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## V. Mapping Community Assets

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We are here to think, this afternoon about the community, nature of the community and relationship to health. We have clearly entered a new era in the popular conceptions of health. Where health was once viewed as a commodity, produced by medical systems, today there is widespread recognition that health is also a capacity that can be maintained or enhanced by ordinary citizens.

Under this new health era banner of prevention and health promotion we see health clubs multiplying, health food proliferating, corporate well-being programs appearing and the consciousness of health growing among Americans of all ages. The new pro health consciousness has created a hidden dilemma, however, for many health professionals and professions. That dilemma is most clearly manifested in the ever growing professional use of the word 'community'.

Under prevention and promotion rubrics we hear of community education, community programs and community participation. However, the meaning of the community focus is much less clear. At the very least, I think community usually means not in a hospital, not in a clinic, or not in a doctor's office. Community is that great 'out there-ness' beyond the doors of professional offices and facilities. It is the social space beyond the edges of our professionally run systems. The dilemma we face, is that while we have great professional skills in managing and working within our systems, our skills are much less developed once we leave the system space and cross over the frontier into the community.

Indeed, one is impressed by the immediate confusion and frustration that is experienced by many professionals when they attempt to work in the community space. For it often seems very complex, disordered, unstructured and above all uncontrollable. And many health professionals begin to discover that their powerful tools and techniques seem weaker and less effective and even sometimes inappropriate when they get into the community space.

It is because of this dilemma that more thoughtful health professionals have begun to think more carefully about the meaning of the social space called a community. They have attempted to better understand how their profession can be more effective and which tools are needed to work in the



community space. The most obvious finding of many of these new professionals is best summarized by Mark Twain's maxim that if your only tool is a hammer, all problems look like nails. And if your only tools are based upon medical models and medical systems, the community then must be a nail if we are to be effective. However, one can quickly recognize with even the slightest reflection that the community is not a nail. It is instead, like a system, a tool that is as distinctive and as useful as the medical system is a tool.

In order to understand these distinctive tools called "health system" and the "community", we need to look at the design, capacities and appropriate use of each of them. Just as we could readily distinguish the different shape and use of a hammer and a saw, it is possible to examine the distinctive shape and usefulness of a medical or health system and a community.

Looking first at the tool we create called a system--its design and shape is well known. A system is best exemplified by the well known organization chart that is a pyramid of boxes connected by lines of authority and responsibility. This pictograph of our medical and health systems should clarify the nature of the tool professionals use and of which they are also a part. This system tool is primarily designed to allow a few people to control many other people. Did you ever see one of these upside down? That would be a structure for many people to control a few. But we always have it this way, because its basic purpose--go to your graduate school of management and ask them--is to provide a mechanism for a few to control many. It enables a manager or administrator to design and assure a standard output from the work of diverse professionals and workers. Therefore, it is clearly a tool designed to control and to produce standardized practices and outcomes. We can usually understand the nature of this system tool most clearly when we think about the production of an automobile. Here a pyramidal system is used to translate from the minds of a few designers and administrators to the hands of thousands of technicians and workers, a uniformly, repetitive commodity called a Chevrolet. The auto company is a system designed to control in order to assure uniform quality. This is also the essential nature of the tool we use and call a medical or health system.

While systems are tools for creating control and uniform repetitive quality, they also depend upon a third element of social organization: a consumer or a client. The frequent use of the words consumer and client is a product of modern system development and proliferation. It has only been in the last 25 years that a previously unknown label was created by medical systems. The first half of my life this phrase never existed. Health consumer. It appeared about 35 years ago for the first time. Our grandparents could not imagine such a new being, because they thought health was a condition, not a commodity. However, our new powerful systems have both needed and created a class of

people called consumers and clients. Therefore, we can recognize that the tool we use called a system is designed to control people, to produce uniform goods and services of quality, and to expand the number of people who act as consumers and clients.

Now, what kind of a tool is the community? It is obviously not a nail to be hammered by the health or medical systems, however, we must be somewhat arbitrary in our answer because there is no widely accepted definition of the design and shape of the out there-ness often called community. If you want to have a fascinating adventure, go to your sociology departments and sit down with the faculty and ask them to give you a definition of the community. You will never leave. So, we have to be rather arbitrary in the definitional work around community. Something beyond out there-ness, but something more specific than that word. There is one very useful definition of the community that focuses on a uniquely American social tool. And this tool was first described and analyzed by a brilliant young Frenchman named Alexis de Tocqueville. In his monumental work titled Democracy in America, de Tocqueville observed that Americans had created a new local social tool. It was a self generated gathering of common people who assumed the power to decide what was the problem. To decide how to solve the problem and then to take the power to act to carry out their own solution. This powerful new tool, he called, named for us, an association and its members were not people, they were citizens.

This is my effort to represent de Tocqueville's notion of the central social tool, newly developed in this country. Not common to Europe at all. And that is the self-defined, non-appointed and non-elected gathering of citizens taking power to decide what is a problem, how it will be solved and then acting together to solve the problem. Alexis de Tocqueville saw that the principle American tool for creating the new society was the self-appointed, self-defining, assemblies of citizens. He recognized that they were, in their local aggregate, the new community of the new world. Through a universe of citizens associated he saw the creation of citizen power that led to a powerful new form of democracy in America.

In his trip across North America, in cities, in towns, in rural areas and on the frontier he saw that the work of society was being done by associations. And, that in their aggregate, they were mutually supportive. They were strengthening each other. People were in several of them and they had a communication system that was very effective. He said this is the great empowerment tool of these new communities. He had come from Europe where decisions were made by nobility, by bureaucracy, by professions, by doctors and lawyers and engineers and professors. And when he arrived here, what he found were localities where decisions were made instead by Tom, Dick and



Mary, aggregated in associations and interconnected in an associational network of locality. He called the people that participated in them citizens, not people or individuals, because citizens is a political term.

It is also interesting to note why he called the book Democracy in America. The reason is--and this is pretty insightful for a 22 year old who was writing this book about us after a year's tour--he said that in England and France, they said they were a democracy, but democracy meant to them the power to vote. He observed that voting is a weak power, albeit necessary, because it is power to give your power away. When you vote, you are in essence giving your power to someone. But, he said, that does not create power. That does not really empower people. And, so, he said, what I am seeing in American communities where associations are doing so much of the work, involving every common person, is the creation of a much more powerful democracy different from ours. So, he named the book, Democracy in America because he saw our communities of association as giving the people the power to make power and to take power rather than to delegate and give it away.

We have just completed a four year study of local initiatives across American cities to increase the economic social and political power of local people in neighborhoods. We found that these type of associations were a major vehicle with which those communities were growing in new ways and becoming healthy again. It was finding this map and not the map of the boxes.

If we examine the nature of our current community of associations, we will see that they are tools of a special shape, design and use. First, associations are structures that depend on the active consent of people. Unlike a system, the associational structure is not designed to control people. Systems ultimately depend upon people blending their uniqueness to a professional vision in exchange for money and security. Associations depend upon the consent of free individuals to join and equally express their creative and common visions.

Second, associations provide a context where care can be expressed. This contrasts with a system where standardized outcomes are the principle expression. Thus, at a gathering of an association of citizens, we see a social form that depends on consent, creativity and manifest care. These elements in their unique combination by citizens create a social tool that is distinct from systems and with capacities different than those possessed by systems. Systems cannot produce care. Care is the consenting relationship, deeply personal between people freely chosen.

Medicare does not care, and cannot care. And as we try to tinker with the goal of 'care', we will faint, because care cannot be produced, managed, or manufactured. Care comes from the social space where people by consent, commit themselves to each other, and that is what the essence of



associational communal space is about. And as that space atrophies care will diminish and in its place service will grow. There is a dynamic relationship between those two ideas. You cannot mandate care. I cannot say to you, "Care for her." I can say to you, "Serve her." The president of our university would like to be able to say to the faculty, "I want you to care for those students," because the surveys of our students, in most big university surveys, say that the faculty does not care for them. But what he can say is educate them. Because education is a product, but care is a condition and a relationship. And we have, I think, misled ourselves in tragic ways by our constant pursuit through systems of the production of care.

I was recently at a national conference of people concerned about youth and the problems of youth. They have come to the end of the line. They cannot figure out anymore youth programs that systems can do that will turn around the behavior and commitments of the young people about whom they are concerned. And so somebody finally stood up and said that until communities care again about and for young people, all our efforts will fail. So it is absolutely critical that we can distinguish between care and service.

Thirdly, associations require citizens rather than clients or consumers. Citizen is a political term. It describes the most powerful person in a democracy. And association is a tool designed to magnify the power of citizens by illuminating and aggregating their unique capacities to solve problems. This contrasts with a system tool that creates and magnifies clients. The Greek root of the word client is "one who is controlled." A client is one who is controlled. This is, of course, the opposite of a citizen who is one who holds the maximum possible power in our form of government.

A community of associations, then, is a social tool that is designed to operate through consent, combining the creative uniqueness of the participants into a more powerful form of expression. Put simply, the unique American community is an assembly of associations that is the vital center of our democracy, the manifestation of our creativity and the vehicle to which our capacity to solve everyday problems is manifested.

Now, the reason that this idea about community is so important in terms of health status is that when you look at the work of our epidemiologists, and try to identify what they suggest to us in a modernized society are the major determinants of health status that are manipulable, that is, non-genetic, there are five basic determinants of health status. Let me remind you of what they are. The first is the behavior of individuals: how much we eat, what we eat, how much we exercise, and what we smoke. All of those have a lot to do with our health status, that is, how long we live and how often we will be ill. The second is our social relations, that is, how we are related in our work, our



neighborhood and our home to each other. I recently saw an interesting study of entry level physicians, asking them to indicate in terms of various sets of demographic types of patients. There were thirty different sets. What they thought were the major causes of illness in their patients, in this particular group, coming to them. Eighty percent of all responses had to do with social relations. Not germs, virus, bacteria or even accidents, but it was their relationships with each other that they identified as the most frequent cause of the use of their office. A third, is the physical environment. Obviously, our health status is related to what kinds of particulates are in the air. What kinds of chemicals are in our food. What kinds of cars we drive. Physical environment is a major determinant. The fourth major determinant of health status is our economic status, which may be a surrogate for the other three. But, certainly, I know from being in an urban research center, that we need no more research that will demonstrate that the quickest way to get sick is to get poor. The best way not to live long is to be poor economically in a modernized society. So, economic status is a major determinant.

And, then finally, access to information on therapy. Now, I know of no recognized epidemiologist who would suggest to us that the fifth determinant is the most significant one in terms of health status. In fact, some great epidemiologists would tell you that the first four are so much more clearly the determinants of health status that we should not even put the fifth on the list. Now think about the tools available to change the variables that determine health status. Think about the medical health system tools. What is the pill that will stop domestic violence. What is the syringe that will deal with American obesity. Look at the second. What is the doctor's advice or tool that will deal with the tensions in marriages, the frustrations in work places or unhealthy behavior in neighborhoods. Let us look at the third. What is it that a hospital can do about the pollution in the air. What is it that a nurse can do about the automobile's design. Let us look at the fourth. Where in the medical system would you go to deal with the poverty and slums on the west side of Chicago. Incidentally, I almost know how not to deal with it. I have been in Chicago for 45 years and when I was a young man there was a modest little medical center on the west side with some good neighborhoods spreading out to the west of it. Today, the medical center is the emerald city. It looks like the Wizard of Oz has created it. Magnificent and opulent, but the west side is a tragic place to live. So, our investment certainly did not do anything about the fourth. And it may be we invested in the wrong thing.

The point is clear, it is not that if you wanted a tool that would change the four major determinants of health status, you would be unscientific if you invested in resources for a medical and

health system. That would be unscientific. You would instead say, what do we know about changing individual behavior and somebody would say, well what we do know is that the most effective means of dealing with a lot of individual behavior problems, having to do with obesity and addictions, is group relationships and associations. We know that social relations are about, and the result of the political and social organization of community. We know that the change of physical environments that make us unhealthy are political questions that grow out of effective and knowledgeable groups acting to do something about the pollution in the air. And we know that economic status is determined again by the nature of a community's commitment to all of its people and their access to resources.

So, de Tocqueville's map is a map of the space and structure that is the major determinant and tool of dealing with health status in our time. So, if your only tool is a medical system, you have a very limited possibility if you are focusing only on the first four.

The vital associational center of America has been weakened since de Tocqueville's observations of American social structure in 1831. Today, the power of American associations and community is less visible and less respected. The reason for the apparent decline of our community of associations, however, is not very obvious to most of us, even though it has been clearly defined by such brilliant social analysts as Ivan Illich in Medical Nemesis, Jacques Ellul in The Technological Society and Robert Bellah in Habits of the Heart. Their work demonstrates that the weakening of the tools of association and community is the direct result of the increasing power of the tools of systems. Indeed, they suggest to us a paradox, or a zero sum game. Their finding is that as the power of system tools grow, the power of community tools decline. As control magnifies, consent fades. As standardization is implemented, creativity is diminished and consent fades. As consumers and clients multiply, citizens lose power.

If you have spent as much time as we do in low income urban neighborhoods, you can almost see that the poorest, most impotent, most exploited are neighborhoods where people have finally come to believe that what they are is a client. The systems have been effective with the little person there. And once people believe that they are only clients, the power of community to deal with the major determinants of health status will be gone.

The implications of this analysis, of course, are profound. For if our health tool is a system, we can only achieve a particular and limited set of goals. We cannot perform the necessary functions and achieve the goals of the tools of the community. And yet it is critical to health promotion and prevention that most of the work be done in and by communities.



Some modern health professionals recognizing this necessity have begun to design complex programs said to interface with, involve or use the community. And as noble as their intentions may be, I think they have failed to recognize the historical evidence demonstrating that as systems grow in capacity, influence and power, communities and associations lose capacity, influence and power. As systems outreach, communities contract. As systems invade, associations retreat.

As we enter the era that seeks healthy communities, we are therefore faced with four tough realities. First, systems and communities are different tools and they are designed to do different work. Second, systems can never replace the work of communities. Third, system growth and outreach can diminish and erode the power of the community's tools and fourth, when systems growth erodes community associations then the system itself, becomes a major cause of community weakness and disempowerment contributing to the creation of a local environment for ill health, unwellness and dis-ease. Put simply, powerful pervasive systems can create unhealthy communities by replacing consent with control and active citizens with compliant clients.

It is fascinating, as one in a center where we have tried to see how local people empower themselves to see how the word compliance has risen in the vocabulary of the health professions. The communities struggle to gain power while the system tries to gain compliance--two great ideas about conflicting roles. In the face of these hard realities there are no easy tricks or technical gimmicks that health professionals can use to overcome either the limits or the potential counter-productivity of the medical systems tools.

There are, however, some very hopeful experiments and initiatives in which health professionals and their powers have enhanced the strength of communities and their associations. Our research shows that these cooperative initiatives suggest that they reflect at least four values when you see system relations with community associations in ways that do not overwhelm or co-op, but support.

Those values are, first, that supportive professionals have a deep respect for the wisdom of citizens in associations. These professionals do not speak of training or paying citizens or associations to do the work of systems. Rather, they seem to recognize that they are fellow citizens and they have only one vote to cast in association with all of their fellow citizens. While they are not a part of the community, they walk with the community in its journey, but they are neither making the path nor leading the group.

Second, community building professionals often have useful healthful information for local folks and their associations. They share that information in understandable forms. For example, they prepare a map that shows where the neighborhood auto accidents occurred last year. They then asked

local citizens in their associations whether they know why the accidents occurred and what the local citizens associations might be able to do about the problems that are revealed by their analysis. They are not the source of the analysis, nor are they the source of the solutions. They are the source of the information that is not easily known by local citizens. They provide information that mobilizes the power of local citizen associations to develop and implement the solutions.

Third, they use their capacity, skills, contacts and resources to strengthen the power of local associations. They are listening for opportunities to enhance local leadership, strengthen local associations and magnify community commitments. We recently had a wonderful opportunity to spend some time with the Director of Public Health in Flint, Michigan, where a public health office has been engaged in trying to understand the associational base of this community and how might we support and relate to its ability to solve the problems that we can. They are not trying to gain space, influence, credit, or resources for their system. Instead, they are asking how the system's resources might enhance the problem solving capacities of local groups.

Finally, the new community building health professionals are escaping the ideology of the medical model. For all its utility, the medical model always carries with it a hidden assumption and it is negative. That assumption is that what is important about a person is their injury, their disease, their deficiency, their problem, their need and their empty half. We usually think that the way to approach a space called community is to do a needs survey--to count up the local emptiness. And when we are done, we map a local community and this is the way the map looks.

So, that if you had a gathering of service professionals from across fields, and you asked them to give you a map of community, this is the map you would get. It is a map of needs and of emptiness. And, it is, of course, a map that excludes the part of a person that is able, gifted, skilled, capable and full. That is not the focus of the medical model, but that was the focus and is the focus of the associations that de Tocqueville defined as the central tool for empowerment and problem solving in the local community.

Communities are built upon the capacities of people who are also deficient and needy, but never built on the basis of their needs. Nevertheless, our research is rarely focused on capacities, gifts and assets, and instead, is focused on deficiencies and needs. Why? Because systems need needs. Communities have no need for needs. In the lower income neighborhoods of Chicago where I have worked most of my life, there is nobody who needs to be told that there is a lot of bad housing around here. However, if you go downtown to the planning department and housing department you will find a fair number of people who are paid full time to count up how much bad housing there is. And, in



fact, if you look at most data, most research, and most literature on housing, there are counts of bad housing. So that it makes very clear, I think, who needs needs. Medical systems need needs. Planning departments need needs. Human services need needs. Schools need needs. But, communities need to identify and mobilize the capacities of local people to define, act, and solve problems. So, the very basic resource of associations is capacities and assets and the resource of systems is deficiencies and needs. We have just published a book called Building Communities From the Inside Out -- A Guide to Identifying and Mapping the Capacities and Assets of Local Communities. It has a section on hospitals and how they have supported community associations.

Let me remind you then, that communities are built by one leg of the carpenters. The community needs the good leg. Medical systems are built on the missing leg. It for this reason that community health professionals inevitably find that they must invert the medical model and focus on capacities rather than needs and deficiencies. Initiatives that enhance healthy associative communities are necessarily built upon the identification and expression of the gifts, skills, capacities and associations of citizens. Incidentally, in the book there is a guide to doing an inventory of neighborhood associations which was recently done in one neighborhood in Chicago where in one month they found 930 associations. So, it is the hidden infrastructure of America. Something you can never see from a system looking down, but you can identify from the community looking up. Community building professionals are not interested in how many girls are parents too soon. Rather, they are interested in what these same girls can contribute to the community. How are these girls connected to local associations to express their gifts. What existing groups will give them a new source of power and identity? What can I and the resources of my medical system do to join the effort to answer these questions without overwhelming or coopting local citizens, their associations and their efforts?

It is clear that in order to build a healthful society we do need two tools. One is a system and the other is a community. But neither can substitute for the other, and it is now clear that systems can displace communities, but they can also enhance them. To enhance community health we need a new breed of health professionals and their primary characteristic will be modesty. They will be people with a deep respect for the integrity and wisdom of citizens and their associations. They will understand the kinds of information that will enable citizens to design and solve problems. They will direct some system resources to enhancing associational powers and above all, they will focus upon magnifying the gifts, capacities, and assets of local citizens and their associations as they solve the problems that create the environments that make people so unhealthful.

Health is not an input. Health is not a commodity. Health cannot be produced. Health cannot be consumed. Health is a condition. Health is a byproduct of strong communities. Health is the unintended side effect of citizens acting powerfully in association to control their environment. And without that citizen power and associative relationships we will be reduced to a nation of clients and impotent consumers, feeling the unhealthful dis-ease from the manipulation of our lives as our lives are managed and controlled by systems. Alexis de Tocqueville had it right in 1831. He saw a vital, creative, vigorous, lively, inventive, and healthful people. He understood that was because they were neither slaves nor were they clients. They were neither serfs, nor were they consumers. Instead, they were citizens and that fact was the source of their help and their newly invented healthful communities. Alexis de Tocqueville thought he was a reporter, but he was also a prophet who understood that the basic source of health is powerful citizens and vigorous associations. He named that health--that condition as democracy.

Let me just conclude by saying two things. The first is that de Tocqueville was accompanied by a friend who was mainly coming to look at slavery and who wrote and analyzed and shared in the dialogue with de Tocqueville. One of the hopeful things that both of them observed was that among Afro-Americans, in spite of all the efforts that had been instituted to break up their power, they had created their own community associations, primarily churches, which was the one associative space that was allowed. They saw that the hope of the people resided in associations within slavery as well, and they wrote about that in 1932.

The second thing has to do with free enterprise. There is a wonderful book that I would recommend; it upsets my students more than any other book I ever assign. If you like to upset students you might assign it. It is called, No Contest and it is a book written by a professor of social psychology, his name is Alfie Kohn. He has been gathering data from research reports, I think all his life, and this book is the summary of what he has collected. The basic point that he is making is that we have evolved into a society where on a cultural continuum of modernized societies, we are the extremist society on one dimension. It is the commitment to individualism as against the group. He begins the second chapter showing some comparative international studies where they are trying to take samples of the population and gain a sense of their commitment to the group as against themselves, the individual and we are way off the scale on that one. Now, the question is how did we get that way. Culturally we are the most disabled society in terms of our ability today to replicate the powerful associational commitments that America was built on, because of our extreme cultural identification with individualism. I do not think this is about capitalism. I think it is about all



systems. The subhead of Kohn's book is, The Case Against The Competition, and he says competition is the belief that for me to win, you must lose. That is what competition means. For me to win, you must lose. It is the idea that 'in ascendance' makes the individual striving over all others the ultimate value. And so, he would say, it is our commitment not to capitalism but to competition at all costs that brings the ascendance of the individual and the decline of our ability to work associatively. Therefore the professional system begins to fill in more and more live space.

The trouble with that is obvious and that is it will not work. And, it is not working. Most of our social problems, today, I think, are the manifestation of the fact that our powerful professionalized systems cannot fix us. How many more youth programs do you think we will have to fund before young people will become, once again, productive and committed people to our society? How many more police will you have to have in Austin before you will begin to feel safe? Is it four times more? Ten times more? Would even a police state make you safe? How many more doctors until our life expectancy finally will jump three years? Do you understand what we are facing? We are facing the fact that professionalized service has reached the boundaries of efficacy and that the real critical issue is the one we have been talking about here today. That is, how do citizens once again, take within their hands the power to solve local problems?

And to distinguish myself from the newtonians in Washington, let me suggest to you that the problem is not government, we are going to find that out quickly. Government is just one system and not the most powerful. The human service systems are much more powerful and much more in their aggregate disabling of community capacity. So, when we knock over government, we are going to find out that we have found the enemy and it is not the government, it is us.