

RESEARCH PAPER

# HEALTH AND THE MODERN CITY >

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# BIO

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# CONTENTS

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**4**  
**HEALTH:  
THE NEW  
SUSTAINABILITY**

**5**  
**A HISTORY  
OF FILTH**

**5**  
**MACRO-  
PROJECTS**

**7**  
**MICRO-  
POLITICS**

**8**  
**TOWARDS  
GUILT-DRIVEN  
SELF-MANAGEMENT?**

**9**  
**BIOPOLITICS  
AND ARCHITECTURE**

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# HEALTH: THE NEW SUSTAINABILITY

**At the beginning of the 21st century cities and regions increasingly often formulate an ambition to be a health or care-oriented city.** Labels such as ‘smart’, ‘sustainable’, ‘resilient’ and ‘healthy’ are used almost interchangeably.

**These strategic choices inscribe themselves in a familiar macroeconomic discourse** that holds that the demand for health care in a postindustrial society such as Belgium is inexorably increasing, whilst the means at the disposal of the state to accommodate these needs are under considerable pressure. Ageing of the population, increasing life expectancy and rising numbers of people suffering from lifestyle diseases (particularly diabetes and cardio-vascular diseases) mean that in the medium-term future many more people will have to rely on health care for a longer period of time. On the other hand, public healthcare expenditures in Belgium have mushroomed over the last decades, outpacing overall economic growth. As a result, these expenditures have taken up a progressively expanding share of the national social security budget. Given these tensions between supply and demand for care a structural reform of the public health system imposes itself. The financial crisis that erupted in 2008 and is still not under control will very likely accelerate this process.

However, as urban designers with a mandate to re-imagine the 21st century provincial city we need to be able to put this kind of orthodox contextual analysis – with its emphatic neo-liberal slant – for a moment between brackets. **By putting health at the center of our concerns we have to confront a complicated nexus that intimately links the project of modernity with nature, urbanity and citizenship.**

# A HISTORY OF FILTH

**For the best part of our long urban history it was the absence of sanitation that formed one of the most obvious and omnipresent features of urban life.**

As a rule, cities were hazardous, festering pools of germs and pollution. Flows of human and animal excrements, wastewater and contaminated surface waters contributed to noxious cocktails from which pestilence regularly spread its fateful wings. An exception, perhaps, was Ancient Rome where health infrastructure was more conspicuously present. Technically capable, the Romans physically altered their environment to reduce the harmful influence of sewage and swamps. Large and numerous aqueducts transported fresh water into the heart of the city and monumental sewage systems carried debris away from urban areas. Public toilets induced a certain measure of personal hygiene. Public baths counted amongst the most prestigious landmarks in Ancient Rome.

Under influence of religious doctrines that associated cleanliness with pride and filthiness with humility this sanitary legacy was lost in the Middle Ages. The early industrializing cities provided uncommonly harsh social and environmental conditions. Whilst the 19th century was still a time of great pandemics (notably cholera that swept in from the Indian tropics), claiming tens of thousands of victims in Europe's major cities, the most obvious trend of that period was the increase of morbidity – the suffering and dying from chronic illnesses spawned by living and working conditions – over the earlier predominant mortality crises of epidemics and plagues (Berg and Cocks, 1997).

BERG, Manfred and COCKS, Geoffrey, *Medicine and Modernity. Public health and medical care in nineteenth- and twentieth century Germany*, Cambridge University Press, 1997.

## MACRO-PROJECTS

**Glaring** social inequalities and environmental blight in explosively growing industrial cities created an urgent need for sanitation and for novel routines of social control. Health infrastructures were instrumental in realizing both. **The early 19th century was the Heroic Moment of modernity's Promethean project: "a period typified by large-scale urban sanitation projects** (water supply and sewerage)

as well as the construction of impressive transport and communication networks. The new technology is admired and fetishized, promoting the myth of progress as an automatic means of producing a better society” (Kaika, 2005). Haussmann’s Paris can likely be considered as the archetype of that modern infrastructural ideal which seamlessly blends sanitation, emancipation and control of the masses (Graham and Marvin, 2001).

KAIKA, Maria, *City of Flows. Modernity, nature and the city*, Routledge, 2005.

GRAHAM, Stephen and MARVIN, Simon, *Splintering urbanism. Networked infrastructures, technological mobilities and the urban condition*, Routledge, London, 2001.

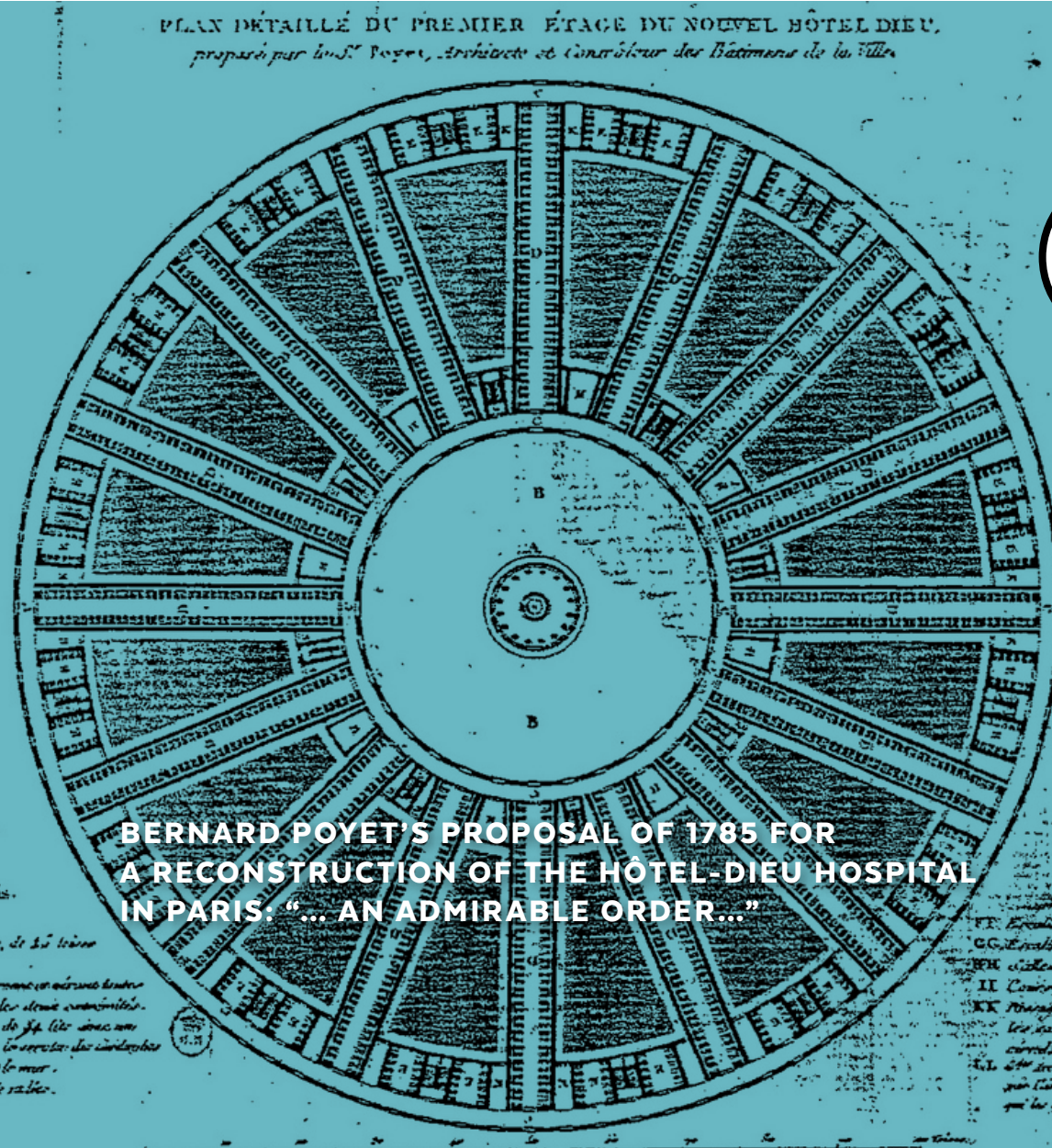


# MICRO-POLITICS

Meanwhile the modern hospital emerged as a laboratory, a ‘machine à guérir’, a locus of thoroughgoing individualization and rationalization (Choay, 1997; Wallenstein, 2009). The historical starting point for this development is the fire in Paris of 1772 which destroyed the ‘general hospital’ Hôtel-Dieu, leading to a public discussion regarding the principles of its reconstruction and, more generally, of the nature of public facilities. It is in the context of this discussion (earlier than Bentham’s first reference to it) that the panoptic model of social control first emerges, namely in Bernard Poyet’s proposal of 1785 for a reconstruction of the hospital relying on a circular form as it “gives rise to an admirable order that easily can be introduced in the hospital, above all since it is founded on its capacity to

CHOAY, Françoise, *The Rule and the Model. On the Theory of Architecture and Urbanism*, MIT Press, Cambridge, 1997.

WALLENSTEIN, Sven-Olov, *Biopolitics and the Emergence of Modern Architecture*, Princeton Architectural Press, New York, 2009.



**BERNARD POYET'S PROPOSAL OF 1785 FOR A RECONSTRUCTION OF THE HÔTEL-DIEU HOSPITAL IN PARIS: "... AN ADMIRABLE ORDER..."**

CIRCLE

provide the most uniform and simple distributions, to allow everything to be seen from one point and to make everything accessible in the shortest possible time.” (Poyet, quoted by Wallenstein, 2009). The panoptic principle has since expanded into a what Foucault calls a ‘diagram’: an abstract machine out of which relations of power emerge that regulate the most minute aspects of daily life and which is capable of assuming many different physical shapes (not only hospital, but also the factory, prison, school, etc.).

**These health-driven processes of regimentation continue today, but with a twist.**

Following Foucault, the disciplinary societies of the 19th and early 20th century relied on the passage of the individual through a succession of enclosures: from the family to the school to the barracks, and so on. Deleuze argues that in the present time this compartmentalisation has been superseded by a continuous, isotropic ‘society of control’, directed at living subjects and their conscience, and supported by a manifold of local and flexible monitoring instances. For example, Maurizio Lazzarato has shown how these techniques of individualization and submission are being used by the State in its attempt to reduce a social problem, namely structural unemployment. Long-term receivers of benefits (‘RMISTes’, i.e. people living on the *revenu minimum d’insertion*) are being individually monitored, using techniques that touch on the most intimate and private aspects of their lives. This kind of micropower “is exercised in a ‘distributive’ manner (its action is deployed ‘from individual to individual’, step by step, and it is communicated by singularities). It deals with each soul, each situation and its particulars, rather than with the unity that is formed by the whole. Its action is local and infinitesimal rather than global and general. (...) It is a continuous and permanent power. It is not exercised intermittently, like the power that is grounded in law, sovereignty or citizenship (...) but all day long during one’s entire life” (Lazzarato, 2010).

LAZZARATO, Maurizio, "Pastoral Power". *Beyond Public and Private*, in: *Open*, 19, pp. 18-32, NAi Publishers, Rotterdam, 2010.

## TOWARDS GUILT-DRIVEN SELF-MANAGEMENT?

We already see from emerging practices that also the health care system will become an arena in which the exercising of this kind of micropower will become increasingly prevalent.



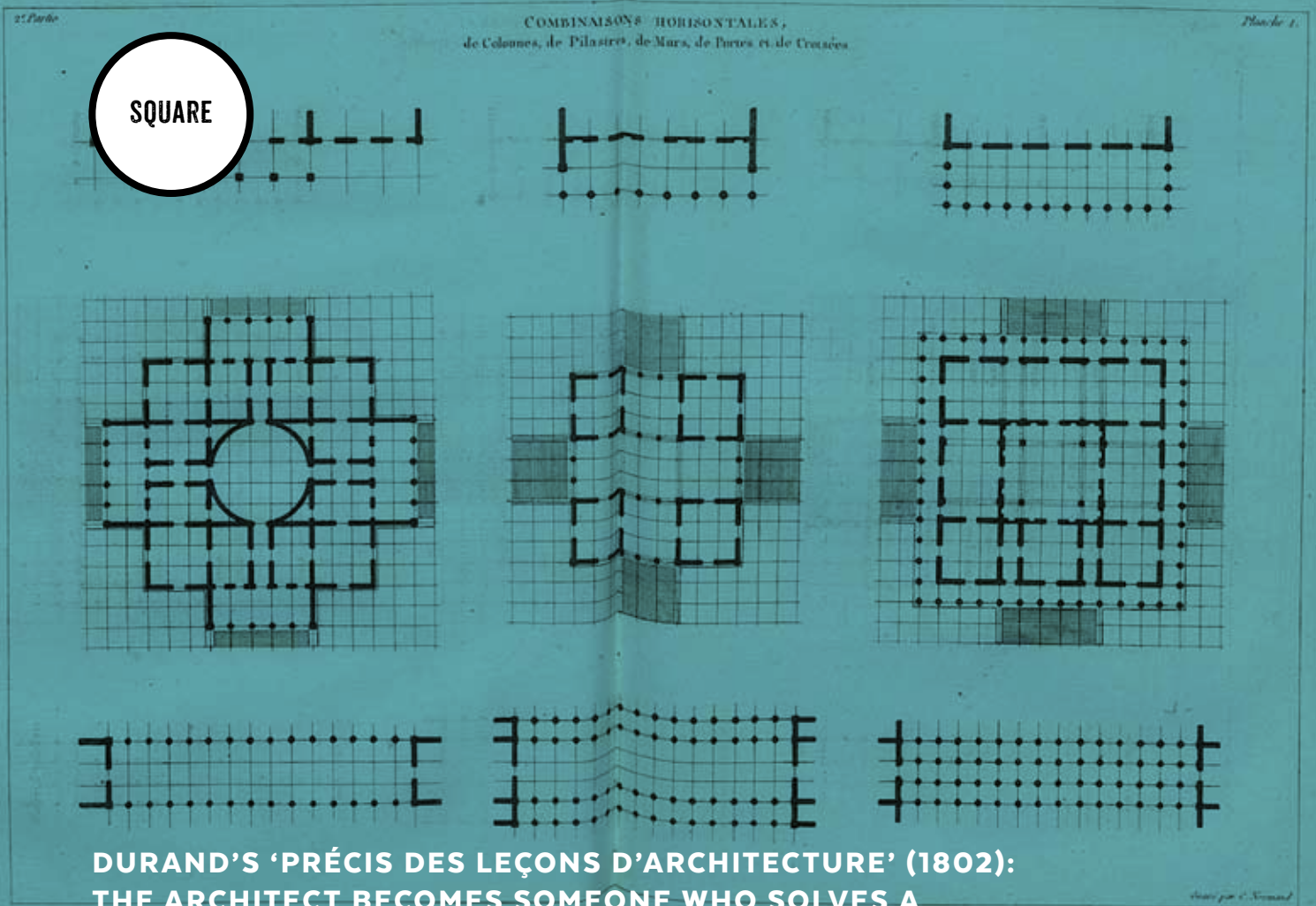
The social problem looms menacingly: a structural deficit in public health resources due to the inexorable forces of ageing, rising life expectancy and an increasing number of lifestyle diseases. Hence, the role of prevention in health care, with a strong emphasis on ‘effective self-management’ and lifestyle change will certainly increase. This will be rooted in heterogeneous and partially commercialized power relationships such as between employers and employees, or health care insurers and insurees. Health care will become an ‘economy of merits and faults’ that will give way to multiple fractal divisions and hierarchies that are more subtle and more mobile than those of traditional oligarchies of wealth and birth (Lazzarato, 2010). Ubiquitous and wearable monitoring technology that is able to detect patterns of movement, dietary intake and sleep will track progress towards pre-established (or jointly agreed upon) health goals. A discourse of responsabilisation of the individual citizen will be embedded in social media-based peer pressure and a more or less subtle institutional production of guilt. Indeed, the rhetoric of responsabilisation fits hand in glove with a control paradigm that puts the onus of resolving the social problem on the individual citizen: **“There is a shift from ‘there is a social problem’ to ‘you are the social problem!’”** (Lazzarato, 2010). Guilt-driven self-management will be reinforced by the increasing penetration of genomics, leading to diagnostic tests that provide a marker of individual’s risk of future illness, and the way in which this feeds into pharmaceutical companies’ quest for profit: “By changing the equation from a ‘healthy’ patient to a ‘patient-in-waiting’, by suggesting that every person, no matter how healthy, is possibly someone who might fall ill, the potential market for a drug is enlarged from ‘diseased’ people to, conceivably, everyone with purchasing power, just as the domain of the therapeutic is enlarged progressively further back towards prophylactic uses consequent to the moment of diagnosis” (Sunder Rajan, 2006).

SUNDER RAJAN,  
Kaushik, *Biocapital.*  
*The Constitution of*  
*Postgenomic Life,*  
Duke University Press,  
Durham and London,  
2006.

## BIOPOLITICS AND ARCHITECTURE

Sven-Olov Wallenstein has noted how **the emergence of this biopolitical regime in the latter half of the 18th century coincided with a paradigmatic change in architecture, and by extension, in urbanism.** The emerging forms of panoptic visibility and surveillance of social space, mobilized not only by the State but also by a whole set of new agents, had to break free from the Vitruvian model that revolved around imitation of Nature. Architecture started to withdraw from the model in the sense of a representation of order, so as to itself become a tool for

the regimentation and ordering of space in its totality. Once the old concept of Nature as preexisting order had been shed by Architecture with a capital A, a new pragmatism, informed by a technical and structural rationality, set in. It is here that the new idea of the 'program' – the sum of specifications for future use – supersedes the classical vocabulary of 'character'. The architect becomes someone who solves a problem rather than someone who expresses sense. Emblematic for this move is the 'mécanisme de la composition' that Jean-Nicolas-Louis Durand introduced in his 'Précis des leçons d'architecture' (1802): he distinguishes a set of basic elements that, similar as words in language, can be combined horizontally and vertically to generate a great variety of building forms and programs.



Soon his modular approach would be taken up to meet the demands for new ‘facilities’ (équipements) that could no longer be derived from traditional types and embodied new demands for efficiency that formed part of a biopolitical program. The new hospital, with its requirement to precisely assess health – relying on techniques of separation, circulation, surveillance and classification – was a crucial laboratory for testing these new ideas (Wallenstein 2009). Françoise Choay (1997) has shown how this rule-based, morphogenetic approach has since impregnated urbanism. We encounter it in the work of Ildefonso Cerdá (who wrote the foundational treatise ‘Teoria general de la urbanizacion’ (1867)), in Christopher Alexander’s Pattern Language, Hillier’s Space Syntax, in the typomorphological approach of the Venetian School (Secchi, Viganò) and in Graham Shane’s Recombinant Urbanism.

The birth of the modern city has been intertwined with the emergence of specifically health-driven processes of sanitation, individualization and rationalization. The 19th century remodeling of cities by means of major infrastructural interventions fostered circulation, cleanliness and control. **A biopolitical regime, supported by increasingly sophisticated techniques of surveillance and classification, is mirrored by a pragmatic and rational architecture and urbanism that seeks to find efficient solutions to an expanding variety of programmatic requirements.** The conception of a spatially isotropic, generalized control mechanism, mobilized not only by the State but also by a whole set of new agents, finds its pendant in the dynamic, interactive, informational and ecological precision of the contemporary Net City (Graham Shane, 2005).

GRAHAM SHANE,  
David, *Recombinant  
Urbanism.  
Conceptual Modeling  
in Architecture,  
Urban Design, and  
City Theory*, Wiley,  
London, 2007.

