social policy

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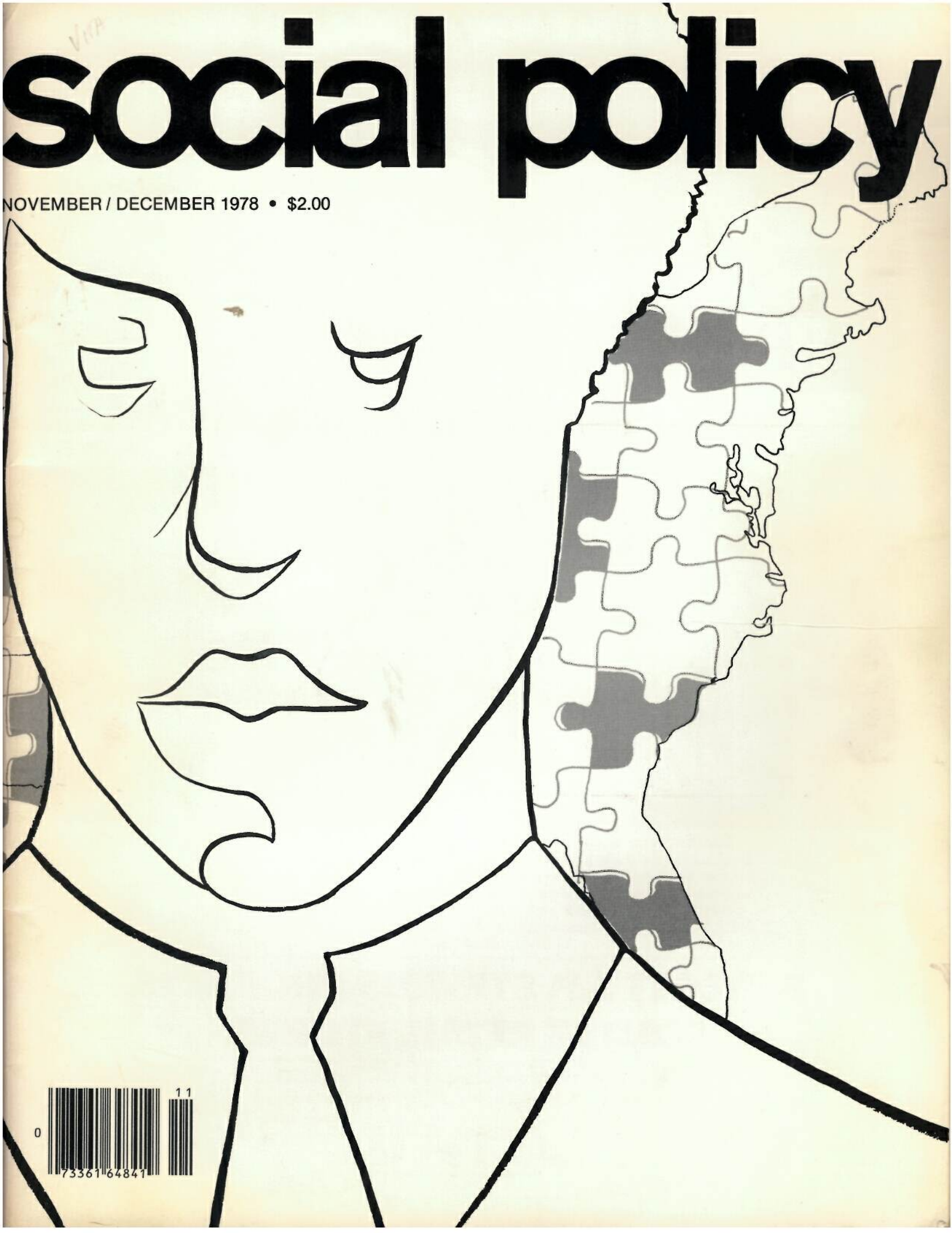

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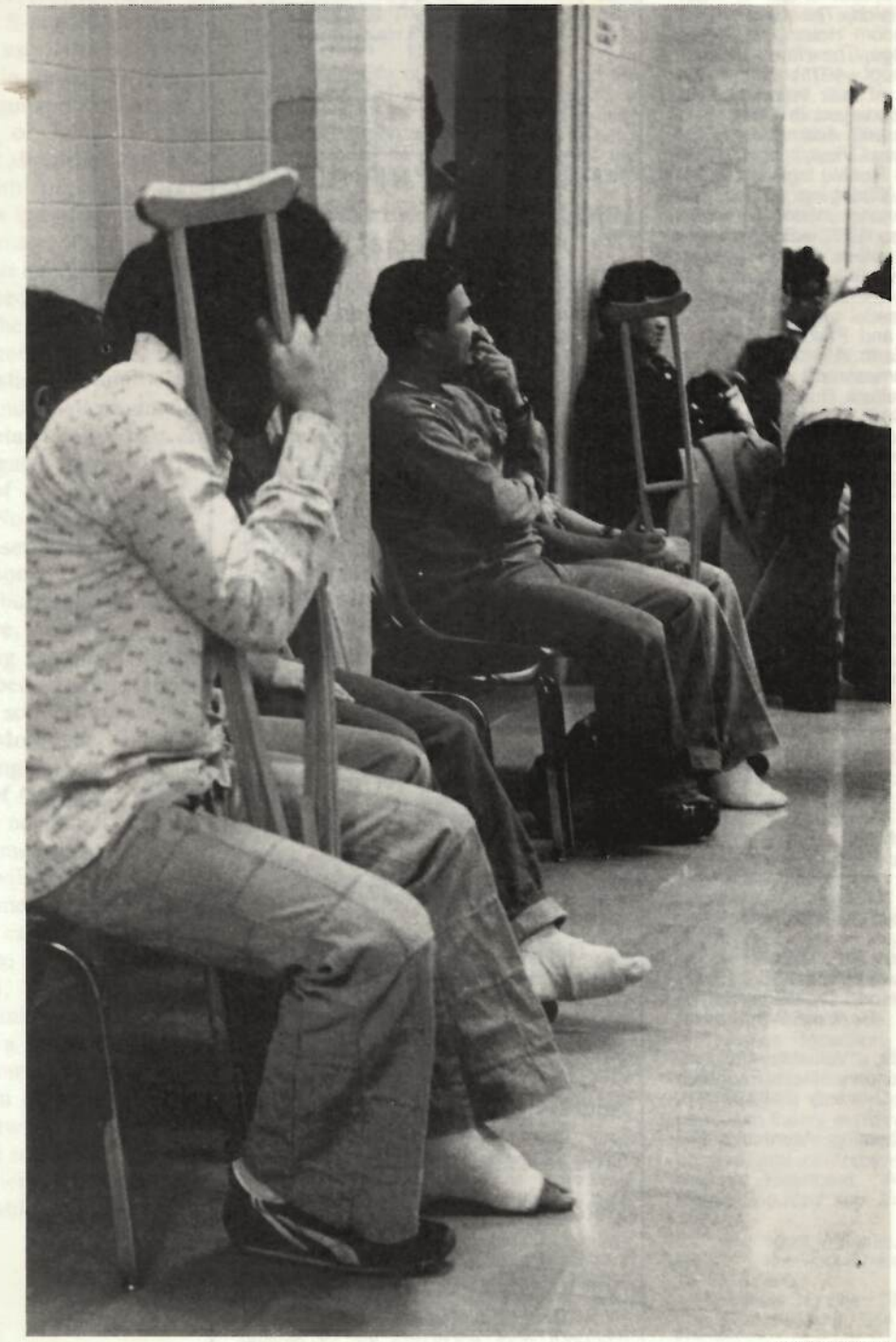
Politicizing Health Care

by John L. McKnight



Michael Weisbrot

Is it possible that out of the contradictions of medicine one can develop the possibilities of politics? The example I want to describe is not going to create a new social order. It is, however, the beginning of an effort to free people from medical clienthood, so that they can perceive the possibility of being citizens engaged in political action.

The example involves a community of about 60,000 people on the west side of Chicago. The people are poor and Black, and the majority are dependent on welfare payments. They have a voluntary community organization which encompasses an area in which there are two hospitals.

The neighborhood was originally all white. During the 1960s it went through a racial transition and over a period of a few years, it became largely populated with Black people.

The two hospitals continued to serve the white people who had lived in the neighborhood before transition, leaving the Black people, struggling to gain access to the hospitals' services.

This became a political struggle and the community organization finally "captured" the two hospitals. The boards of directors of the hospitals then accepted people from the neighborhood, employed Black people on their staffs, and treated members of the neighborhood rather than the previous white clients.

After several years, the community organization felt that it was time to stand back and look at the health status of their community. As a result of their analysis, they found that, although they had "captured" the hospitals, there was no significant evidence that the health of the people had changed since they had gained control of the medical services.

The organization then contacted the Center for Urban Affairs where I work. They asked us to assist in finding out why, if the people controlled the two hospitals, their health was not any better.

It was agreed that the Center would do a study of the hospitals' medical records to see why people were receiving medical care. We took a sample of the emergency room medical records to determine the frequency of the various problems that brought the people into the hospitals.

We found that the seven most common reasons for hospitalization, in order of frequency, were:

To convert a medical problem into a political issue is central to health improvement.

1. Automobile accidents.
2. Interpersonal attacks.
3. Accidents (non-auto).
4. Bronchial ailments.
5. Alcoholism.
6. Drug-related problems (medically administered and non-medically administered).
7. Dog bites.

The people from the organization were startled by these findings. The language of medicine is focused upon disease—yet the problems we identified have very little to do with disease. The medicalization of health had led them to believe that "disease" was the problem which hospitals were addressing, but they discovered instead that the hospitals were dealing with many problems which were not disease. It was an important step in increasing consciousness to recognize that modern medical systems are usually dealing with maladies—social problems—rather than disease. Maladies and social problems are the domain of citizens and their community organizations.

A STRATEGY FOR HEALTH

Having seen the list of maladies, the people from the organization considered what they ought to do, or could do, about them. First of all, as good political strategists, they decided to tackle a problem which they felt they could win. They didn't want to start out and immediately lose. So they went down the list and picked dog bites, which caused about four percent of the emergency room visits at an average hospital cost of $185.

How could this problem best be approached? It interested me to see the people in the organization thinking about that problem. The city government has employees who are paid to be "dog-catchers," but the organization did not choose to contact the city. Instead, they said: "Let us see what we can do ourselves." They decided to take a small part of their money and use it for "dog bounties." Through their block clubs they let it be known that for a period of one month, in an area of about a square mile, they would pay a bounty of five dollars for every stray dog that was brought in to the organization or had its location identified so that they could go and capture it.

There were packs of wild dogs in the neighborhood that had frightened many people. The children of the neighborhood, on the other hand, thought that catching dogs was a wonderful idea—so they helped to identify them. In one month, 160 of these dogs were captured and cases of dog bites brought to the hospitals decreased.

Two things happened as a result of this success. The people began to learn that their action, rather than the hospital, determines their health. They were also building their organization by involving the children as community activists.

The second course of action was to deal with something more difficult—automobile accidents. "How can we do anything if we don't understand where these accidents are taking place?" the people said. They asked us to try to get information which would help to deal with the accident problem, but we found it extremely difficult to find information regarding when, where, and how an accident took place.

We considered going back to the hospitals and looking at the medical records to determine the nature of the

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accident that brought each injured person to the hospital. If medicine was thought of as a system that was related to the possibilities of community action, it should have been possible. It was not. The medical record did not say, "This person has a malady because she was hit by an automobile at six o'clock in the evening on January 3rd at the corner of Madison and Kedzie." Sometimes the record did not even say that the cause was an automobile accident. Instead, the record simply tells you that the person has a "broken tibia." It is a record system that obscures the community nature of the problem, by focusing on the therapeutic to the exclusion of the primary cause.

We began, therefore, a search of the data systems of macroplanners. Finally we found one macroplanning group that had data regarding the nature of auto accidents in the city. It was data on a complex, computerized system, to be used in macroplanning to facilitate automobile traffic! We persuaded the planners to do a printout that could be used by the neighborhood people for their own action purposes. This had never occurred to them as a use for their information.

The printouts were so complex, however, that the organization could not comprehend them. So we took the numbers and transposed them onto a neighborhood map showing where accidents took place. Where people were injured, we put a blue X. Where people were killed, we put a red X.

We did this for all accidents for a period of three months. There are 60,000 residents living in the neighborhood. In that area, in three months, there were more than 1,000 accidents. From the map the people could see, for example, that within three months six people had been injured, and one person killed, in an area 60 feet wide. They immediately identified this place as the entrance to a parking lot for a department store. They were then ready to act, rather than be treated, by dealing with the store owner because information had been "liberated" from its medical and macroplanning captivity.

The experience with the map had two consequences. One, it was an opportunity to invent several different ways to deal with a health problem that the community could understand. The community organization could negotiate with the department store owner and force a change in its entrance.

Two, it became very clear that there were accident problems that the community organization could not handle directly. For example, one of the main reasons for many of the accidents was the fact that higher authorities had decided to make several of the streets through the neighborhood major throughways for automobiles going from the heart of the city out to the affluent suburbs. Those who made this trip were a primary cause of injury to the local people. Dealing with this problem is not within the control of people at the neighborhood level—but they understood the necessity of getting other community organizations involved in a similar process, so that together they could assemble enough power to force the authorities to change the policies that serve the interests of those who use the neighborhoods as their freeway.

Effective health action identifies what you can do at the local level with local resources.

The third community action activity developed when the people focused on "bronchial problems." They learned that good nutrition was a factor in these problems, and concluded that they did not have enough fresh fruit and vegetables for good nutrition. In the city, particularly in the winter, these foods were too expensive. So could they grow fresh fruit and vegetables themselves? They looked around, but it seemed difficult in the heart of the city. Then several people pointed out that most of their houses are two story apartments with flat roofs. "Supposing we could build a greenhouse on the roof, couldn't we grow our own fruit and vegetables?" So they built a greenhouse on one of the roofs as an experiment. Then, a fascinating thing began to happen.

Originally, the greenhouse was built to deal with a health problem—inadequate nutrition. The greenhouse was a tool, appropriate to the environment, that people could make and use to improve health. Quickly, however, people began to see that the greenhouse was also an economic development tool. It increased their income because they now produced a commodity to use and also to sell.

Then, another use for the greenhouse appeared. In the United States, energy costs are extremely high and are a great burden for poor people. One of the main places where people lose (waste) energy is from the rooftops of their houses—so the greenhouse on top of the roof converted the energy loss into an asset. The energy that did escape from the house went into the greenhouse where heat was needed. The greenhouse, therefore, was an energy conservation tool.

Another use for the greenhouse developed by chance. The community organization owned a retirement home for elderly people, and one day one of the elderly people discovered the greenhouse. She went to work there, and told the other old people and they started coming to the greenhouse every day to help care for the plants. The administrator of the old people's home noticed that the attitude of the older people changed. They were excited. They had found a function. The greenhouse became a tool to empower older people—to allow discarded people to be productive.

MULTILITY VS. UNITILITY

The people began to see something about technology that they had not realized before. Here was a simple tool—a greenhouse. It could be built locally, used locally and among its "outputs" were health, economic development, energy conservation and enabling older people to be productive. A simple tool requiring minimum "inputs" produced multiple "outputs" with few negative side effects. We called the greenhouse a "multility."

Most tools in a modernized consumer-oriented society are the reverse of the greenhouse. They are systems requiring a complex organization with multiple inputs that produce only a single output. Let me give you an example. If you get bauxite from Jamaica, copper from Chile, rubber from Indonesia, oil from Saudi Arabia, lumber from Canada, and labor from all these countries, and process these resources in an American corporation that uses American labor and professional skills to manufacture a commodity, you can produce an electric toothbrush. This tool is what we call a "unitility." It has multiple inputs and one output. However, if a tool is basically a labor-saving device, then the electric toothbrush is an anti-tool. If you added up all the labor put into producing it, its sum is infinitely more than the labor saved by its use.

The electric toothbrush and the systems for its production are the essence of the technological mistake. The greenhouse is the essence of the technological possibility. The toothbrush (unitility) is a tool that disables capacity and maximizes exploitation. The greenhouse (multility) is a tool that minimizes exploitation and enables community action.

Similarly, the greenhouse is a health tool that creates citizen action and improves health. The hospitalized focus on health disables community capacity by concentrating on therapeutic tools and techniques requiring tremendous inputs, with limited outputs in terms of standard health measures.

CONCLUSIONS

Let me draw several conclusions from the health work of the community organization.

First, out of all this activity, it is most important that the health action process has strengthened a community organization. Health is a political issue. To convert a medical problem into a political issue is central to health improvement. Therefore, as our action has developed the organization's vitality and power, we have begun the critical health development. Health action must lead away from dependence on professional tools and techniques, towards community building and citizen action. Effective health action must convert a professional-technical problem into a political, communal issue.

Second, effective health action identifies what you can do at the local level with local resources. It must also identify those external authorities and structures that control the limits of the community to act in the interest of its health.

Third, health action develops tools for the people's use, under their own control. To develop these tools may require us to diminish the resources consumed by the medical system. As the community organization's health activity becomes more effective, the swollen balloon of medicine should shrink. For example, after the dogs were captured, the hospital lost clients. Nonetheless, we cannot expect that this action will stop the medical balloon from growing. The medical system will make new claims for resources and power, but our action will intensify the contradictions of medicalized definitions of health. We can now see people saying: "Look, we may have saved $185 in hospital care for many of the 160 dogs that will not now bite people. That's a lot of money! But it still stays with that hospital. We want our $185! We want to begin to trade in an economy in which you don't exchange our action for more medical service. We need income, not therapy. If we are to act in our health interest, we will need the resources medicine claims for its therapeutic purposes in order to diminish our therapeutic need."

Health action develops tools for the people's use, under their own control. To develop these tools may require us to diminish the resources consumed by the medical system.

These three principles of community health action suggest that improved health is basically about moving away from being "medical consumers."

The experience I have described suggests that the sickness which we face is the captivity of tools, resources, power, and consciousness by medical "unitilities" that create consumers.

Health is a political question. It requires citizens and communities. The health action process can enable "another health development" by translating medically defined problems and resources into politically actionable community problems. ■