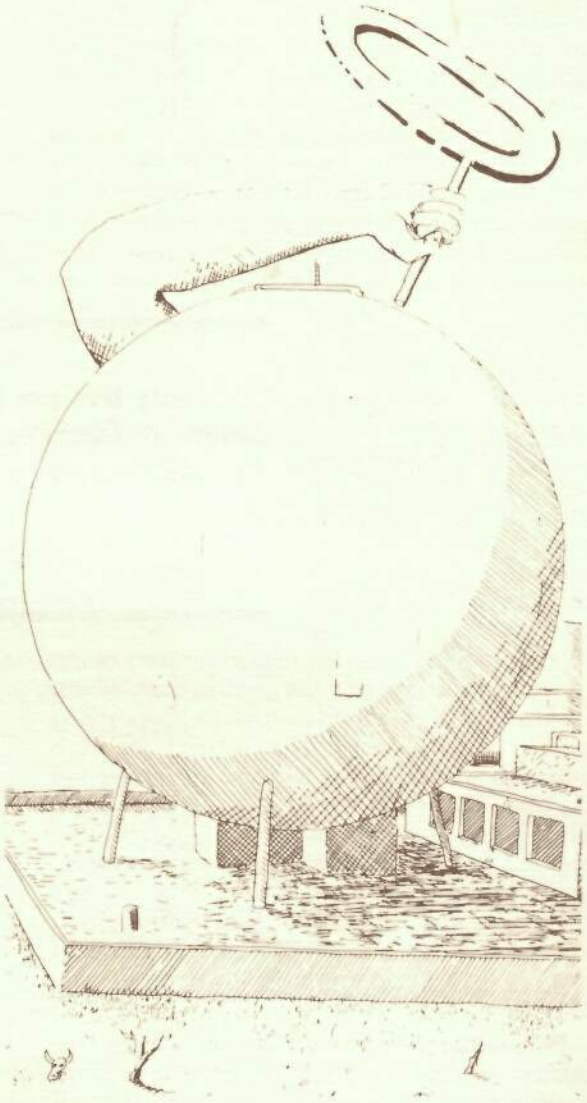
BB → JLM

HEALTH/PAC BULLETIN

Health Policy Advisory Center

Volume 11, Number 6
July/August 1980
HPCBAR 1-44
ISSN 0017-9051

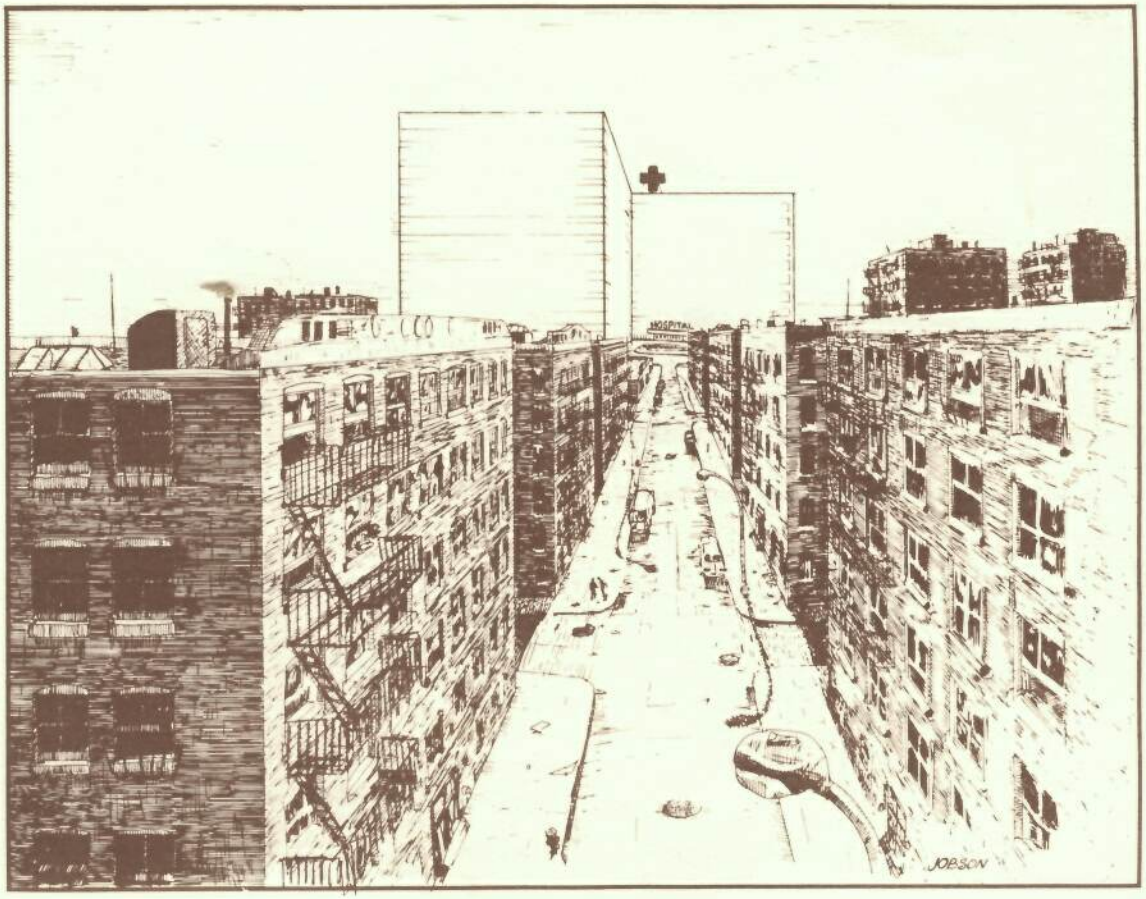


Cost-Benefit Analysis

THE REGULATION OF BUSINESS OR SCIENTIFIC PORNOGRAPHY

Suddenly everyone is talking about the problem of risk. Popular articles about the "risks of daily life" are appearing everywhere (1); new academic courses are being introduced to ask the "hard questions" about the meaning and acceptability of risk (2); universities throughout the country are cooperating with industry to establish "risk institutes" (3) and the National Science Foundation has launched a new program in "risk analysis" to inquire into how best to measure and assess risks (4).

The present article does not address the question of risk *per se* but rather asks where this discussion came from. Why are we concerned about it now? What influences are prompting and shaping this discussion, and the institutional responses to it? There are many plausible answers to these questions: the growing awareness of the environmental and health implications of products and processes; the increasing complexity and intercon-



Community Health in a Chicago Slum

When health activists talk about community involvement in health they usually mean participation in the governance of existing institutions delivering services. "Organizing" the community is seen as a necessary political activity to redress community grievances about inadequate, insensitive and unresponsive providers. Much health activism in the 1960s and 1970s has focused on transferring power through a consumer/community majority either in governance (OEO Neighborhood Health Centers) or in the planning process (National Health Planning Act). It has been left to the sociologists and medical anthropologists to examine the relationships between community social fabric and its health status.

The article by John L. McKnight that follows tells of the experiences in political action among a poor Chicago community concerned about its health. He examines the relationship between a community's sense of self determination and its health status. This community, having gained access to and control of its health care providers, still found itself enduring the same health problems. The community asked the Center for Urban Affairs at Northwestern University, where McKnight is Associate Director, for help with this puzzling and continuing problem. Unburdened by professionalism, the staff helped citizens reveal the realities of the community that led to "health problems." Much to almost everyone's surprise, the causes of hospital admissions were not very sensitive to manipulation of medical services, but could be addressed through political and social action and organization. This revelation came as no surprise to McKnight, who had previously said, "The evidence indicates that our health now requires major changes in individual, social, economic and environmental relationships rather than medical investments." The relationship between the community and the

Center is ongoing, and the community continues to explore further improvements in their health achieved through the kinds of activities described below.

This paper, first presented at a 1978 seminar sponsored by the Dag Hammarskjold Foundation, Uppsala, Sweden, is the seminal work on "community diagnosis." It raises some basic questions about current changes in the health care services system(s). It also demonstrates that lay citizens have the power and resources to change a community's health outcomes with a little help from their friends.

This article begins a series which will address the current status and nature of community health services. The series will include articles examining the history of community health and mental health services, the relationship between the economy, community support systems, and individual dysfunction, and the problems of defining community. The series will attempt to address such important questions as "What is the relationship between a community's political and economic self-determination and its health status?", "Who defines who is the *community and what are the consequences?", "What are the unique essentials of community health services?" and "What is the relationship between health services and community development?" We look forward to receiving your response to these important questions, too.*

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 community organization which is voluntary, not a part of the government. The community organization encompasses an area in which there are two hospitals.

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

The two hospitals continued (analogous to colonial situations) to serve the white people who had lived in the neighborhood before transition. The black people, therefore, struggled 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 hospoitals 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.

The Causes of Hospitalization

It was agreed that we would do a study of the hospitals' medical records to see why people were receiving medical care. We also 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:

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 "diseases." It was an important step in conscientization 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.

Community Action

Having seen the list of maladies and problems, the people from the organization considered what they ought to do, or could do, about them. I want to describe the first three things that they decided to do because each makes a different point.

First of all, as good political strategists, they decided to tackle a problem where 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 cause about four per cent of the emergency room visits at an average hospital cost of $185.

There were two results of the community action, first, neighborhood residents learned that their action, rather than the hospital, determines their health . . .

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 (not house 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 in the hospitals decreased.

. . . Second, people came to find out where the majority of accidents were taking place and what the major illnesses were for the community

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 hospital and looking at the medical records to determine the nature of the accident that brought each injured person to the hospital. If medicine were 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

Community health action may help lead people away from being strictly 'medical consumers' to full access to medical care. Health is a political question and requires citizen and community involvement

primary cause.

We began, therefore, a search of the data systems of macroplanners. Finally we found one macro-planning 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 macro-planning to facilitate automobile traffic! We persuaded the planners to do a "print-out" 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 print-outs were so complex, however, that the organization could not comprehend them. So we took the numbers and translated them on to a neighborhood map showing where the 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 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. First, the opportunity was offered 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.

The second consequence was that 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 understand the necessity of getting other community organizations involved in a similar process, so that together they can assemble enough power to force the authorities to change the policies that serve the interests of those who use the neighborhoods as their freeway.

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 storey 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 — adequate 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 roof-

tops 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 adminstrator 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.

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 its "outputs" were, at least, *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 'unitility". It has multiple inputs and one output. This is a unique tool, this toothbrush. If a tool is basically a labor-saving device, this toothbrush is an anti-tool. If you added up all the labor put into producing this electric toothbrush, 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.

The health action process (1) strengthened community organization, (2) identified what one could do at the local level, and (3) helped people develop tools to help themselves

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 dollars 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 dollars! 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."

The three principles of community health action suggest that "Another Development in Health" is basically about moving *away* from being "medical consumers" with the central goal being full access to medical care. Rather, the experience I have described suggests that the sickness which we face is the captivity of tools, resources, power and consciousness by medical "unitilies" 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.

—John L. McKnight

(John L. McKnight is Professor of Communications and Associate Director of the Center for Urban Affairs at Northwestern University.)