Commentary

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

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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 an erosion of the social fabric represents a 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 new health programmes aimed at redirecting the emphasis towards socialisation, such as social prescribing, which centres around the referral of patients to community-based activities. The community-building approach advocated here views health as tied to socio-political, economic, and environmental conditions, and while not discounting the value of individual agency, it 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 do not have a health problem *per se*, but rather a village problem.

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Introduction

While reversing medical overreach and promoting a social model of public health[1] is strongly endorsed, social prescribing falls significantly short of challenging the dominant medical model, which is primarily focused on managing sickness[2] rather than health promotion or the broader agenda of population health. Community building following the principles and practices of Asset-Based Community Development (ABCD)[3] is, I propose, a more comprehensive and compelling alternative.

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,

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and practitioners in the not-for-profit sector are recognising that they cannot unilaterally cure illness, end suffering, or outwit death. Many are now coming to the realisation that health and wellbeing are not products to be dispensed by professionals and consumed by 'the sick' or the 'worried well'[4] but rather holistic social, political, economic, and ecological processes. In the UK, the Netherlands, Canada, and other jurisdictions, 'social prescribing'[5] is being put forward as sample evidence of this transition from medicalisation to socialisation in practice. But one of the questions that will be explored here is whether this is really, in fact, happening or not.

Social prescribing has been defined as 'a mechanism for linking patients with non-medical sources of support within the community'[6]. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending schemes, and self-help initiatives. Additionally, it can include support for employment opportunities, benefits, housing, debt services, legal advice, or parenting problems. Social prescribing is usually delivered via some expression of primary care such as 'exercise on prescription' or 'prescription for learning', although there is a range of different models and referral options.

Despite its shortcomings, which will be discussed in more detail, many consider social prescribing to fall under the umbrella of community-oriented approaches that signal 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 health professions and Big Pharma were they to authentically treat communities in these more expansive terms as the primary unit of health? Here, I wish to cast doubt on the prevailing relatively sanguine characterisation of social prescribing as being a model that takes a pincher movement involving pressure from two different forces, medicalisation on the one hand, social or communalisation on the other. These forces, at best, act contiguously to reduce medicalisation and increase community health production. Social prescribing, in most of its current operational forms, is far too transactional and overly governed by national health systems 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:** The current healthcare system operates on a two-dimensional plane oriented towards a. the health of isolated individuals and b. the potency of their

organisations (whether that be under the banner of claims that they are trying to reform the institutional system while maintaining the status quo).

2. **Community is either forgotten or an afterthought:** In this view, 'community' is not considered a foundational third dimension of health and considered one of the social determinants of health, but rather it is either forgotten or is an afterthought (e.g., it is 'nice to have, once we sort out the systems and services stuff').
3. **When community is considered at all, it is thought of in extractive terms:** Community tends to be viewed as a resource that can be tapped for its assets, rather than a place with its own health creation and production capacities; a place that offers not only services but life-giving care. The giveaway terms which reveal an extractive mindset are *harnessing assets*, *harvesting assets*, and *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 do not function like that. Instead, they are places with assets/resources which are largely invisible, disconnected, and yet to be mobilised. The job 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. Thereafter, one of their roles should be to create a dome of protection around community inventiveness.

As those familiar with systemic change may 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 while at the same time advocate for citizenship and civic participation in order to benefit from community assets outside of the medical domain. It springs from an 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 prevalent in social work and socialised 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 **co-operatives** to grow local capacity to respond and create community-led alternatives to traditional health services.

All six (inclusive of ABCD) interlace into an ethical approach which I will refer to as ABCD Community Building.

An Overview of ABCD

ABCD is about people living in communities taking responsibility for each other and their local resources. It is a description, not a model, of how residents grow collective efficacy in healthcare delivery[7] and what they use to do so[8]. 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 local assets are available and not what outside actors think should be present or what they believe is absent. The primary goal of ABCD is to enhance collective citizen visioning and production[3] through a process that combines four essential elements: resources, methods, functions, and evaluation (**Figure 1**).

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1. **Resources**	2. **Methods**
Six assets or resources **that** enhance local well-being: 1. Contribution of residents 2. Associations 3. Local institutions 4. Local places: built and natural environments, ecosystems, biosphere 5. Exchanges: fiscal and non-fiscal 6. Stories that encode cultures heritage, and customs	Communities use methods that identify and productively connect previously disconnected local resources: • 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 the inside out • Connect local resources; especially those that are exiled furthest away from community life

3. **Functions**	4. **Evaluation**
The seven functions are common activities that communities collectively undertake, using the resources/assets above. These functions are *bottom-up* (grassroots), *disaggregated*, *hyper-local*, and *citizen-led*. • Enabling health • Assuring security • Stewarding ecology • Shaping local economies • Contributing to local food production • Raising our children • Co-creating care	Evaluation is totally owned by the community, albeit often with outside support. Residents intentionally reflect on and learn about the journey together so that they are consciously aware of what is impactful. They also evaluate the extent to which they are engaged with the first three essential elements: resources, methods, and functions. This process is *not an audit* but rather developmental, iterative, and enabling of mid-course correction where necessary. Particular attention is paid to: • Gift exchange • Deepening of associational life • Inclusion of the gifts of those who are traditionally excluded

Figure 1. The four essential elements of an asset-based community development process.

The Case for the ABCD Community Building Approach

The ABCD Community Building approach as the way forward in healthcare is based on a simple premise: if upward of 20 percent of people visiting their doctors are not doing so for biomedical reasons but rather primarily due to social isolation[9], in effect, they are 'symptom carriers' of social or political issues[10], then caring societies ought to seek to get to the root of these issues and not just simply 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 that there will no longer be a community left 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. From this viewpoint, 'community' can be understood as a verb, not a noun, in the sense that it is a dynamic organisation and a consequence of group and individual efforts and not an arbitrary conglomerate from which we make referrals. This perspective offers a more nuanced community-owned approach to health. Two examples will be used to illustrate how this more inclusive and emergent approach to community can be animated:

1. A foundation that is supporting US residents in Rochester, New York, to become more health-producing.
2. A cooperative movement in the region of Emilia Romagna, Italy.

The Greater Rochester Story

Greater Rochester can be considered an exemplary model for effectively supporting community building that precipitates citizen-led health production. By funding urban and rural neighbourhoods, the Greater Rochester Health Foundation has enabled the community to become health-producing in a way that is both groundbreaking 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.

The foundation's Neighbourhood Health Improvement Initiative[11] funds 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 they are funding initiatives that some might argue fall outside their organisational mission and objectives as follows:

> 'Our daily lives and the neighbourhoods 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 neighbourhoods support health and healthy behaviours better than others. In healthy neighbourhoods, we feel safe walking outside, can access green space for recreation and physical activity, and we can purchase and eat healthy, affordable

food. Healthy neighbourhoods are free of abandoned housing that attracts crime and are places with trusted neighbours to turn to when in need. Neighbourhood environments such as these are the vision for the grantees of the Neighbourhood Health Status Improvement initiative.'

Since 2008, this foundation has supported asset-based, grassroots efforts to improve the physical, social, and economic environments of neighbourhoods in the Greater Rochester area and surrounding counties[12].

In the UK, the contrast between what is known to make people healthy and how money is invested in the healthcare system is stark (**Figure 2**). This example provides indicators as to where change is really needed. Health is not only medical; it is also political and profoundly social.

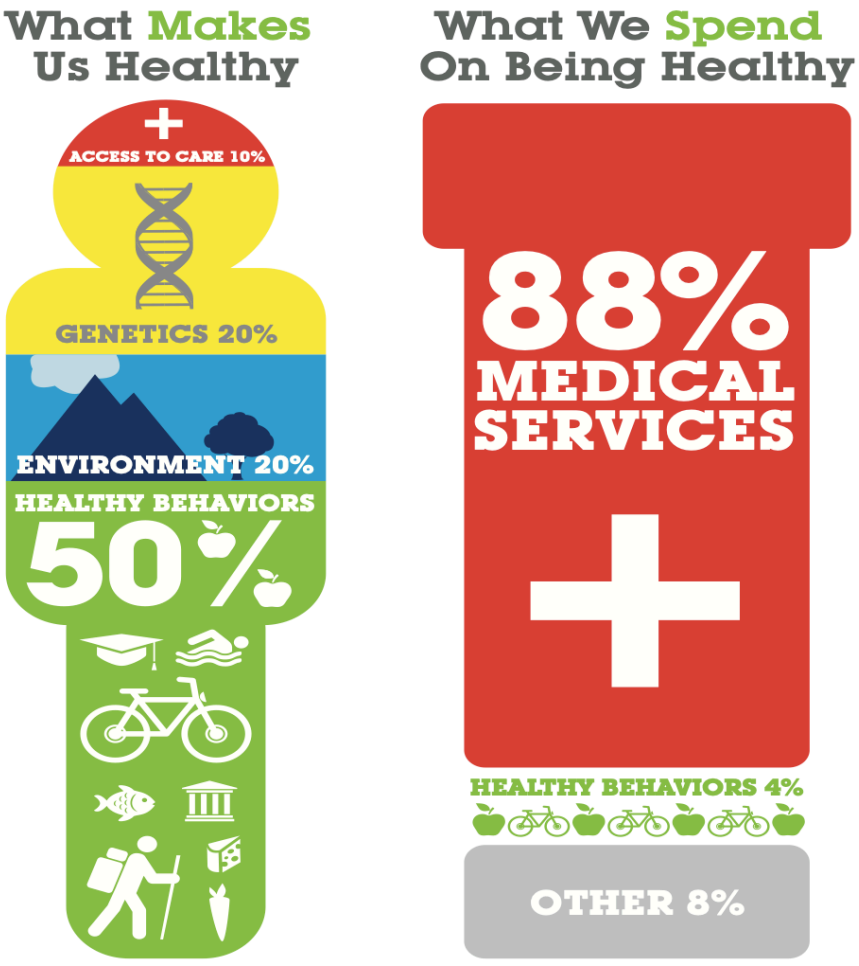

Figure 2. What makes us healthy versus what we spend on being healthy[13].

Emilia Romagna

In the Italian region of Emilia Romagna, where co-operatives produce a third of its gross domestic product, a new health and social care frontier is emerging. It has been present for a long time, but only recently has it been recognised and appreciated. Emilia Romagna has a population of nearly 4.5 million people, and its capital city is Bologna. From an economic perspective, it is unique in that about two out of every three people are co-op members. Co-ops are part of the DNA of the region, and now the movement is beginning to morph into a new market: the provision of social services[14]. This is the single biggest growth area for the co-op movement in the region. More data is still needed to accurately assess whether co-op members have the capacity to create more cost-effective and care-filled alternatives relative to more traditional large and bureaucratic institutions.

In the UK, maybe somewhat ironically, among the last of the remaining community co-operatives are funeral undertakers. But Mervyn Eastman and others have led a resurgence of the co-operative movement across the country[15]. The potential of movements like these is 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 emphasise 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 that enables community health production with greater sensitivity to the social determinants of health.

As mentioned earlier, one of the reasons some people routinely visit their general practice doctors, or use other services such as emergency rooms or social service care, is that they feel lonely and purposeless. Feelings of loneliness and lack of purpose are predominantly community issues[16] that are often precipitated by structural inequalities as opposed to clinical/medical issues, which explains why the community should take the lead in addressing their needs. However, redirecting people into community activities without simultaneously doing much-needed community building and forming relationships with isolated citizens is doomed to fall short of the mark.

Simply reforming the healthcare system so that it stops the “revolving clinical door” scenario and ends the inappropriate prescription of drugs will not be sufficient. 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 systemic reform without facilitating community building at the neighbourhood level is

analogous to neglecting to rotate crops over many years: as with land that is mono-cropped, communities that have been overwhelmed by top-down interventions lose their carrying capacities (ability to connect) and their ability to be health-producing. Instead, we must restore the social fabric of our communities and do so as collective citizens and not as isolated clients of healthcare systems and partner institutions.

All Institutional Progress is Contingent upon Understanding Their Limits

All instruments of 'helping' have a threshold past which they cease to be effective, or worse, become counterproductive. Hence, all progress is contingent on understanding the limits of the intervention[17]. Typically, if we observe closely, at the edge of our institutional competencies, there are professionals who can do what we cannot. If we honour them when we find 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 side 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 it also recognises that each partner must have the space and support to function on their own terms. That means that as well as being clear about the role of each partner, we must also understand the limitations, that is, the functions we will not take on because our partners are better placed to do so. Institutions are generally not adept at declaring their limits in this way, especially when it comes to relating with communities that lack institutional authority and resources. In contrast, they tend to be better 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, which is rarely mentioned, is that they cannot produce care. What those who linger in waiting rooms need most is a life of purpose and not just a dependable service. What they yearn for is belonging, acceptance, and natural community. This forms the basis for the gift of care, and it 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, but caring communities cannot be prescribed or programmed.

Current healthcare systems address health issues through a sickness idiom and only rarely facilitate or precipitate community-led health production. However, this is the avenue through which genuine transformation is most likely to progress. If care is produced through reciprocal relationships, and such relational processes are critical to people's health and well-being, then the prime objective should be to develop a mechanism to support the creation of a culture of care within natural communities. This can be accomplished by welcoming and supporting neighbours who have been exiled to clinical waiting rooms, homeless hostels, and emergency helplines. An inclusive approach must be chosen, and contributions, large and small, of all residents must be recognised.

How Do We Nurture Health-Producing Communities?

An association of citizens that welcomes 'the stranger' constitutes a powerful and diverse community, and these attributes provide greater resources for health production.

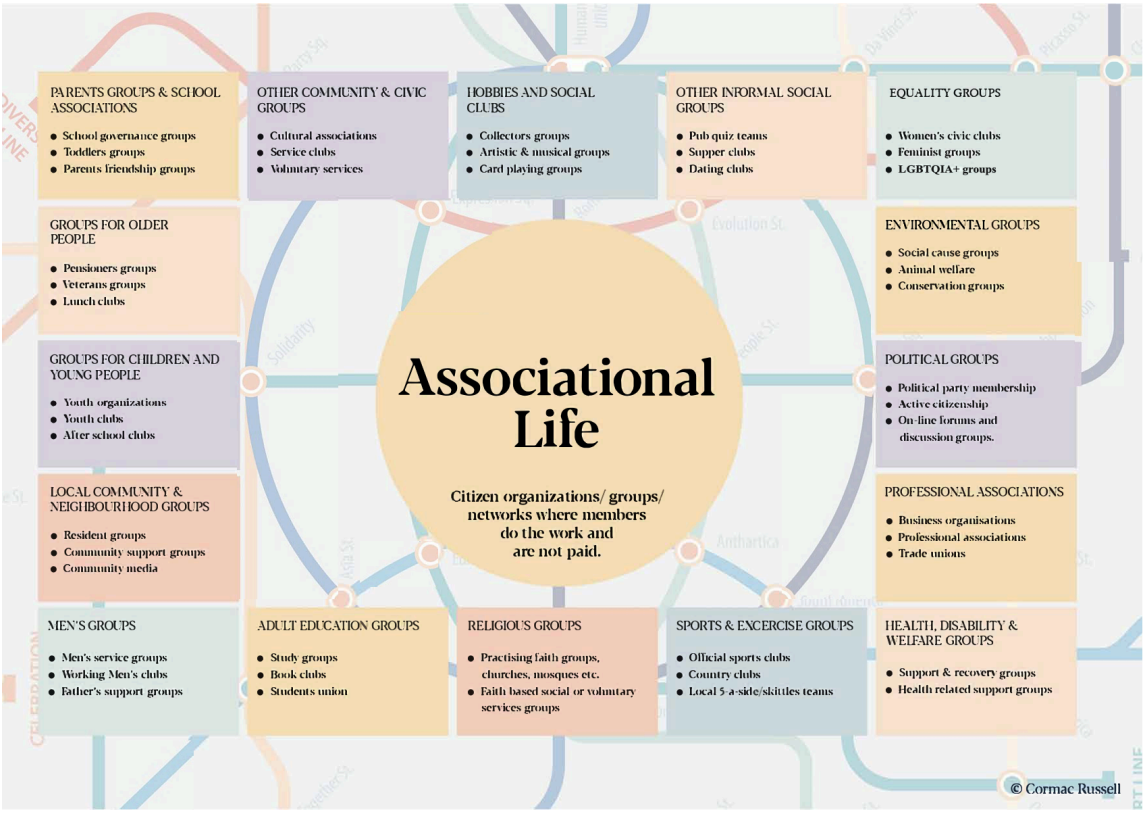

Figure 3. Typology of the associational life.

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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 accomplish this is to develop a typology of associational life (**Figure 3**) at the beginning of the community-building process to serve as a baseline and then to support local residents in determining 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 encouraging and reinforcing 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 gaining traction? Are groups in the neighbourhood sometimes congregating to discuss what they can do together and what limitations they have? Are we seeing more citizen-led action and less institutionalisation? How might we usefully support such community efforts?

Conclusion: The Way Forward

The future will continue to manifest the consequences of social fragmentation. 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 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 of dollars 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 at the same time being advertised as a radical innovation: the fence at the cliff face.

Thomas Kuhn, who popularised 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 merge with other efforts to facilitate 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 to support a resurgence in co-operatives, would trigger a step change. The seeds of change already exist, but more work is necessary to lay the foundation for substantive action.

The first step is recognition of the root cause. We must come to the realisation that we do not have a safety problem, nor a social care problem, nor a youth problem, nor even a health problem; what we have is a village problem. The solution does not lie in reforming each institutional silo but in organising our silos the way people organise their lives, so that the neighbourhood becomes our primary unit of change. Such a step change demands genuine place-based action, pooled budgets, and the release of resources to work upstream to stem the subsidence of our social foundations. In the final analysis, the actualisation of true population health will only be conceivable when alienated citizens rejoin their communities and make contributions; then health will be enjoyed by all. This journey begins at the local level, with caring communities driving the discourse and healthcare systems taking on a supplementary role.

Statements and Declarations

Author Contributions

I, Cormac Russell, as the sole author of this manuscript, affirm that it is an honest, accurate, and transparent account of the policies and practices reported; that no important aspects have been omitted; and that it was produced independently without external funding.

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