

PUBLIC HEALTH POLICY AND THE MODERNIZED POOR

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## Preface

The author wishes to stress that the findings, principles and policies described in this paper are specifically directed toward post-industrial societies such as the United States. The policy formulations are not conceived as universal principles applying to all societies of varying levels of development or forms of economic organization.

The history of public health efforts in industrialized societies demonstrates the symbiotic relationship of structure and sickness, ministration and malady. As the epidemiology of modernization disclosed the health giving nature of sewage systems, pasteurization and immunization, parallel public health structures for implementation were developed. Responding to infrastructural needs, mass epidemics, and evolving complex urban economies, the public health structures became large scale, centralized, systems built on mass ministrations and the monitoring of mega-systems through the use of macro data sets.

The epidemic is the idiomatic mother of our modern public health system. Nurtured on masses of people and millions of deaths in an epidemiological sweep of space and time, we were inspired to create counterfoil systems of such scope and grandeur that in the United States nearly 11% of the national wealth is now annually dedicated to a monumental system in defense of our health.

As the public health system's maturing efforts became effective in dealing with many health hazards, the infant medical profession began its development toward a centralized, managed system and slowly eclipsed the public health structures in terms of power, resources and hegemony. In the popular imagination of industrialized societies, the excitement of stripping varicose veins overshadowed the pedestrian replacement of sewer pipe. Dr. Barnard's star ascended. Dr. Salk's declined.

the victims whose maladies are still untouched by the treatments of the medical or public health systems. Therefore, those concerned with the health status of the poor are reassessing their policies. The basic tools available to the public health structure are of three types - treatment, environmental reform and popular education.

An examination of current policy proposals directed at overcoming the health problems of the poor reveals a basic assumption that the cure depends upon using these tools more extensively and with greater intensiveness. Public health policymakers urge that the network of community clinics be extended in poor areas and doctors given more incentives, or coerced, to serve in them; that environmental reforms must be intensified through new legislative and regulatory efforts; and that health education efforts be amplified through more pervasive use of mass media and the schools.

Regrettably, our experience now suggests that these policies are unlikely to succeed. The extension of the medical system is unlikely because of the national leadership's commitment to limit the growth of public budgets. And it can be argued that the present system is already accessible as is demonstrated by studies indicating that the poor have the largest number of per capita visits to medical facilities in the U.S.

Cutting back environmental regulations is one of the primary goals of the new national administration. It can also be argued that the existing systems were not class specific but had their support

In the United States there have been two responses by public health interests to the dominance of the medical/therapeutic idiom. The first has been the medicalization of prevention. Some elements of the public health structure are now redirecting their efforts toward serving as adjunct recruitment systems for medical care. Identifying hypertension, overpopulation and drug addiction as the epidemics of our time, they use mass media and popular education to direct citizens to medical offices where they can get their pills and methadone. Because many of these new clients will not self-administer their chemicals with regularity, the public health field has expanded to incorporate social-psychologists who are helping to develop compliance strategies.

The second response of public health interests is much more important to our discussions at this conference. As the medical/therapeutic structure has become a major economic interest group in the United States, the poor have become a burden upon the medical system's development. Therefore, the therapeutic elite have increasingly defined the poor as a "public health problem" with sophisticated arguments regarding the limits of medicine as a tool to deal with the basic health consequences of urban and rural poverty.

As the poor are "given" to the public health structure, there is a stark contrast between the health status of the poor and the remainder of society. In the slums and ghettos of the United States, devastation pervades. The life expectancy and infant mortality statistics quantify the misery. The wards and emergency rooms of the local hospitals house

precisely because they largely benefited the middle classes.

The extension of public education methods through mass media seems more likely to occur. However, the evidence is not persuasive that targeting individuals through mass propaganda has been an effective means of effecting health behavior. Rather, peer groups seem to have more effect. It is also clear that the mass media are unlikely to have class specific effects relating to the poor.

Thus, at two levels projected health policies appear to be quite limited tools in the struggle to improve the health of the poor. First, the politics of the United States, and many other western industrialized nations, seem to be shifting away from support of those public structures and policies developed by public health interests. Second, the prospect of efficacy if the public health tools were more rigorously applied is often dubious or unproven in terms of the maladies of poor people.

Our experience suggests that the policies of public health systems have generally reached their efficacious limit because of the structural and political assumptions upon which they are now built. They are not structural reflections of the specific maladies of the poor. Rather, they have become mirror images of the centralized systems they seek to use as vehicles to make the poor healthy.

Consider the tools of the public health system from the perspective of the citizen in a poor urban neighborhood. The citizen lives in a situation where her income is inadequate, arson is prevalent, feral dogs roam the streets, autos rule the public space, schools produce

ignorance, young people are useless, crime is an epidemic and drugs and alcohol are the cure. In the local hospital, the most frequent maladies are auto accidents, drug overdoses, animal bites, gunshot wounds, stabbings, poisoning, rapes and accidents.

Compare her situation with the public health tools. How many more clinics, doctors or hospitals will it take to cure these maladies? What environmental regulation will treat her condition? What television program or school curriculum will cauterize her neighborhood? Her life is sickening even though she lives in a neighborhood where the sewers work, the milk is pasteurized, children immunized, public programs pay for medical care, air pollutants have been somewhat reduced and schools attempt health education for children.

What, then, is the problem?

It is increasingly clear that no matter how intensively we use the existing tools, the problem will remain. This is not to denigrate these tools, nor to suggest that they have not been helpful in the past. However, it is our experience that they have reached, and exceeded, the healthful limit of their power. A healthful future for the person in the poor neighborhood now depends upon a different form of action, a new set of tools.

One does not have to be an ideolog or an epidemiologist to recognize that the maladies she now experiences are caused by powerlessness. She has reached that stage where there is no effective treatment that can be administered to her. She is peculiarly immune to the injections,

ministrations and education bestowed upon her. She is perfectly resistant to most efforts to deal with her as an object of concern, care or cure. Her health now depends upon her empowerment and the empowerment of her neighbors. They will heal themselves with economic power, political power and control of their own tools.

Let me stress that this is not a rhetorical or ideological statement. Rather, it is an objective report of the reality of post-industrial America based upon the bitter failures of thousands of health efforts that have dealt with every problem but power. The dismal array of abandoned programs, palliative remnants and "burned out" health workers gives testimony to the ineffectiveness of health policies that ignore empowerment.

Unfortunately, in the context of healthful empowerment, many of our current public health tools and the structures for their use are not only ineffective - they are fast becoming part of the cause of the malady they seek to cure.

In many communities where the poor struggle for economic survival, the total public payments for their medical care are greater than the public income payments they receive! Thus, in an unbelievable therapeutic inversion, those sickened by poverty are given more medical service than income.

The environmental reforms also represent a peculiarly inverted political process. Elite professionals have usually defined the problem, developed the reform, lobbied the statutes and monitored the programs.



As these reforms are now being dismantled, professionals resist with limited effect because they have no real constituency. Those they "served," including the poor, were not empowered or involved in the process of change. They were blindly "treated" to a better life.

The modernizing health education efforts have recently used mass propaganda media to reform the behavior of the poor. Schools of the poor have also been used for the same purpose. Nonetheless, the media has been the message. The elite public health centralists have amplified their message and used poor's community institutions to correct behavior. One can hardly imagine more effective methods for emphasizing the impotence of the powerless. It is little wonder that the messages have so consistently been ignored.

With each magnification of intensity in the use of the traditional public health tools, the impotence of the poor is now extended, powerlessness amplified, malady multiplied.

Health has fallen victim to those professionals and policymakers who have attempted, and failed, to treat a political issue as a technical problem. Healthful communities are increasingly sickened by the abuses of mega tools controlled by elite health centralists - left and right.

We are obviously in desperate need of a new set of guidelines for those health policies effecting the poor in post-industrial societies such as the United States. Our research leads us to suggest four basic principles.

First, all increases in expenditures for therapeutic medical services

should be faced with a "burden of proof." Medical advocates should be required to demonstrate that their therapies will be more healthful than applying the same budget to the income of the poor, their community organizations or an alternative preventive approach.

Second, all health developments should be tested in terms of their capacity to strengthen local authority and legitimize the competence of the community. This is a test that can only be applied by the powerless. Its legitimacy is demonstrated when their decision is decisive rather than advisory or "participative." The primary indicator of the effective relocation of authority and legitimacy will be the withering away of the health establishment.

Third, the tools and techniques claimed to improve health should be evaluated in terms of their empowering capacity. Are they usable by their "beneficiaries?" Understandable? Controllable? Or are they mystifying, mega-scale, manipulative devices and methods that necessarily require elite dominance to achieve their "healthful" effect? Again, the burden of proof should be with the advocates of megatools. How will the impotence their tools create cure sickening powerlessness? Americans remember all too well one of our military leaders in the Viet Nam war who said we destroyed a village in order to save it.

The fourth guideline is at once the most important and the most difficult to understand: health is basically a condition and not an intervention - an output, not an input. The basic healthist misunderstanding of health is best understood by the modernized poor. Injected, treated,

cured, cared, educated, and manipulated toward compliance, these people know better than anyone else that these interventions are not the source of their health. Instead, each day their lives are physiologically sickened by their impotence confirmed by their intervenors. They are reduced to being mythical creatures called "health consumers" that only exist in the unicorned minds of fantasy figures called "health providers."

Health is a condition, an indicator, a sign. In post-industrial societies, health status measures the power, competence and justice of a people. It tells whether tools control people or people use tools. It indicates whether systems rule or people control.

Our research indicates that is impossible to produce health among the poor. It is possible to allow health by liberating people who are dominated by the economies, structures and tools reflected in modernized health systems.