

Community Medicine

Chapter 1

We Don't Have a Health Problem, We Have a Village Problem

Cormac Russell

Managing Director, Nurture Development and faculty member, Asset-Based Community Development (ABCD) Institute, at DePaul University, Chicago.

Email: cormac@nurturedevelopment.org

Abstract

Post-industrial societies often lack the social embeddedness that citizens require to fully participate in the civic, environmental, and economic life of their communities. Such erosion of the social fabric represents a social and health hazard. Growing awareness, among clinicians and their health allies, of this social malaise and its correlation with poor health outcomes has led to an increased focus on population health and community approaches. It has also given rise to some new health programmes aimed at demedicalising and relocating the emphasis towards socialisation, such as social prescribing, which is concerned with referring patients into community-based activities.

While reversing medical overreach and promoting a social model of public health [1] is to be strongly endorsed, in this paper, however, I contend that social prescribing falls significantly short of challenging the dominant medical model, which is primarily focused on managing sickness [2], not health promotion or the broader agenda of population health. Community building following the principles and practices of Asset-Based Community Development is, I propose, a more comprehensive and compelling alternative. The community building approach advocated here views health as tied to socio-political, economic and environmental conditions,

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and while not discounting the value of individual agency, it asserts the need for collective agency for health creation and the pursuit of social and economic justice for all. Hence, I argue we do not have a health problem *per se*, we have a village problem.

Keyword: population health; social prescribing; community building; Asset-Based Community Development; medical systems and institutions; healthcare systems; community; community development; social determinants of health; health creation and production; circles of support; personal budgets; cooperatives; relief programmes; Greater Rochester Health Foundation; Emilia Romagna; cooperative movement; helping professions; community-led health production; associational life; social fragmentation; healthcare systems and institutions

1. Introduction

Some aspects of medicine are going through a spasmodic transition from the business of treating sickness to the art of healing and health creation. Increasingly, savvy doctors, allied health professionals and practitioners in the Not-for-Profit sector are recognizing that they cannot unilaterally produce health, end suffering, or outwit death. The most discerning among them now see that in fact health and wellbeing are not products to be dispensed by professionals and consumed by ‘the sick’ or the ‘worried well’ but rather holistic social, political, economic and ecological processes. In the UK, the Netherlands, Canada, and other jurisdictions, ‘social prescribing’ is being put forward as sample evidence of this transition—from medicalization to socialization- in practice. But is it?

Social prescribing (SP), as defined by Lynn Friedli et al, is ‘a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending schemes and self-help initiatives, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. Social prescribing is usually delivered via some expression of primary care—through, for example ‘exercise on prescription’ or ‘prescription for learning’, although there is a range of different models and referral options [3].’

Despite its shortcomings which I will discuss here in some detail, many consider social prescribing to come in under an umbrella of community-oriented approaches that signal a growing acceptance of a perspective elegantly articulated by the American poet and essayist Wendell Berry: *Community is the smallest unit of health, not isolated individuals*. What would the implications be for the health professions and Big Pharma were they to authentically treat communities in these more expansive terms as the primary unit of health; as health producing in their own right? Here I wish to cast doubt over the prevailing rather sanguine characterization of social prescribing as being a model that takes a pincer approach which simultaneously reduces medicalization and increases community health production because as its very name reveals in most of its current operational forms it is far too transactional and too governed by

the health system that created it to be deemed a genuine community alternative to medical hegemony or individual consumerism.

Consider the hallmarks of our current medical system with which social prescribing is coupled:

1. **The focus is on the individual and the system:** To start, the current healthcare system is operating on a two-dimensional plane where it is primarily oriented towards the health of isolated individuals and reforming the system.
2. **Community is either forgotten or an afterthought:** In this two-dimensional world, ‘community’ is not considered a foundational third dimension of health, one of the social determinants of health; it is either forgotten or is an afterthought (‘nice to have, once we sort out the systems and services stuff’).
3. **When community is thought of at all, it is thought of in extractive terms:** Community tends to be viewed as a place that can be tapped for its assets, rather than a place with its own health creation and production capacities, a place that offers not services but immensely life-giving care. The giveaway terms which reveal an extractive mindset are: *harnessing assets, harvesting assets, tapping into community assets*.
4. **Community assets are not viewed as resources to be discovered, connected, and mobilised:** The problem with treating communities as asset banks to be tapped into is that communities simply do not work like that. Instead, they are places with assets/resources which are largely invisible, disconnected and yet to be mobilized. The job of public institutions, including those in the Community and Voluntary sector, is, therefore, to support citizens and their associations to discover, connect and mobilise those assets. Thereafter, their role should be to create a dome of protection around community inventiveness.

As those familiar with systems change know, you can never only change one thing. In a climate of fiscal retrenchment where there is little alternative funding for community development efforts, initiatives with funding even when primarily driven by health-related impacts, like social prescribing, tend to dominate.

There is an alternative way forward to the health system-led approach critiqued above, which would integrate clinicians’ efforts around healthcare and advocate for citizenship and civic participation while benefiting from the contributions of wider community assets outside the medical domain. It springs from an asset-based community development (ABCD) perspective and includes other approaches:

1. **Community Organising** efforts at the neighbourhood scale,
2. **Circles of Support** for those who are most isolated and for whom referral is simply not enough.
3. **Local Area Coordination** which actively advances the ‘good life conversation’ and pushes back against the case management culture in Social Work and social care,
4. **Personal Budgets** which afford people income in place of services and offer choice and control around how they spend it,
5. **Support and active** investment/sponsoring of **Cooperatives** to grow local capacity to respond and create community-led alternatives to traditional health services.

All six (inclusive of ABCD) interlace into a virtuous approach which here I call ABCD Community Building.

2. An Overview of Asset-Based Community Development

Asset-Based Community Development (ABCD) is about people living in local places taking responsibility for each other and their local resources. It is a description, not a model, of how local residents grow collective efficacy [4] and what they use to do so [5]. It is based on anthropological accounts from residents with regards to what they use to become collectively productive and powerful as citizens. ABCD, therefore, involves paying attention to what is in a local place, not what outside actors think should be there, or what they believe to be absent.

The primary goal of ABCD is to enhance collective citizen visioning and production [6] through a process that combines four essential elements: Resources, Methods, Functions, and Evaluation (**Table 1**).

Table 1: Four Essential Elements of an Asset-Based Community Development Process

1. Resources	2. Methods
<p>Six assets or resources enhance local well-being:</p> <p>6. Contribution of Residents</p> <p>7. Associations</p> <p>8. Local Institutions</p> <p>9. Local places: built and natural environment; 10. ecosystems, biosphere.</p> <p>10. Exchange: fiscal and non-fiscal</p> <p>11. Stories that encode cultures, heritage; customs.</p>	<p>Communities use methods that identify and productively connect previously disconnected local resources:</p> <ul style="list-style-type: none"> • Discover what is there, make the invisible visible • Welcome the stranger • Portray the resources for all to see • Share learning, impact, and resources • Celebrate community building efforts • Vision the future from inside out • Connect local resources; especially those that are exiled furthest away from community life.
3. Functions	4. Evaluation
<p>The seven functions are common activities that communities collectively undertake, using the resources/assets above. These functions are <i>bottom-up</i> (grassroots), <i>disaggregated</i>, <i>hyper-local</i> and <i>citizen-led</i>:</p>	<p>Evaluation is totally owned by the community, albeit often with outside support. Residents intentionally reflect on and learn about and from the journey together, so that they are consciously aware of what is impactful. They also</p>
<ul style="list-style-type: none"> • Enabling Health • Assuring Security • Stewarding Ecology • Shaping Local Economies • Contributing to Local Food production • Raising our Children • Co-creating Care 	<p>They also evaluate the extent to which they are engaged with the first three essential elements: Resources; Methods; Functions. This process is <i>not an audit</i>, it is developmental, iterative, and enabling of mid- course correction where necessary. Particular attention is paid to:</p> <ul style="list-style-type: none"> • Gift exchange • Deepening of associational life • Inclusion of the gifts of those who are traditionally excluded

3. The Case for the ABCD Community Building Approach

The case for the ABCD Community Building approach as the way forward in healthcare is based on a simple premise: If upward of 20 per cent of people attending their doctors are not doing so for biomedical reasons but due primarily to social isolation [7]—in effect, they are ‘symptom carriers’ of social or political issues [8]—then caring societies ought to seek to get to the root of those issues, and not just to provide one-sided ameliorative relief-based interventions that solely address the symptoms. This social justice orientation aimed at creating a more equitable social order, in preference to relief programmes, is what effective Public Health initiatives have sought to do for multiple decades, as has Community Social Work and Community Development in more general terms.

Bishop Desmond Tutu put it as follows, paraphrasing many before him:

“There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they’re falling in.”

If we do not directly invest in our community—its economy, ecology, and cultures— we may

one day find there is no longer a community at all. We cannot expect to engage with and refer socially isolated people to communities via social prescribing or any other method of referral unless in tandem we support citizens to collectivise their efforts to build their communities from the inside out and we shift practices away from transactional referrals toward more authentic reciprocal connections. ‘Community’ in this sense is understood as a verb, not a noun; in other words, it is the state that is the consequence of our efforts, not a static thing at which we point or towards which we make referrals. This perspective offers a more nuanced community-owned approach to health. To illustrate how this more dynamic and emergent approach to community can be animated I will share two brief examples:

The first: A foundation that is supporting US residents in Rochester, New York to become more health producing.

The second: A cooperative movement in the region of Emilia Romagna, Italy.

4. The Greater Rochester Story

If you are seeking out a model for effectively supporting community building that precipitates community-led health production, this example is exemplary. The Greater Rochester Health Foundation is unique in funding urban and rural neighbourhoods to become health producing, and they do it in a way which is both ground-breaking and principled. The essence of what sets them apart from others is that they work on a minimum ten-year time frame and do not impose health targets or institutionally predefined outputs or outcomes.

As part of the Greater Rochester Health Foundation Neighbourhood Health Improvement Initiative [9], they are funding residents’ groups to recruit community builders/animators to work in their neighbourhoods to reweave the social fabric of their communities and increase collective efficacy at the block level. The Foundation explains why— even though they are a health foundation—they are funding initiatives that some might argue fall outside their organizational mission and objectives, as follows:

‘Our daily lives and the neighborhoods in which we live them—where we raise our families, work, and play—along with our personal health habits, affect health in countless and complex ways. Some neighborhoods support health and healthy behaviors better than others. In healthy neighborhoods, we feel safe walking outside, can access green space for recreation and physical activity, and we can purchase and eat healthy, affordable food. Healthy neighborhoods are free of abandoned housing that attracts crime and are places with trusted neighbors to turn to when in need. Neighborhood environments such as these are the vision for the grantees of the Neighborhood Health Status Improvement initiative.

Since 2008, Greater Rochester Health Foundation has supported asset-based, grassroots

efforts to improve the physical, social, and economic environments of neighborhoods in the Greater Rochester area and surrounding counties [10].’

In the UK, the contrast illustrated in **Figure 1** between what makes us healthy and how money is invested in the healthcare system is stark. The contrast also provides an important marker as to where change is really needed. Health is not primarily medical, it is political, but it is also profoundly social.

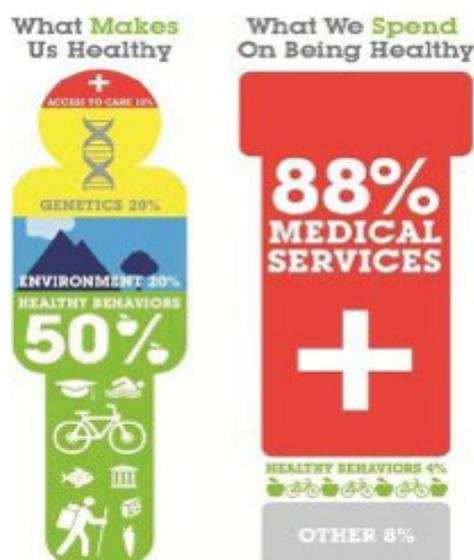


Figure 1: What Makes Us Healthy vs. What We Spend on Being Healthy [11].

5. Emilia Romagna

In the Italian region of Emilia Romagna, where co-ops produce a third of its GDP, we are seeing the new frontier of health and social care. In truth, it has been there for a long time, but few thought to look there before now. Emilia Romagna has a population of nearly 4.5 million people, its capital city is Bologna, and from an economic perspective, it is unique. About two out of every three people are co-op members. Coops are part of the DNA in the region, and now the movement is beginning to morph into a new market: the provision of social services [12]. This is the single biggest growth area for the co-operative movement in the region. Could it be that with the social values of the co-op movement, its members have the capacity to create more cost-effective and care-filled alternatives to more traditional large and bureaucratic institutions?

In the UK, somewhat ironically among the last remaining community co-operatives are funeral undertakers. But Mervyn Eastman and others are doing a fine job in leading a resurgence of the co-operative movement across the country [13]. The potential of movements like these are illustrated through the example of Emilia Romagna, and while the context of this region is special, the potential for local expressions in other parts of the world is significant.

Both the Greater Rochester and Emilia Romagna approaches emphasize the importance of community building, cooperativism and citizenship. Together they illustrate the limits of

the current approach to health issues, up to and including social prescribing, and champion an alternative approach which enables community health production which takes due account of the social determinants of health. As is commonly known, one of the reasons people who are not biomedically unwell are falling into routines of visiting their general practice doctors or using other services such as emergency services or social service care is that they feel lonely and purposeless.

Feelings of loneliness and lack of purpose are predominantly community issues [14]—albeit that they may and often are precipitated by structural inequalities—not clinical/medical ones, which explains why the community should lead in addressing them. Furthermore, this view explains why simply reforming the healthcare system so that it stops the revolving clinic door scenario and ends inappropriate prescription of drugs will not be sufficient. Redirecting people back into community activities without simultaneously doing the much-needed community-building work with the wider community, and the complex relationship-building work with isolated citizens is doomed to fall short of the mark.

Instead of siloed, piecemeal reforms, we must more fundamentally address the root causes by building up our communities from the inside out. To engage in systems reform without facilitating community building at the neighbourhood level is analogous to monocropping land over many decades: as with land that is mono-cropped, communities that have been overwhelmed by top-down interventions lose their carrying capacities (connect-ability) and their ability to be health producing. Instead, we must restore the social fabric of our communities and we must do so as collective citizens and not isolated clients of healthcare systems and partner institutions.

6. All Institutional Progress is Contingent on Understanding Their Limits

All instruments of ‘helping’ have a threshold past which they cease to be effective, or worse, they become counterproductive. Hence all progress is contingent on understanding the limits of one’s intervention [15]. Typically, if we search them out, at the edge of our institutional competencies there are others who can do what we cannot. If when we find them, and we honour them—in this interface between the limits of our capacities and the full potential of theirs—we can begin to form genuine change-making efforts and partnerships.

Authentic partnerships can only exist when each partner brings unique assets and irreplaceable functions to the table. The logic of partnership is that the union enables all parties to do something together that they cannot do apart, but also recognizes that each partner must have space and support to do what they do best on their own terms. That means that as well as being clear about what it is each partner can do, we must be clear about our limits: the functions we will not take on because our partners are better placed to do so. It seems on the main that institutions are not so good at declaring their limits in this way—especially when

it comes to relating with communities that lack institutional authority and resources—yet are excellent at defining the limits of the communities they serve and thereafter asserting how they can serve the priorities of said communities with their institutional competencies.

One of the more fundamental limits of institutions, of which we rarely hear mention, is that they cannot produce care. What those who linger in waiting rooms need most is a life of purpose, not just a dependable service. What they yearn for is belonging: the experience of unforced and unpaid-for acceptance, what most call ‘care’ and natural community. That ‘gift’, the gift of care, is one which cannot be bought, managed, scaled, or otherwise commissioned. Yet it is that gift which is the antidote to loneliness and the elixir of life. We can contribute to caring communities and invite them into our lives on our own behalf and that of others, but caring communities cannot be prescribed or programmed.

Current healthcare systems address health issues through a sickness idiom, they rarely however facilitate or precipitate community-led health production; albeit that this is an avenue through which genuine transformation is most likely to progress. Since, if care is produced through reciprocal relationships, and such relational processes are critical to people’s health and well-being, then surely the pivotal question is: how might we support the creation of a culture of care within natural communities? Further to this are the questions: How might we support the nurturing of communities that have a welcome for the neighbours who have been exiled to clinical waiting rooms, homeless hostels, and emergency helplines? How might we instead precipitate the creation of communities that care enough to break people out of institutions and say to them: “Come home. We cannot build community without your contributions”?

7. How Do We Nurture Health Producing Communities?

The plural of citizen is association; in the same way you have a flock of birds, you have an association of citizens. Building on this premise, an association of associations that welcome ‘the stranger’ constitutes a powerful and diverse community. Powerful and diverse communities are in themselves health producing.

We ought not to measure the strength of a community by the capacity of its leaders, but by the depth of its associational life and how it welcomes the stranger. One way to do this is to develop a typology of associational life (**Figure 2**) at the beginning of the community building process to serve as a baseline and then to support local residents to figure out what they would like to do to contribute to the well-being and the deepening of the associational life of their community. If doctors wish to be supportive of community health production, then they can start by cheering on the quickening of associational life as it gets deeper and more connected. They and others can contribute by regularly asking: Are we seeing neighbours whose gifts were not previously received, participating more? Are we seeing associations driving change and feeling more powerful? Are associations in the neighbourhood sometimes

coming together to talk about what they can do together, that which they cannot do alone? Are we seeing more citizen-led action and less institutionalisation? How might we usefully support such community efforts?



Figure 2: Topology of Associational Life.

8. Conclusion: The Way Forward

The future will continue to manifest the consequences of social fragmentation. And as more neoliberal administrations dismantle social infrastructure within our communities, growing numbers of people will be prescribed out of communities and redefined as clients within the healthcare systems. The carriers of the symptoms of social fragmentation will sit in doctors' waiting rooms, linger in hospital beds, fill disproportionate airtime on emergency helplines and cost local governments and social care institutions billions in ethically saveable resources. Until we address the root causes, social prescribing and similar ameliorative interventions run the risk of becoming the ambulance at the bottom of the cliff, driven by well-meaning but beleaguered volunteers; while being advertised as the radical innovation: the fence at the cliff face.

Thomas Kuhn, who popularized the term *paradigm shift*, noted that at the edge of every dominant paradigm are new ideas that sometimes coalesce to form a new paradigm. To end on a positive note, perhaps it is possible for social prescribing initiatives to pivot from prescribing social solutions to coalesce with other efforts to precipitate collective citizen-led health creation. Perhaps they can begin to genuinely support the birthing of approaches like those we are seeing in Greater Rochester. This form of ally building, alongside strategic investment in supporting the resurgence of the cooperatives, would I believe trigger a step change. The seeds of change already exist but will scatter in the wind unless we stop solely pulling people out of the river when it is too late and start to address the subsidence of the ground under their feet.

It is time to awaken to the fact that we do not have a safety problem, nor a social care problem, nor a youth problem, nor even a health problem; we have a village problem. In our hearts, we know the solution to each does not lie in reforming institutional silo by institutional silo but in organizing our silos the way people organize their lives so that the neighbourhood becomes our primary unit of change. Such a step-change demands genuine place-based working, pooled budgets, and the release of resources to work upstream to stem the subsidence of our social foundations which is causing people to fall into the river quicker than we can pull them out. In the final analysis, the restoration of population health is only conceivable when people who have been defined out of communities secure the power to redefine those communities; then health will be enjoyed by all. That journey begins at the local level, with caring communities of place in the driving seat, and with the health care system in the backseat taking on a supplementary role.

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