Review of: "We Don’t Have a Health Problem, We Have a Village Problem"

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Potential competing interests: No potential competing interests to declare.

Title of the manuscript: We Don’t Have a Health Problem, We Have a Village Problem (Authored by Cormac Russell)

Reviewer: Izanette van Schalkwyk

The author stated that clinicians in modern, highly developed countries are starting to understand that health problems are not just about physical or medical issues but are deeply connected to people's social lives. This holistic understanding comprises that health and well-being include social, political, economic, and ecological processes. According to Russell, in these post-industrial societies, many people don’t have strong social ties or support systems that help them feel connected to their communities. Without these connections, people can struggle to take part in important parts of life, like being involved in their community. This lack of social connection can increasingly lead to worse health outcomes.

Russell referred to the awareness of medical professionals prompting a shift toward prioritizing population health and community-centred approaches. He used the construct of social prescribing, described as ‘a mechanism for linking patients with non-medical sources of support within the community,’ for the transition from medicalisation to socialisation in practice. However, he critiqued social prescribing, in most of its current operational forms, by stating that it is far too transactional and overly governed by national health systems to be deemed a genuine community alternative to medical hegemony or individual consumerism. For instance, he reasoned that community assets are not viewed as resources to be discovered, connected, and mobilised. Russell reasoned that “the problem with treating communities as asset banks to be tapped into is that communities do not function like that.” He confirmed that the work of public institutions, including those in the community and voluntary sectors, is to support citizens and their associations to discover, connect, and mobilise these assets.” This valid argument prepares the way for community organising efforts at the neighbourhood level.

Russell suggests the use of a comprehensive approach following the principles and practices of Asset-Based Community Development [ABCD] as an alternative for people living in communities to take responsibility for each other and their local resources. The description of how residents can grow the collective efficacy of healthcare delivery and what they could use to do so is based on anthropological accounts from residents with regards to what they use to become collectively productive and powerful as citizens.

He then indicated that innovative health initiatives have emerged, including social prescribing programmes. These

programmes aim to reorient healthcare by emphasizing social integration, whereby patients are referred to community-based activities to address underlying social determinants of health. Russell stated that these community-building approaches are illustrated by using two examples to illustrate this more inclusive approach to community, namely US residents in Rochester, New York, and in the Italian region of Emilia Romagna.

The building of community assets/strengths from the inside out embraces a bottom-up approach toward reforming the healthcare system to gradually stop the “revolving clinical door” scenario and ends the inappropriate prescription of drugs. This implicates engaging in systemic reform by facilitating community building at the neighbourhood level. This means that when human beings purposefully engage to restore the social fabric of communities, then we ought to take hands as collective citizens of healthcare systems and partner institutions.

He succeeds in showing that health should be viewed holistically and tied to socio-political, economic, and environmental conditions. It is also important that this viewpoint does not discount or ignore the value of individual agency, and he asserts the need for a collective approach to health creation and the pursuit of social and economic justice for all. Hence, the main argument here is that we – as citizens of a global village – do not have a health problem per se, but rather a village problem.

Review (van Schalkwyk)

The manuscript effectively shows the pressing need to recognise and harness the social determinants of health and well-being in modern, first-world, i.e., western countries. It articulates the limitations of purely biomedical approaches and advocates for a holistic framework that integrates social, political, economic, and ecological considerations. This perspective is timely and aligns with global trends emphasising population health and community-centred approaches.

Russell successfully indicated the use of a) a holistic perspective: The manuscript's emphasis on viewing health as intertwined with broader socio-political and economic factors is a critical step forward in rethinking healthcare delivery systems; and his b) critique of social prescribing by e.g. discussing the transactional nature of current social prescribing practices and their over-reliance on national health systems raises an important concern of superficial solutions that fail to fully empower communities, and offering c) an alternative based on the principles and practices of the Asset-Based Community Development (ABCD) model - Russell’s support for ABCD principles presents a compelling case for bottom-up, community-driven healthcare reform. This approach is well-aligned with global calls for systemic reform that mobilizes local resources and fosters collective efficacy. By providing illustrative examples from Rochester, New York, and Emilia Romagna, he bridges theoretical arguments with practical applications.

Limitations of the manuscript could be a) an overgeneralisation of the "Village Problem": While the manuscript’s framing of health challenges as a "village problem" is indeed insightful, it risks oversimplifying the complexity of global health disparities. Local contexts and structural inequities may require nuanced interventions beyond a collective, village-centric approach. Also, b) insufficient engagement with individual agency and the impact of culture and ethnic influences: Although the manuscript acknowledges individual agency, its focus on collective solutions could have been more balanced by exploring how individual empowerment and community efforts can synergize; and c) the limited diversity of

examples: The reliance on examples from the U.S. and Italy may limit the manuscript's applicability to low- and middle-income countries or culturally distinct settings, which often have unique challenges and opportunities in healthcare reform. Then again, examples from low- and middle-income countries could strengthen the reasoning that we should uncover the root causes of health problems as collective citizens.