Health in the Post Medical Era

by John McKnight

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The modern history of the form of well-being that is measured by morbidity and mortality rates has developed through three eras, each profoundly different from the other. These eras are actually reflections of the industrialization and urbanization processes of which changing "health" status is merely one dimension.

We have not widely recognized these eras so they have no generally accepted names. Therefore, we will give them provisional labels.

THE ENGINEERING ERA

As the great industrial revolution took form in the eighteenth century, human dislocations created massive new health threats as rural populations began their exodus to the forming cities. Epidemics became a common condition of life.

An important part of the story of the nineteenth century is the struggle to contain and control these epidemics. The improved health status of the relocating population reflects this achievement, essentially a victory derived from an engineering mode. Three great efforts account for most of the health improvements:

Systems were developed to produce, deliver and distribute adequate food supplies to the burgeoning urban populations. What had been a half-starved population finally secured adequate nutrition to maintain themselves at a reasonable level of host resistance.

Sewer and water systems were developed, excrement and drinking water separated and the era of sanitation initiated.

The process of pasteurization of food was developed and systematized through public policies.

The victory of these efforts to engineer environment and public systems has accounted for more years of extended li than all the preceding or succeeding e forts. It was a triumph executed by thos nineteenth century health workers wh laid track, built roads, laid sewers, du wells and marketed milk. It was a victo for the redesign of environment.

By the close of this era, the public heal profession was burgeoning. The medic profession was still more likely to hu than to help.

THE MEDICAL ERA

The history of this era is much b ter known. It may be said to ha become established early in t twentieth century, at that ti when the odds that the average doc might help rather than hurt became ev In the United States, the forms and pr tices of the medical era were standardi through the Flexner report. By the 192 allopathic medicine emerged as the do nant system and its interventions beca the norm.

This system made two major contri tions to the health of the public during most productive period. The first inno tion was the development of vaccines the creation of large scale systems for t administration. The second was the covery, mass production and extensive of antibiotics.

While it is true that these two contr tions of modern medicine are dwarfe the effects of the prior engineering i ventions, they were vital contributio the late stages of the struggle against i tion and infectious diseases. General lic access to these health resources pe by the 1960s. Since that time, there been no new allopathic interventions equal health status effects. The Me Era can be alloted, approximately, th years from 1920 to 1960.[1]

THE POST MEDICAL ERA

We have now entered times in which there is agreement that the four major determinants of physical well being are individual behavior (smoking, lack of exercise), social organization (stress, burn-out), the physical environment (pollution, workplace) and economic status (poverty, over-consumption). To the degree that these determinants can be altered to improve general health status, it is clear that the interventions of allopathic medicine are not appropriate. These tools of medicine cannot be expected, for example, to stop mass smoking addiction or relieve stressful workplaces or preclude pollution of air or end poverty. Different tools, different actors, different interests are required to affect these health determinants. It is this reality that defines our time as the Post Medical Era. It is not that allopathic medicine has failed. Rather, the nature of societal change and the conquest of many diseases have relegated allopathic medicine to the same place in contemporary health efforts as sanitary engineering. Both are needed for maintenance purposes but their capacity to effect further significant improvements in health status is negligible.

Thomas McKeown has said that we assume that we are ill and made well. It is nearer the truth, he suggests, that we are well and made ill. It is this distinction that may best define the underlying difference between the ideologies of the Medical Era and the Post Medical Era. The allopathic practitioner "made people well" in the Medical Era. In the Post Medical Era, behavior, systems, environments and economies make people ill, but medicine can't make them well.

There is a great paradox regarding the Post Medical Era. Throughout the entire 40-year Medical Era, the United States never devoted more than 4.5 percent of its Gross National Product (GNP) to medical care. However, as the Post Medical era emerged in the 1960s, the percentage of GNP consumed by medical care began to climb by magnitudes reaching 11 percent in the early 1980s.

For those concerned about popular health status, the contradiction is startling. This was a time when a shift of resources to the four modern determinants of health was the obvious instruction of the best medical research. Yet the decade's expenditure in allopathic medical therapy nearly trebled the proportion of the national wealth dedicated to its interventions.

We do not yet have the perspective to understand clearly why we have engaged in such irrational behavior. Whatever the reasons, it is clear that our investments in the out-dated allopathic medical system will not significantly improve our health.

Therefore, we propose that the Post-Medical Era can be definitively distinguished from the Medical Era by calling it the Health Era. The primary purpose for this change in label would be to assure a distinction between scientific health activities and ritualistic medical activities. A secondary purpose would be to provide the definitional basis for public understanding of the difference between medical policies and health policies.[2]

THE HEALTH ERA

Those who are concerned about improving the health status of the people of the United States, now face formidable barriers because in the short term, scarce public resources will be chasing, never catching, the ever-escalating costs of allopathic medical interventions. Most Americans will continue to believe that these allocations will improve their health. Their perceptions will be heightened by regular media reports of miracle medical breakthroughs. Many will argue that we should not increase spending for arms because, among other reasons, we need to use our resources for medical care. The hospital and drug industries will happily join the coalition of medical professionals, medical media enthusiasts and those who believe that the insignia of the Good Society is a hospital with open doors.

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This peculiar coalition is a powerful force. While it gives lip service to the imperatives of the Health Era, the political result of its cumulative successes is to expand medical hegemony. Rather than midwifing the Health Era, the coalition serves, unwittingly perhaps, to prolong the existence of a moribund Medical Era with fiscal intensive care.

The coalition that is likely to create the politics to achieve the Health Era has not yet formed. Potential candidates certainly include elements of the women's health movement, many Health Systems Agency planners defrocked by President Reagan (but liberated from their medical masters) and organized victims of the expanding

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1. The author recognizes that this brief account may overstate the contribution of allopathic medical intervention as a determinant of popular health status. For the more skeptical view, see the work of the great English epidemiologist, Thomas McKeown, especially *Medicine in Modern Society* and *The Role of Medicine: Dream, Mirage or Nemesis.*

2. This distinction is now critical from a policy perspective. In the United States the lack of a distinction between allopathic medicine and health has resulted in such radical misuse of the language that many scientists, professionals and even lay people have fallen into the habit of calling organizations designed to provide allopathic medical intervention "health care systems." The most aberrant of these usages mislabels a client of allopathic intervention a "health consumer." The wisdom of the editors of this journal is clearly demonstrated by their choice of title—*Health & Medicine.*

WHO WILL SURVIVE?

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It also meets another criterion, that we must learn from the experiences of other nations, both rich and poor. Sweden's health care system, for example, is largely county-based. Cuba and China, though in quite different ways, have emphasized the importance of community-based prevention and treatment services and their relationship to political forces. If we fail to learn from our own and others' successes and failures—and to make the lessons relevant to the concerns of the people we serve—we shall surely lose our way.

Nonetheless, despite the murkiness of my crystal ball, the future is bright—because it must be. We will avoid nuclear war, we will reverse the arms race, we will share with other peoples, we will bring light to the current darkness, and we will work with others to build better services in a better world—because we must. The next twenty years are critical. For the next few dangerous years we must use the opportunity of fighting back to build the coalitions, develop the plans and refine the tactics. We must use the remaining years of the century, much more effectively than we have in the past, to produce structural change. We must—and we will.

BLOCK GRANTS

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ment decisions.

Public interest groups and consumer organizations should immediately begin to scrutinize the quality of state data collection procedures. Even with the federal reporting required under categorical grants it has been hard to get data comparable between states. At this time, federal sources of data are rapidly drying up. The Census Bureau, under the Administration's knife, is curtailing its production of data and is planning to gather less geographically detailed information. The National Center for Health Statistics has already reduced its reporting. Within a very few years, Illinois' abysmal infant mortality ranking, even if it worsens, may well have disappeared from view. Lack of data may make it impossible to rank states, or evaluate and monitor programs.

Wisdom from Washington projects more and more programs "blocked" in the future. Targets include income-related entitlements like Medicaid or food stamps. The de-federalized programs would eventually depend on taxes raised as well as adminstered at the state level, with appropriations dependent upon state legislatures. The lesson from Illinois' experience with relaxed Federal supervision and concommitant state miscreancy is: the ability of state governments to subvert public policy is at least as good as that of the national government.

References

1. National Association of Community Health Centers, Inc. "The Case Against Block Grants, 1981"
2. State of Illinois Office of the Auditor-General "Management Audit on the Administration of Federal Grants. Emergency Medical Services, Maternal and Child Health" May, 1979
3. *Ibid*, p. 21
4. Midwest Center for Health Planning, "A Review of the Illinois SHPDA-SHCC Organizational Structure and Recommendations for Change" Feb. 1979
5. Illinois Legislative Investigating Commission, "The WIC program in Illinois: A report to the Illinois General Assembly" November, 1979

POST MEDICAL ERA

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iatrogenic effects of allopathic medicine.

It is even more likely that the Health Era coalition will be composed of interests and actors whose purposes and goals are *not* self-consciously related to health at all. It is arguable, for example, that strong neighborhood organizations effectively struggling for a changed physical environment as well as equity and justice for the residents are the primary health organizations of our cities. Other primary health groups may include reinvigorated unions that seriously alter the work environment (physically and socially) and refuse to continue trading real income for the benefits of medical intervention in the form of a hefty insurance package. Certainly the coalition will include some organizations representing older Americans, especially those which press for a productive, inter-generational space rather than a pre-paid place in a nursing home.

There are many other potential members of the coalition: their primary characteristic, an emphasis upon community; their method, collective action; and their basic goals, equity and justice. Their unintended side-effect is health.

Thus, the Health Era is not about the pursuit of equitable medical care. It is about justice. The pursuit of equitable medical care can thwart justice by valuing institutions over community, professional expertise over collective action and therapy over health.

There are many health advocates who will say that this is a false dichotomy. They argue that we can have much more of both medicine and health, two eras in one. However, indisputably the Health Era demands a loosening of the power structure that presently allocates to the medical sector control of so much money, so many people and so many tools. This power attracts and misdirects millions.

In the Place of Health stands the Monument of Medicine, golden, brilliant, inspiring, commanding. In the Era of Health, medical monumentalism will necessarily fall away to make room for the celebration of community and the politics of well being.