DIAGNOSIS AND THE HEALTH OF COMMUNITY

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Presented at the Sun Valley Forum on National Health

August 17, 1992

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Paradoxically, the growth of consumer societies has seen a decline in the health giving utility of the consumption of medical services. This phenomena has been documented by such illustrious research scholars as the English epidemiologist, Thomas McKeown in *The Role of Medicine: Dream, Mirage or Nemesis*, Sociologist Rene Dubose in *The Mirage of Health* and economist Victor Fuchs in *Who Shall Live*. Each finds, from a different disciplinary focus, that modernized consumer societies experience less and less health return for higher and higher medical investments. Indeed, Fuchs summarizes the research by reporting that, "There is no reason to believe that the major health problems of the average American would be significantly alleviated by increases in the number of hospitals or physicians" and he concludes that "the greatest current potential for improving the health of the American people is to be found in what they do and don't do to and for themselves ... and collective decisions affecting pollution and other aspects of the environment."[1]

While it is true that the environment has always been a primary determinant of health status, medicine has offered a remedy without environmental change. It is the truth of our times that that offer is now failing. We are forced to seek improved health in improved environment because the medical alternative is steadily diminishing in efficacy. Nonetheless, Rene Dubose observes that, "To ward off disease or recover

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[1] Victor R. Fuchs, "A Tale of Two States" in Peter Conrad (ed.) *The Sociology of Health and Illness*, St. Martins Press, New York, 1990

health, men as a rule find it easier to depend on the healers than to attempt the more difficult task of living wisely."[2]

It is our curious fate, then, to live in a consumer society where our tremendous purchasing power will not buy health from healers. We are, instead, destined to have to seek health by "living wisely." And it is this new search for health that has resulted in the current use of medically unfamiliar words and concepts such as wholistic, wellness, promotion and community. They speak not of healers but of attitudes, values, relationships and environments where it is possible to live wisely.

While it is possible to imagine "wise environments," it is not readily apparent how medical systems, clinics and professionals are relevant to them. Is there a place for "healers" in the developing world of wellness? Is there a contradiction between the ways of professional systems and the nature of wise, just communities?

For more than 20 years, ~~our Cen~~the Center for Urban Affairs at Northwestern University has been studying the nature of healthful local communities. These studies have mainly focused upon urban neighborhoods where lower income people reside. These neighborhoods clearly reflect the outcomes of urban environments where consumer power is minimal. But they also incorporate thousands of innovations and initiatives to develop community capacity, promote wellness and approach people and place wholistically. In studying these innovative efforts, ~~we have~~ the Center has attempted to document the nature of the relationships, attitudes, values and practices that create "wise environments," ~~And we have observed~~ and the relationship of medical systems and professionals to these local community building efforts.

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2 Rene Dubose, *The Mirage of Health*, New York: Harper, 1959

Our studies suggest four forms of system and professional relationships that have the potential to enhance community capacity and individual well being.

Reinvestment Practices

A 1984 study conducted by our Center determined the number of dollars provided by Federal, State and County sources designated for the low-income residents of Cook County — the county that incorporates the City of Chicago.[3] The study found that a total of $4,851,113,300 was appropriated by these three governments to specifically benefit low-income people. This amount, divided equally among the Cook County residents with incomes below the official poverty line, would have provided a per capita income of $6,200. Thus, a family of three including a mother and two children would theoretically be the beneficiary of $18,600 on a capitation basis. This figure was, at the time, near the median income for a family of that size.

Further analysis of the Cook County data indicated that 35% of the total allocation was provided in direct cash benefits to Cook County's low-income people. 65% of the allocation for low-income people was provided in the form of services or vouchers for commodities. The medical care system received 38% of all the dollars allocated for the benefit of low-income people.

Statistically, the data indicate that on a per capita basis, the family that might have received $18,000 income would find $7,068 given to the medical system.

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[3] Kallenback, D. and Lyons, A., *Government Spending for the Poor In Cook County*, Center for Urban Affairs and Policy Research, Evanston, Illinois, 1989

As a matter of epidemiological policy, is it healthful to use over one third of the public income of poor people for healers rather than wise environments? What would the research of McKeown, Dubose and Fuchs tell us about this form of public investment? Is it a health-filled policy choice? Does it create wise environments and build healthful communities?

Whatever the answer, it is clear that the medical system is a major, prosperous, growth industry receiving heavy public investments that are appropriated for low-income people. While this industry consumes a considerable portion of the wealth of poor people, it also has the potential to reinvest that wealth in these people. It is this reinvestment relationship that has created healthful community building relationships between local medical systems and low-income citizens.

A reinvestment policy recognizes that strengthening the local community economy and income of individuals results, in part, from the economic decisions of the medical system. This can occur in at least 4 ways:

A. Purchasing from local producers and suppliers of goods and services.

B. Hiring residents of the local area.

C. Targeting contracts for goods and services to support creation of new businesses.

D. Investing institutional resources in local financial institutions such as credit unions, coops, and community development loan funds.

As medical resources are re-invested in these ways, the economic status of the local community will be strengthened with the resulting improvement in health status predicted by environmentally oriented epidemiologists.

Institutional Auspices

In many low-income communities, medical systems, professionals and enterprises are the centers of greatest wealth. They are also, and consequently, locations of prestige, legitimacy and authority. They often stand out as the one neighborhood lighthouse that shines as a beacon throughout the city and society.

Because of this unique, authoritative status, they have great potential to become community building assets by using their institutional auspices. The functions performed by some local medical institutions include:

A. *Advocacy* — Joining coalitions of neighborhood groups, medical leaders can lend their weight to local community development efforts. One hospital president, for example, joined a group of local leaders in lobbying Federal officials to fund a highway that would spur local economic growth.

B. *Convening* — A local medical facility convened leaders of forty neighborhood groups to create a coalition to focus on housing rehabilitation. Because local medical groups deal with so many diverse local interests and leaders, they often are in a unique position to call these groups together to focus on local environmental issues.

C. *Economic Power* — Often, local medical systems have economic credibility that other local institutions and organizations do not. One local hospital became the fiscal agent for a newly developing neighborhood economic development corporation. Another used money received as an award for community service to give $1,000 grants to local merchants for street facade improvements.

D. *Personnel* — People working in local medical groups have many skills in addition to those related to medical services. The president of one local hospital reports that, "We were important (to the local neighborhood groups) as a technical support group. The intelligence of our staff, as accountants, architects, as spokesmen, was put at the community's disposal. We helped the neighborhood organize politically so that it was in a position to bargain for government

resources on its own. We haven't got any money of our own, but we're smart and ambitious and we can be a catalyst."

E. *Space* — Often, medical facilities have space unused during various times of the day. In overcrowded urban neighborhoods, this space can be a valuable asset. One hospital has a gym that is used as a part of the local school's physical education program and after-school sports activity. Another hospital provides office space for the local Tenant Security Patrol organization.

In all these ways, medical personnel and facilities can invest in local communities. The potential is clear. There is power to advocate, convene, access external resources and involve personnel and space. This power is a community asset. Its use can be as critical to regenerating healthful community life as medical intervention in the maladies of people who reside in powerless places.

Healthful Information

Medicine has the unintended side effect of mystifying the cause and cure of malady. Many people encounter a life interruption, call it a disease, take it to a doctor or hospital where it is treated un-understandably by people who speak in mystifying tongues. The result is for the "person" to become a "patient" in the face of malady. The malady becomes a commodity of the medical profession. And health becomes a consumable as citizens become "health consumers."

Wise communities have the information necessary to avoid becoming frequent consumers of the services of medical industries. And yet it is the coding, commodification and mystification of the medical industries that is a

major barrier to community wisdom. This fact is demonstrated by the health initiative of a neighborhood organization in a low-income community.[4]

The organization engaged a university to do a study of the medical records of the local hospital's emergency room. They actually wanted to see whether the hospital was doing a good job or was discriminatory. The study resulted in the following list of the seven most common reasons for emergency hospitalization in order of frequency:

1. automobile accidents
2. interpersonal attacks
3. accidents (non-auto)
4. bronchial ailments
5. alcoholism
6. drug-related problems (medically administered and ~~on-medically-administered~~)
7. dog bites

The community people were startled by this list. They had the idea that hospitals dealt with "disease," but as one local resident observed, "Those aren't medical problems, those are community problems." The list was healthful information because it accurately relocated the health question from the medical to the community domain.

As a result of this demedicalized information, community health action developed. The neighborhood group offered bounties for the

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4 A complete description of this initiative can be found in "Politicizing Health Care," *Social Policy*, November/December 1978, Volume 9, Number 3

identification and capture of the feral and stray dogs that were causing most of the dog bites.

The organization developed a map of the places where auto accidents occurred with frequency. Based upon this information, they developed and implemented plans to deal with the major traffic hazards in the neighborhood.

In response to bronchial problems, they decided that poor diet was a cause. Believing that local people were not healthful because of inability to purchase fresh fruits and vegetables, they developed greenhouses on the flat roofs of local apartment buildings to create work, income and nutrition in the place of bronchial therapists.

This wise community initiative demonstrated a vital, health-giving capacity of medical people. Medical people are, as McKeown, Dubose and Fuchs remind us, the constant economic beneficiaries of unjust, disorganized, powerless communities. As long as they interpret this fact in terms of their "life-giving" therapies, the communities they "serve" will be misled, weakened and diseased. However, the translation of medical data into "community-friendly" information is a critical contribution to wise, healthful community life.

Anti-Diagnosis

The obvious center of the medical mentality is the focus upon malady, deficiency, disease, and need — the empty half of the glass. Clearly, the empty half is present. And just as clearly, the full half is present.

The medical system needs the empty half.

The healthful community needs the full half. Indeed, every community has been built by the capacities of needy people and the skills of deficient people. No community was every built by a group of "full," un-needy, un-diseased people. Communities are built in spite of the dilemmas, problems, deficiencies and diseases of its people.

Nonetheless, potentially powerful communities can be disabled by alien systems that sponsor and propagate a culture of need and deficiency. If this culture of deficiency comes to dominate a local community, it will lose the power of wise citizenship and succumb to the maladies of clienthood and medical consumption.

The essence of the medical mentality is diagnosis — the ability to name and describe the emptiness of your neighbor. As a technique, this skill can be valuable. However, as a pervasive cultural value, it will inevitably blind communities to the capacities, assets, skills and gifts that are essential to their power, wisdom and health.

The diagnostic culture is a disease infecting many low-income communities. Its literal manifestation is the "needs survey" that insists that local residents focus upon their emptiness. While this emptiness, deficiency, malady and disease is *needed* by growing medical systems, it is use-less to those who grow healthful communities.

The raw material of community is capacity. The raw material of medicine is deficiency. In this harsh reality is a competition for resources based upon an ideological struggle. The community building interest is in an anti-diagnostic ethos focused on gifts to be manifested. The medical interest is in a pro-diagnostic ethos focused upon brokenness to be fixed. Each is a world view that shapes how power and resources are allocated and which values are affirmed and legitimized. Each creates a map of community that

guides community residents, local groups, major institutions and governments toward competing visions of healthful communities.

The diagnostic ideology creates a community map of needs and deficiencies (Table I). This map empowers medical, social and service systems. It creates a powerful resource magnet. It converts citizens to clients and producers to consumers. It announces to citizens in community that "you will be better because we know better."

The anti-diagnostic ideology creates a map of capacities and assets (Table II).[5] This map empowers citizens, associations and enterprises. It can also create a powerful resource magnet. However, in an era of scarce resources, it must inevitably compete with the pro-diagnostic interests.

It is the reality of this competition for the fiscal, political, social and psychic powers of society that is at the heart of the public health debate and the policy decisions we face.

It would be a hopeful conclusion of this paper to suggest that there is an obvious synthesis of these two maps — a win-win strategy that enhances both the needs and asset maps. Such a conclusion would be dishonest.

Instead, we should be guided by the critical honesty of Hippocrates, the founder of medicine as a profession. His oath concludes with a mandate to recognize that "above all," medicine's highest value is to "do no harm." In terms of community health, the oath translates into a recognition that an anti-body of wise communities is anti-diagnosis.

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5 Tables I and II are from a report titled *Mapping Community Capacity*, Center for Urban Affairs and Policy Research, Northwestern University, Evanston, IL, 60208. ~~This report is a guide to community development based upon an asset model.~~

TABLE I
Neighborhood Needs Map

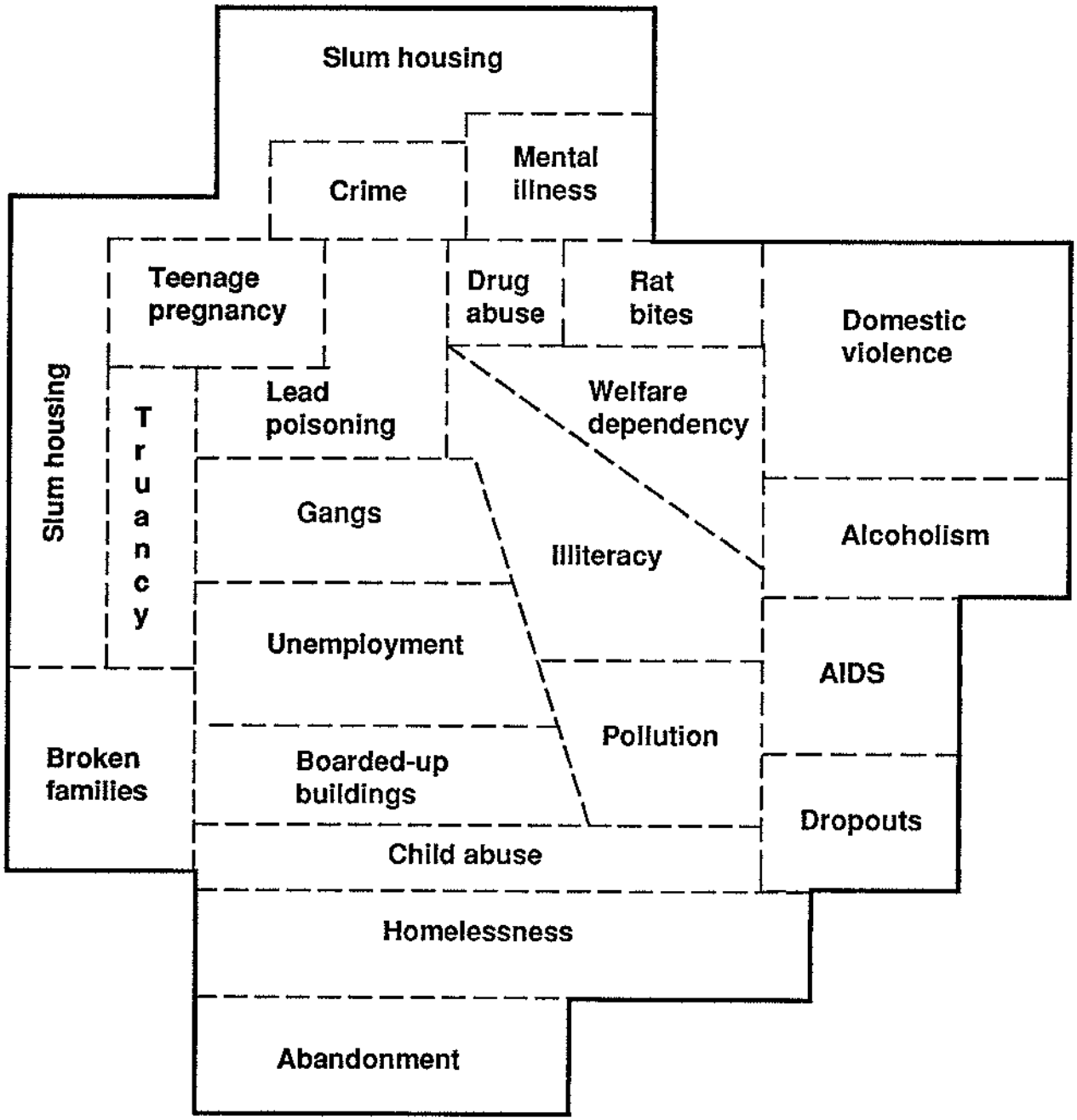
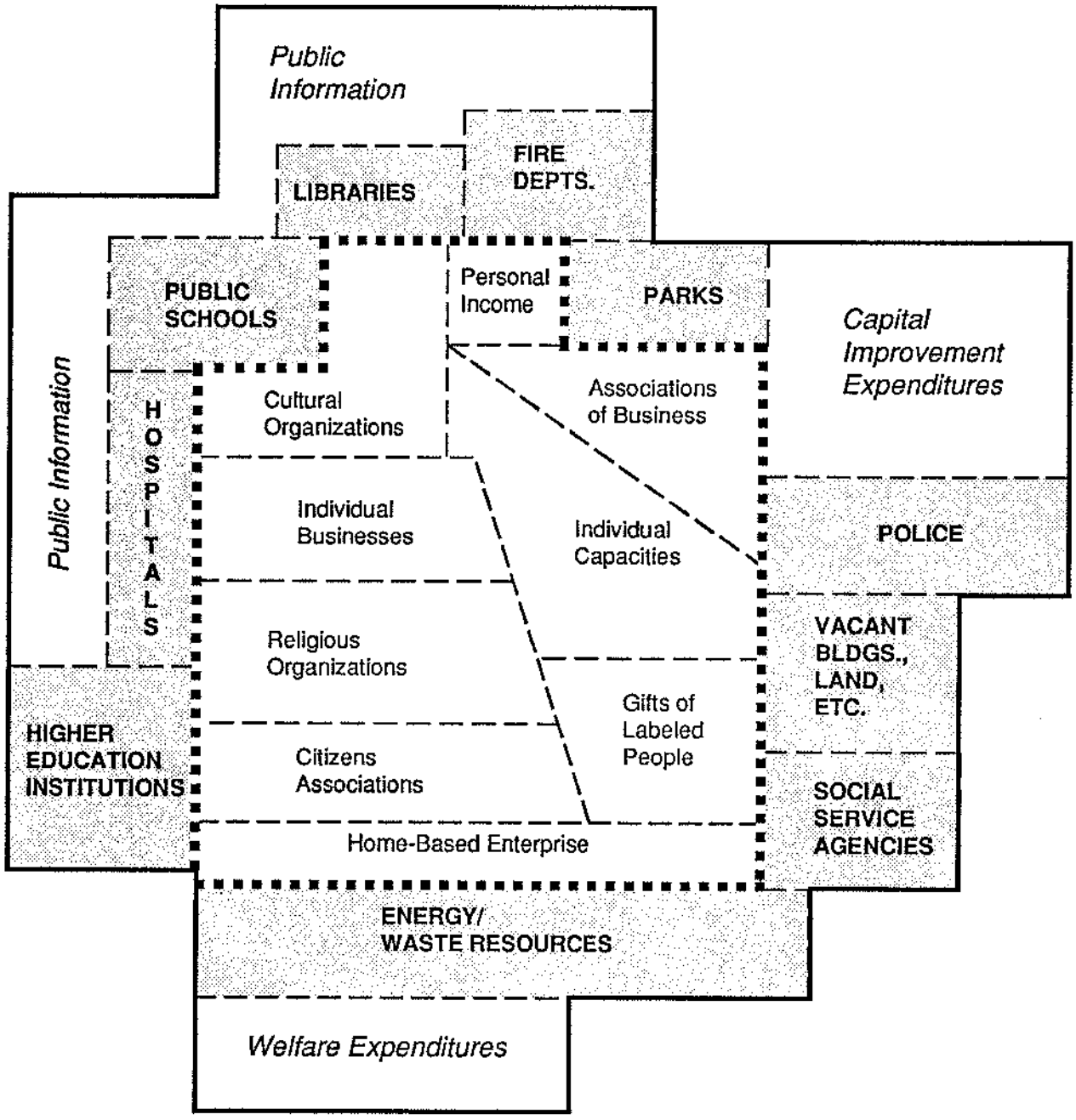


TABLE II
Neighborhood Assets Map



Legend

Primary Building Blocks: Assets and capacities located inside the neighborhood, largely under neighborhood control.

Secondary Building Blocks: **ASSETS LOCATED WITHIN THE COMMUNITY, BUT LARGELY CONTROLLED BY OUTSIDERS.**

Potential Building Blocks: *Resources originating outside the neighborhood, controlled by outsiders.*