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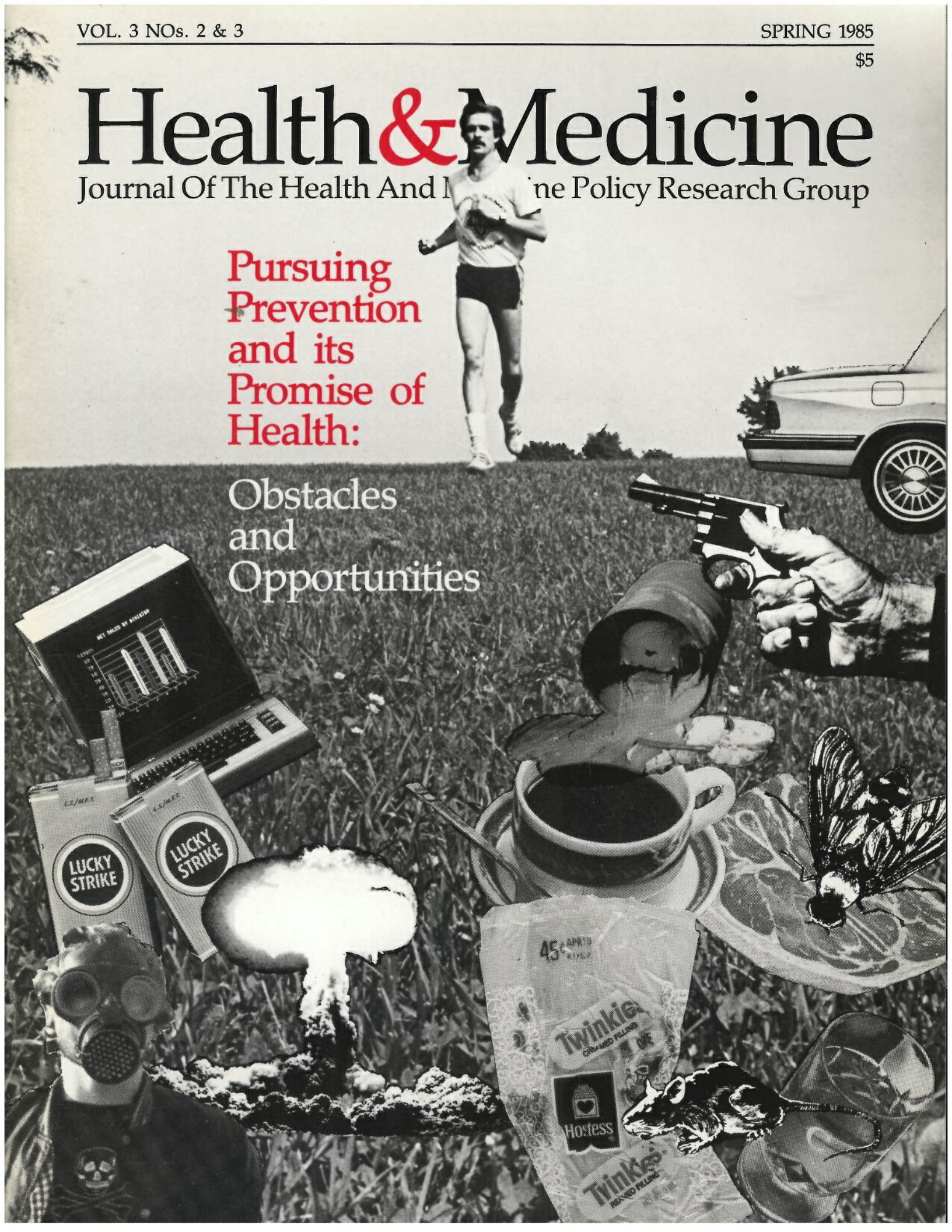
Pursuing Prevention and its Promise of Health:

Obstacles and Opportunities



Meg Gerken

Prevention and Poverty

How valid, particularly for the large underclass, are prescriptions for health administered by external bureaucracies? In this Perspective, empowerment is identified as the vital precondition for salubrious change, perhaps even survival for this sector.

by John L. McKnight

Consider the reality of the poor, those without power in our society. Their income does not sustain body and soul. Their housing is dangerous. The automobile dominates their limited public space. Schools fail to liberate their children. For their young there is no economic space. Crime is ubiquitous. Many seek respite in drugs and alcohol. In the local hospital, the human damage from this reality is recorded in the admission diagnoses: trauma due to accidents, auto injuries and interpersonal violence; drug overdose, poisoning, premature pregnancy and premature delivery, alcoholism and the like.

Consider the ability of the established public health strategies to abate these health hazards. Though their water is potable, their sewers work, their milk pasteurized, their children immunized, their medical care funded and health curricula in place in their schools, for the powerless life remains intractably sickening.

Why?

The traditional preventive tools of public health are not appropriate instruments to enhance health in this environment. A healthful future for the person in the disempowered neighborhood requires a different form of action, a new set of tools for prevention.

Many recognize that these modern maladies are *caused* by powerlessness. It is less well understood that there is no effective treatment which can be *administered* to the powerless. They are usually resistant to the preventive ministrations and education bestowed upon them. They respond as if immune when treated as an *object* of concern, care or cure.

This failure to thrive of the missionary strategy has a dismal array of abandoned

programs, palliative remnants and "burned out" health workers. Indeed, some of these well-intentioned programs have worsened the very ills they seek to remedy.

The powerless struggle continually for economic survival. Yet, of the public resources allocated to them, payment for their medical care (to the providers) is frequently greater than the income payments they receive! Thus, in a mindless therapeutic miscalculation, those sickened by inadequate income are given more medical service than income.

Modern health education efforts use mass media to reform the behavior and lifestyle of the powerless. Public health leaders amplify their preventive message through powerful electronic megaphones: eat better, exercise, don't smoke or drink, balance work with recreation. How better to assure awareness of their impotence by the poor than through these Marie Antoinette prescriptions? Health has fallen victim to those professionals and policy-makers who treat the political issue of powerlessness as a technical problem.

We need a different *prevention guideline* for the powerless in post industrial societies. Our research leads us to suggest that there are four basic empowering principles:

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. Cannot communities and families take better care of many nursing home inmates in the local environment?

All preventive health plans should be tested in terms of their capacity to strengthen local authority and legitimize the competence of the local community. This, incidentally, 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." Thus, a strategy to address teenage pregnancy or alcoholism would develop programs and allocate resources based on valid community consensus.

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The tools and techniques of health education should be evaluated in terms of their empowering capacity. Are they usable and controllable by their "beneficiaries?" Or are they mystifying, mega-scale, manipulative devices and methods that necessarily require outside dominance to achieve their "healthful" effect? Again, the burden of proof should be with the advocates of megatools. They should demonstrate how the impotence their tools usually create can cure sickening powerlessness.

This guideline is at once the most important and the most difficult to understand: regard health basically as a condition and not an intervention—an output, not an input. The input misconception of health is best understood by the modern poor themselves. Injected, treated, cured, cared, educated and manipulated toward "compliance," they know that these interventions are not the source of their health. Rather, they transform the poor into 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 and is measured by 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.

It is impossible to *produce* health among the powerlessness. It is possible to *allow* health by transferring tools, authority, budgets and income to them. It is this kind of a transfer program that is the basis for prevention of the maladies of powerlessness.

Public policy, especially health policy, is the abiding interest of John McKnight, the Associate Director of Northwestern University's Center for Urban Affairs. He is a member of the Health and Medicine Policy Research Group.