autonomous from the state and its institutions, political parties, and the church, also financially. Instead, we are funded by people and social collectives only. We believe in the principle of rotation in all organizational roles in the clinic and the representation of the clinic to the outside. We regard ourselves as part of the anti-fascist and anti-racist movement of the community.



Social Clinic of Solidarity (KIA Thess), 2012.

"Against a system, which impoverishes life. We support you! We support solidarity." An invitation for a discussion about the dissolution of the Greek public healthcare system and the creation of the Social Clinic of Solidarity in Thessaloniki.

So how do we address inequalities in our everyday work? In our collective, we must address both the inequalities among the different people who come to the clinic seeking its services and the inequalities between the people working in the Solidarity Clinic and those who come to the clinic. First, preventing inequalities among people who come to the clinic requires never demanding anything in exchange from them. No proof of their situation, financial or insurance status, their origin, whether they are national citizens or have any sort of papers, etc. Everybody can come, if they feel that they cannot meet their needs in the national health system, we are doing our best to cover these needs. Everything that we give to the people is completely free, that is all medical and dental services, psychological support services, and all necessary medicines. If somebody needs any other sort of services that we cannot directly provide, for example, treatment from a medical sub-specialization, we have a wide network of medical doctors in the city who treat our patients for free. If we need laboratory tests, we work together with a network of laboratories in the city, so the people are being offered their services for free. If a bigger structure such as a hospital is necessary, we send these people there. We help them find their way through the state health system so that they receive the help and health services they require. As a result, everybody is being treated exactly the same way and procedure. Moreover, the clinic is a place where no discrimination regarding sex, race, origin, or sexual orientation is accepted. It is crucial to understand that from the moment in which someone enters the clinic. In very rare cases in the past when people in the clinic behaved in a discriminative manner, we very strongly stopped such behaviors. Second, we are trying to address the inequalities between the people who treat and the people who are treated. There is a very strong hierarchy between the medical doctors and the patients treated in the classical healthcare system. We try to address this inequality in our practice as we regard the people who are treated in the clinic as an active part of the medical treatment and decision-making. Instead of being passive receivers of medical treatments, we encourage them to participate in and define these treatments. Another important strategy is the formation of the so-called 'Different Medicine' group, which assembles all the people who treat patients from different medical and psychological specialties in the clinic. This Different Medicine group treats people in long sessions, combining multiple medical

and paramedical professionals of physical and mental health. We are trying to see medicine from the perspective of the person who comes to get medical services. Therefore, we speak about solidarity, not charity. To avoid inequalities in our daily practices, we are organized in ways to ensure that the people receiving medical services are always on par with our medical staff in the clinic.

The Solidarity Clinic is an organic part of urban movements struggling for direct impacts in the community to address health inequalities.

Beyond that, we regard our collective of the Solidarity Clinic as part of the urban anti-fascist and anti-racist movement in Thessaloniki. We participate in urban struggles such as demonstrations and try to provide these struggles with medical coverage. For example, over the last few years, we have been supporting a big struggle around mining in a small village (Skouries, Megáli Panagía) on the outskirts of Thessaloniki. There we participated in demonstrations and other activities happening during the summer, with speeches, discussions, etc. Moreover, we created a medical facility – a workers' clinic– in a side venue of the squatted factory VIOME in Thessaloniki, which was recovered by the workers of the former factory. We have tried to establish a medical clinic inside the factory and to strengthen it against attacks from the state, in particular against brutal eviction by the police. Here, we also follow our approach to create a clinic in participation with the people who work there for the people who work there and other workers in the city. In this way, we attempt to be an organic part of this urban movement and to create relations with all the other movements in the city. At the same time, we believe that it could be valuable for grassroots movements to focus more on the primary health system because it has direct impacts on change in the neighborhood and the community.

RIGHT TO THE CITY Building Alliances

Richard Bůžek: Andreas Exner, as an activist researcher in Graz, you are dedicating your work to a feminist and socio-ecological transformation of society with a particular focus on solidarity-based economies. You have worked together with grassroots health activists in Austria. Which lessons can be learned from these struggles for a fruitful collaboration of right-to-the-city movements and grassroots health initiatives?

Andreas Exner: It is not easy to answer this question. Since about 2010, I was involved in a couple of initiatives, working with grassroots health activists in various ways of life. Mainly health professionals, but also people interested in health issues more generally. Moreover, I have a foot in fields of struggles that you could easily connect with right to the city and I am somehow affiliated with the right to the city network, which is mainly based in Vienna. The first observation is that in my opinion struggles concerning right to the city on the one hand and health on the other are poorly developed in Austria. You could say that probably for many countries, it always depends on your level of ambition or perspective, and how you assess things. I want to stress that these struggles have to increase. To connect different struggles related to health or right to the city issues in other realms of urban life, there has to be some activity going on.

Social justice necessitates more confrontational strategies to shift public policies significantly.

From the few instances where conflicts erupted in open struggles in Austria over the last years since the financial crisis of 2008, it is important to embody the perspective of the solidarity economy. In Styria, the province where I live and work, a forceful struggle as a response to austerity measures was pursued for a couple of months, with some activities even until quite recently. The austerity measures in Styria happened on a much lower level than those we know from Greece, but there were some similarities. In 2011, the former coalition between the conservative Austrian People's Party (ÖVP) and the Social Democratic Party (SPÖ) enforced budget cuts amounting to up to 25% in the social and cultural sector. This austerity policy was an outcome of the state-backed bank bailouts in the wake of the 2008 financial crisis. The budget cutbacks hit people at the bottom of the social ladder hardest, those who depend on various sorts of social assistance, and people with disabilities. Also, the cultural sector was affected. In the resistance that developed against these austerity measures, it became apparent that alliance building is fundamentally important for successful struggles against budget cuts, which in that case primarily affected the health system, but also for broader issues of the right to the city. For instance, if you think about people depending on personal assistance who cannot move any longer where they want to move when the state cuts back spending in the social sector that you would associate with the health system in the larger sense, then a very basic human right is not safeguarded, protected and enabled any longer. Therefore, it was crucial that many different actors came together. The first step was an alliance of cultural producers and activists affected by the austerity measures with the Communist Party (KPÖ), which is quite strong, especially in Graz, but also in the province of Styria at large. In a second step, health professionals and care workers jumped in and very quickly built an alliance including about 600 different organizations on the level of the province. They formed a coalition that they called *Plattform 25* and organized mass rallies. The first rally gathered around 10'000 people, which is also quite a huge number for Graz, the second allegedly gathered 15'000 people. As a result, they were quite successful in at least influencing the public discourse against these austerity measures.



Photograph by *Plattform 25* (2011).

Mass rally against cuts in provincial health and social care budgets, Styria 2011.

So, what can we learn from these struggles? There has been a debate on the strategic learnings from these processes, and several publications stress that alliance-building and cooperation across ideological fault lines are very important. This needs time. A broad variety of actors – for instance, health professionals, affected people, and their family members, political parties, parts of the trade union, and cultural activists – was one factor of the relative success in shaping at least the public discourse. However, there are also downsides.

Struggles against austerity measures in Styria hardly changed any material policies.

What we can learn from this failure is that you may be able to influence public discourse focusing on the quality of life and social justice issues, but you fail to shift public policies significantly. How can this happen? I think more confrontational strategies are necessary for these matters. Especially in Austria, it is a big problem that trade unions as very important actors in all these struggles are in my opinion geared towards cooperation at nearly all costs. Thus, the trade union probably would not have even engaged with these tremendous assaults on public health, if there had not been independent organizational processes going on that I briefly described above. When the unions jumped in, they hijacked the process as some said, they did not call for strikes but entered negotiations with the provincial government. So they told the *Plattform* to keep quiet until the outcomes of the negations between the trade union and the government would be presented. They warned that strikes or plans of occupying facilities would endanger the negotiations. In the end, the union conducted the negotiations, while the *Plattform* did not call for any strike, but the results were frustrating and discouraging for the movement. Hence, the lesson from this local struggle would be that while we can demonstrate with thousands of people in the streets when it comes to negotiations, we cannot achieve anything if political pressure wanes and negotiations are left to the unions. However, the *Plattform* engaged in ongoing activities over the following years up until 2014. For instance, the implementation of these changed policies involved struggles about how to interpret laws, etc., but in the end, it was a mixed result and this points to some further lessons.

The right to the city requires a framework of radical democracy, which inhibits harmful measures on a population's health and well-being.

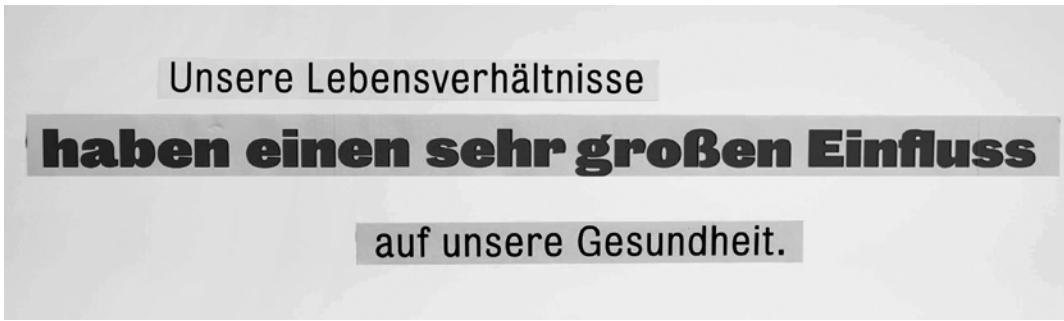
First, emphasizing again, alliance building across very different actors is highly important, which requires a certain openness towards others. Second, social movements have to think more about how to organize confrontational strategies in a very ambivalent relationship with trade unions. I think we need the trade unions on board, but at the same time, we also have to put pressure on the trade unions from the outside. Third, in general, we need to shift the framework within which public policies are discussed towards what Henri Lefebvre and others at his time in France called *autogestion*, which means self-government or deep democracy. You could also call this framework 'radical democracy', where it becomes increasingly unthinkable, that governments impose horrific measures on the population because the framework in itself would inhibit that thought from even occurring and social onslaughts to be planned and imposed. In this sense, the right to the city would mean that it becomes practically unthinkable that any kind of actor imposes harmful measures on a population's health and well-being. The examples of the Solidarity Clinic and the *Poliklinik* from this polylogue are particularly inspiring in this regard because they prefigure a change in economic relations towards economic democracy, an economy of *autogestion*, which is crucial to

realize health as a right to the city in this deeper sense connected to self-government, often framed as commons or solidarity economies. I think it is particularly significant and interesting that within the health sector, in the narrow sense, examples of organizational democracy emerge. These approaches should be highlighted and multiplied.

RIGHT TO THE CITY Beyond Individual Health

Richard Bůžek: Bettina Franke and Jonas Löwenberg, both of you are professionals in psychotherapy and social work and engage in the Social Healthcare Center *Poliklinik Leipzig*, founded in 2020 as a collective of medical staff and social workers. Informed by the Social Determinants of Health approach, how exactly do you organize healthcare in a different way to address the structural cause of disease on the scale of urban neighborhoods? Where do you see intersections for collaboration with other active urban movements to change these structural causes of disease?

Bettina Franke and Jonas Löwenberg: We are a group of health professionals who were dissatisfied with the actual conditions in the healthcare system and our roles within that. We strive to create a new alternative for primary and social healthcare in Leipzig's district Schönefeld. On the one hand, we want to provide primary healthcare in interdisciplinary teams, thus we have medical doctors, psychologists, and social workers. We also work together with people from academia and with artists to expand our understanding of health. And we are also very inspired by the Greek Solidarity Clinics and their approach to overcoming the normalized hierarchies in the healthcare system, where doctors are on top and the care team or even the patients are at the bottom. We want to organize healthcare provision in a way in which the main caretaker for a person is chosen depending on the patient's needs, preferences, and main issues.



Poliklinik Veddel, Gesundheit ist politisch! Was bedeutet Prävention in der Poliklinik Veddel?, Germany (2019).
VIDEO ▸ cache.ch/1706

"Our living conditions have a major impact on our health."
Still from the film *Gesundheit ist politisch! Was bedeutet Prävention in der Poliklinik Veddel?* by Poliklinik Veddel.
The film illustrates the importance of various social determinants of health in the context of disease prevention.

Moreover, with the *Poliklinik*, we want to create a social center, where people can come together to transform the social determinants of health, for example living conditions, discrimination, unemployment, availability of healthy diet, education, etc. Our health and well-being depend on social determinants far more than on individual behavior. For example, the risk of developing diabetes is higher for people with low incomes than for those with high incomes. In our healthcare center, we take a look at the living conditions together with

the people who come to us. For instance, the high blood pressure of a person may be stress-related, so treatment with social or psychological counseling might be more appropriate than simply medication against the mere symptom.

With the *Poliklinik*, we want to create a social center, where people from the community are empowered to transform the issues that affect their health.

Our goal is to empower people in the community to work together on the issues that affect their health. Obviously, we see possibilities for collaboration everywhere. We work together with strikes, such as the nursing strikes that are happening right now in Germany, feminist strikes, or anti-racist rallies. Furthermore, we cooperate with the *Medinetz Leipzig*, an initiative that offers support and facilitates medical care to people without health insurance. We also cooperate closely with a renters' initiative, which connects people, who are affected by fraudulent service charges and other problems caused by the property management of powerful large-scale corporate landlords. These are the kind of initiatives, which we want to work together with and strengthen in our community. Leipzig has a great tradition of grassroots initiatives. For a few years, people who experience psychiatry have self-organized their association to support each other. They employ their own social workers and form independent groups to help each other. We are also inspired by initiatives in Berlin that are making a community and healthcare center by and for trans-, and inter- and queer communities like *Casa Kuà*. We take up these inspirations and hope to support building them in our community in Leipzig-Schönefeld.

RIGHT TO THE CITY Spatializing Health

Richard Bůžek: Iris Dzudzek, Susanne Hübl and Lisa Kamphaus, you are from the Critical Urban Research Group Münster. What role does urban space play for collective transformations of structural health inequalities?

Iris Dzudzek, Susanne Hübl, and Lisa Kamphaus: Health is fundamentally political. Health inequalities are rooted in dominant social structures such as capitalism, racism, and patriarchy, which are mediated through (urban) space. Health inequalities stem from social processes. Consequently, social structures can potentially be changed through collective and transformative productions of space.[7]



Residents from the Hansaviertel community in Münster discuss (structural) causes of health and disease in a participatory mapping workshop.

Photograph by Lisa Kamphaus (2022).



Photograph by Lisa Kamphaus (2022).

Neighborhood walk with residents from the Hansaviertel, Münster, to experience health impacts in urban space.

Urban space is key here. Health and sickness are determined by social relations, which necessarily operate through space. These social relations and practices materializing in sites and human bodies can be proximate such as the workplace or mold infestation in an apartment or far away such as the causes of bad working conditions. In this sense, health and sickness are embodiments of global-local relations.[8] As Vasilis, Bettina and Jonas have shown from their concrete work in the Solidarity Clinic in Thessaloniki and the *Poliklinik Leipzig*, community healthcare centers are concrete sites, where people affected by such global, national, regional, or local relations, which articulate in the form of illness, seek medical treatments. And these anti-hierarchical and radical democratic healthcare centers are also sites, where the very roots of illness and related forms of structural violence[9] resulting in seemingly individual experienced suffering e.g. from discrimination, bad housing, or harmful working conditions can be identified, addressed, and transformed as collective problems that have to be changed to strengthen health for all.

On the urban scale, health is both experienced unequally through embodiments of social and environmental conditions and transformed through social coalitions.

The urban, then, is not only the site where the social and environmental conditions that make people sick are experienced and embodied unequally in people's everyday life but also where people can organize and build broad social coalitions within the community, the city, or the state, empowering them to reshape the social conditions affecting their health. In this vein, community healthcare centers provide crucial spaces to re-appropriate health and the multiple urban resources the city potentially provides, in the sense of health as a right to the city. Such collectivization strategies aim at re-politicizing health through building broad social coalitions across ideological fault lines which are challenged by unequal power relations within such coalitions or vis-à-vis the state. Collective struggles for social justice, then, are also struggles for health as a right to the city. To transform the social structures that determine health, urban health and right to the city movements need to act in concert.

Notes

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Further Readings

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