A review of the evidence on health inequities and community cohesion with recommendations for strengthening the health assets approach.

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On behalf of Public Health Wales

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Prepared for Public Health Wales

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Summary and Recommendations

- The traditionally accepted model of health is based on deficits and malfunction, so we talk of health in terms of illness rather than wellness and we talk of communities in terms of needs and problems rather than of capabilities and resources. An assets-based approach focuses on the resources that people and communities employ to remain well and to bounce back from adversity.
- Understanding assets-based approaches to health begins with the social-ecological model of health, which views health as within personal, community, environmental and economic systems which are nested and interconnected. The individual's health and wellbeing is influenced by these systems, and they in turn may have an influence upon them. In other words, sustainably improving population health requires making changes in the physical, social and economic circumstances of people's lives, not merely altering individual behaviours.
- The role for professionals and government in delivering health through an assets-based approach remains vital but differs from that which we are used to. In an assets model, professionals and communities work together to 'co-produce' health, while the role of all levels of government is to enable and monitor, supporting the process, ensuring that the voices of communities are heard, and acted upon, by policy-makers and that success is shared and celebrated. Seen in this way, we can surmise that health is not only the business of the health professions, but is a shared endeavour involving all professionals and all citizens.
- The aim of public health policy in an assets model is to develop a resilient and cohesive community, by helping to build social capital which at once bonds the community, binds it with others and empowers it to have influence on local and national decision processes. This may be achieved by ensuring that communities have access to the skills and knowledge needed to assess their strengths and develop their capacity to adapt. For some, these tools already exist within the community, but for others, including the most disadvantaged, it will be necessary to nurture them through leadership and community development.
- Although there are small scale examples from across the globe of how these approaches to health development have changed people's lives and increased wellbeing, there is insufficient evidence of changes in health outcomes, whether seen in deficit terms (as mortality and morbidity), or asset terms (as changes in social capital and wellbeing). Government has a role in an assets model of developing and publishing the evidence base to ensure and enable good practice across the country and across the world.
- There is widespread interest in assets models and the Welsh Government has the opportunity to be internationally prominent in developing and disseminating these ideas by building on existing partnerships with other countries and developing new ones.

Recommendations

- Health assets approaches have the potential to begin to address inequities in health and improve the health of the population of Wales. A high level commitment to an assets approach to public health will be needed if it is to be successful, such a commitment should include expressed support and involvement from broad spectrum of representatives at local

and national level and across disciplinary boundaries. Reiteration of the importance of the social determinants of health and their role in addressing inequities should be accompanied by wider discussion of the salutogenic framework among policy-makers across Wales.

- The Welsh Government should work with Public Health Wales and local authorities to identify approaches to building social capital through community leadership and development. The appropriate skills are already available within PHW, local government and the voluntary sector in Wales, they require nurturing and developing. Efforts should be made to ensure that they are available and accessible to those working in and with communities.
- The Welsh Government should initiate an on-going programme to measure, monitor and publish levels and changes in social capital and wellbeing across the country.
- A programme of research involving Public Health practitioners and academic partners, taking broad approach to evidence, should be commissioned. It would require generating learning from participatory action research and qualitative work as well as social surveys and controlled research. Additionally, an overarching evaluation, utilising measures of wellbeing as well as more traditional outcome measures would add enormously to the public health evidence base and should be commissioned.
- The Welsh Government should work closely with other administrations in the UK, in Europe and across the world on the development of the assets approach. The model of action in Scotland is of particular interest, but activity in England and in other countries should be utilised to help increase the knowledge base.

Background

The origins of good health and wellbeing are complex. The health promotion glossary defines health as a positive concept and a resource for everyday life, rather than the object of living. It emphasises social and personal resources as well as physical capabilities (Nutbeam, 1998). Public health policy successfully concentrated on the protection from infectious disease, before moving on to an emphasis on reducing long term illness through interventions and information to help to change behaviour, however success in the latter has been greater among more affluent groups, so that despite the overall improvement in health, inequities have also increased. Some authors have criticised the concentration on interventions to change behaviour, arguing that health harming behaviours like smoking, poor nutrition and a sedentary lifestyle are not simply the result of evidence informed choices, but are embedded in the understanding of social norms and practices and the circumstances of people's daily lives, influenced by their past experiences (Singh-Manoux and Marmot, 2005; Angus et al., 2007; Spencer, 2007).

Lindström and Eriksson (2010) see health protection and prevention as analogous to protecting swimmers in a swift flowing river by a barrier or a lifebelt, whereas a more sustainable approach is to improve swimming ability, which they conclude is like health promotion. Health promotion is a process of enabling people to exert greater control over the determinants of health. It includes actions directed at strengthening the skills and capabilities of individuals, and action directed towards changing the social determinants of health so as to alleviate their impact on public and individual health (Nutbeam, 1998).

The Ottawa Charter for health promotion identifies three basic strategies: advocacy to create the essential conditions for health; enabling people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. Within the Charter, five priority areas for action are defined (WHO, 1986):

- Building healthy public policy
- Creating supportive environments for health
- Strengthening community action for health
- Developing personal skills, and
- Re-orienting health services

These strategies focus not on illness, but on the capacity of individuals and communities to maintain health by employing the resources they are able to access. This perspective has strong links to a number of related discourses which cross disciplinary boundaries. Shirani (2011) examines the links between a number of related theoretical concepts discussed in relation to health improvement and addressing inequities in health. These include community development and organising, resilience, social capital, social coherence and empowerment. All of these concepts are encompassed within the assets approach, which is now becoming accepted as an alternative strategy for public health, especially in addressing inequities (Ashton, 2010; Foot and Hopkins, 2010; Foot, 2012)

The Marmot Review for the Department of Health in England concluded that challenging health inequities effectively required work at a local level which involved and included those people most affected by disadvantage (Marmot, 2010). The assets approach is one way to achieve participation in governance and empowerment, and to shift the public health focus to the resources and capacity

of communities to work with professionals to improve local health and wellbeing. Kretzmann and McKnight (1993) contend that deficit-based approaches, although they highlight the need for action can also have negative effects, forcing community leaders to focus on their communities' worst side in order to attract resources (Sharp et al., 2000). The assets approach, while having a good deal of support among experts (Ashton, 2010; Burns, 2010; Foot and Hopkins, 2010) is supported by little detailed outcome research. Most of the evaluative work is in the form of case studies of small scale implementations with quantitative and epidemiological evidence slow to emerge. Much of the evidence considered in this paper draws on theoretical foundations of the assets approach and examines available case studies. The paper will also offer recommendations for policy development and for further research priorities.

Introduction: the origins of the assets approach

The foundations of an Assets approach are in the notion of health as a resource for everyday life (Nutbeam, 1998) and in the understanding of health as a complex, social-ecological system (McLeroy et al., 1988; Brofenbrenner, 1994). The social ecological model of health places the individual at the centre of nested, embedded and interconnected systems which exert influences on his or her health and wellbeing and which he or she may influence. Barton and Grant build on the model developed by Dahlgren and Whitehead (1991) to incorporate the global perspective, emphasising the imperative of sustainability and climate change in emerging discourses around health issues.

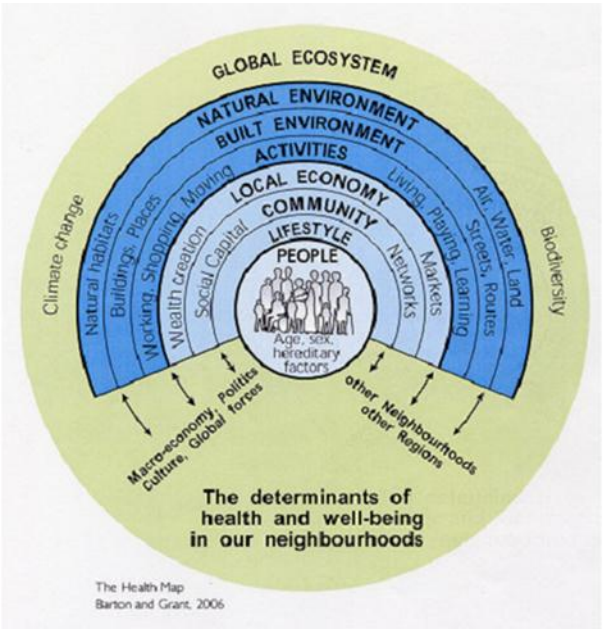

Figure 1: A health map (Barton and Grant, 2006)

Within the social ecological system, the assets approach explores the detail of the interaction between the nested system levels, questioning about how the capabilities and characteristics of individuals and communities might contribute to the interactions that take place. This model also emphasises that actions to improve health need not focus on individual behaviour, but can be targeted at other societal, economic and environmental systems to yield improvements in health status.

For individuals and communities, the ability to draw on resources is crucial, however access (whether to income, environment or health care) is unequal. Marmot et al. (2008) called for equalisation of access to power and wealth as a step to equity. Echoing the call for a re-balancing of access to resources or assets, Scambler (2007) identifies six categories of assets that are salient to health and wellbeing and which in part mirror the determinants of health:

- *Biological assets* – people in poverty mat have poorer access to health care and are more likely to have babies of low birthweight, making them more susceptible to chronic illness, perhaps due to poor maternal nutrition.
- *Psychological assets* – vulnerability to adverse life events is more common among people who live on low or irregular incomes and have poor housing.
- *Social assets* – people who participate in social activity and have strong personal relationships are more likely to be healthy.
- *Cultural assets* – are gained through socialising agents such as education and faith and have benefits through the lifecourse in terms of material and personal security.
- *Spatial assets* – people are, in part reliant on their environment as a source of health. Industrialisation (or deindustrialisation) can have an impact on physical health and wellbeing.
- *Material assets* – absolute and relative economic wellbeing have both been associated strongly with physical and mental wellbeing.

To an extent, assets may interact, reinforce or be substituted for one another, so that as Antonovsky (1987) found, psychological assets of resilience and a sense of life as a coherent whole could to an extent compensate for a lack of material or spatial resources.

Referring to the increasing inequities in health outcomes and the failure of successive governments of the UK and Scotland to successfully address the social determinants of health, in a speech at the founding of the Assets Alliance for Scotland, Dr Harry Burns, the Scottish Chief medical officer told delegates that *'what we have tried to date (although well meaning) has not worked'* (quoted in Friedli, 2012). Acknowledging the same failure on a global scale, the WHO report (Marmot et al., 2008) on the social determinants called for action in three areas: improving daily living conditions, equalising access to resources and power and diligence in research and monitoring acknowledging that models of health focused only on disease will fail to address the health status of the most disadvantaged in society.

Whitehead has identified four potential approaches to reducing inequities in health: strengthening individuals or communities, improving living and working conditions and creating healthy public policy at the macro level (Whitehead, 2007). Researchers in Scotland have theorised that increasing inequities have complex causes but it is likely that the mortality rates have risen as a result of changing conditions among the social determinants of health: increased social and economic inequality, deindustrialisation and a breakdown of community structures being a consequence of UK government policies in the 1980s (McCartney et al., 2011). Similar conclusions have also been reached about the experience of the South Wales Valley communities. The closure of the pits and steelworks represented not only a decline in the local economy, but a cultural crisis (Bennett et al., 2000). They argue that a range of social networks and activities were grounded in the workplace and in the trades unions, but also had wider importance in the life of the local community, these

were undermined by industrial decline. There was, and remains, a deep sense of loss in mining and steelmaking communities which had relied on these industries for their existence for many decades (Elliott et al., 2010; Shepherd, 2010).

In Scotland and in parts of England (Ashton, 2010; Burns, 2010; Foot and Hopkins, 2010; Foot, 2012), public health authorities are now turning to models of public health which emphasise the importance of developing individual and community resources as a bulwark against powerful pressures on wellbeing from the determinants of health. Whereas the traditional 'deficit' approach identifies problems, needs and deficiencies and attempts to compensate with services provided for communities, assets approaches work by identifying the physical, psychological and social resources that individuals and communities have access to and aiming to help them to seek, identify and find solutions to their problems(Foot and Hopkins, 2010). By seeing people in communities as part of the solution and empowering individuals and communities to increase control over their futures, it is argued that they can create sustainable local solutions to local problems.

Influential with President Obama and a leader in this field is the Chicago based Assets Based Community Development Institute (ABCD) (Kretzman and McKnight, 1993). From an ABCD perspective, an issue critical to building successful communities is how local people, with their supporters shift from consumer to producer roles. In both the United States, as here in the UK, 'participation' or 'collaboration' has often meant that agency or government remain in control of how services are delivered, with tokenistic user or citizen involvement (Peck et al., 2002; Shepherd, 2005; Ashton, 2010). In ABCD, the agency or government remains a stakeholder and is an essential partner, but has a supportive or facilitative role, in the co-production of local services. This co-production process (Stephens et al., 2008; Pestoff, 2009) represents an alternative approach to delivering public services where professionals work genuinely with those they serve, sharing governance and provision of services with those who use them: as it has been put *'professionals should be on tap, not on top!'* (Ashton, 2003).

The emergence of co-production as a salient notion in public services suggests that to date governments have perpetuated a failed model which is professional led and professional focused, despite the consistent acknowledgement of the importance of service user involvement. The consumer model of public services – where professional systems deliver services to passive clients – neglects a central issue of provision: that the role played by those in receipt end is at least as important as that played by the professional in achieving desired outcomes (Nelson et al., 2011).

The premise of co-production is that that people's needs are better met when they are work with professionals in an equal and reciprocal way to support themselves and their community. It is a radical approach to public services that is built around six characteristics:

- Recognising people as assets;
- Building on people's capabilities;
- Promoting mutuality and reciprocity;
- Developing peer support networks
- Breaking down barriers between professionals and users;
- Facilitating rather than delivering; (NESTA, 2012)

While these approaches have been advocated for many years, particularly in health promotion and among community development professionals (Ewles et al., 2001; Anderson et al., 2006; Cropper et al., 2007), the deeply entrenched paternalism in delivery of services predominant within the public sector, represents a major barrier to would amount to a paradigmatic shift in thinking and acting for service providers and commissioners. Politicians too may be concerned about the potential for failure and the possibility of 'inefficient' use of resources. They might also feel threatened by active and empowered citizens providing alternative leadership to their own communities (Ashton, 2010).

Search Strategy

Initially, searches were undertaken of 8 databases likely to yield previous systematic work in this area (EPPI Centre, Health Evidence Canada, Cochrane Collaboration, Campbell Collaboration, TRIP Database, PubMed, Centre for Reviews and Dissemination, WHO Publications and NICE), using search terms based on 'health assets', 'salutogenesis', 'community health development', 'social capital', 'community cohesion' and 'resilience'.

Further searches of 'Google Scholar' used the same search terms and added peer reviewed and 'grey literature relevant to the study. In addition to electronic searches (and in the end more important in identifying appropriate texts), hand searching of reference lists both added to the relevant literature and broadened the scope of the review.

Scans of titles and abstracts from the initial searches confirmed the absence of a significant number of systematic reviews or empirical papers based on controlled research and the preponderance of theoretical papers, policy documents and descriptive case studies.

The review is based on a synthesis of the relevant literature and the development from that literature, of an emerging model for public health practice in Wales.

Health Assets Approach

- A health assets approach takes a positive view of health, concentrating on wellness rather than illness and draws on the theory of salutogenesis;
- is participatory, requiring the involvement and participation of citizens and service users as co-producers of health;
- is multi-disciplinary, requiring the involvement of professionals from across public services;
- is oriented to action and change in the social determinants of health, seeking to build community resources to improve health.

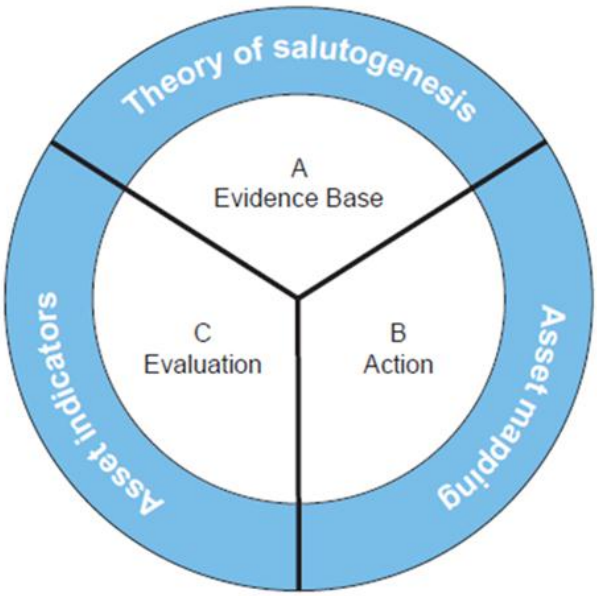

Figure 2: An assets-based approach to public health (Morgan et al., 2010)

Health assets or resources

A health asset can be defined as any or resource, characteristic or factor which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. Scambler's (2007) classification of assets categories provides a helpful beginning although it requires transformation into tools for data gathering. Assets accentuate positive ability, capability and capacity to identify problems and activate solutions, which promote the self-esteem of individuals and communities leading to less reliance on professional services.

In 'Building Communities from the Inside Out' (Kretzman and McKnight, 1993), the emphasis is placed on turning issues from negative 'problems' into positive 'opportunities'. Similarly, Whitehead's (2007)options for addressing inequities refer to 'strengthening' individuals and communities. Within both of these, we can see that change in the social determinants and in inequities might be achieved through approaches which offer a positive approach. There is evidence that the structural characteristics of disadvantaged neighbourhoods, including social networks and the levels of community organisation can moderate impact of disadvantage, while the role of institutions such as human services and opportunities for participation in community life are also important. (Harrop et al., 2005).

For community development professionals, the underlying values of the assets approach will be very familiar. Community development is a process which aims to build effective and influential communities. It values social justice and equality. Community development involves intensive work with communities and individuals to identify their strengths, needs, rights and responsibilities, to plan and take action and to evaluate the outcome of actions. Communities, according to Kretzman and McKnight (1993) are built primarily from the inside, but with help and support from the outside. Morgan and Ziglio's (2007) model draws substantially on this approach, advocating an assessment and utilisation of community assets at a micro level to bolster health and promote wellbeing. It involves changing the relationship between citizens and people who are in positions of power to enable ordinary people to establish and maintain control over their lives (Gilchrist, 2009).

Morgan and Ziglio (2007) argue that public health policy has focused on the failure of communities and individuals to avoid illness, rather than on their potential for health improvement or wellbeing. In proposing a new approach to public health, they draw on Antonovsky's ground-breaking work (Antonovsky, 1987; Lindström and Eriksson, 2006) on salutogenic models to as the theoretical basis for a new approach to community health and wellbeing. In doing so, they take a crucial step away from currently dominant approaches to public health. The foundation of this is an approach to health as 'a resource for everyday life' (Nutbeam, 1998), a profoundly different view to the norm among policy-makers and one which represents a paradigmatic shift in thinking for policy-makers and people alike, breaking the hold of the health care system on health issues (Hunter, 2010).

Before explaining how such a model might be operationalized, it is important to discuss some of the key concepts on which the approach rests.

Salutogenesis

Salutogenesis is central to the assets model. It is a term, derived from the Latin for health (salus) and the Greek for origin (genesis), first used by the American medical sociologist Aaron Antonovsky , who contrasted the dominant approach to understanding health in terms of deficits or disease (Morgan and Ziglio, 2007) with a positive approach that focuses on the 'health end' of a health-disease spectrum including attempting to explain how people continue to flourish in adverse conditions. Antonovsky speculated that people employ what he termed 'generalized resistance resources' (GRR) to maintain and develop their health (Suominen and Lindström, 2008).

> *"With the salutogenic model, the concern is with full and active adaptation to environments that are plagued by stress. To adapt, people look for those inputs from the social (e.g., social support) and physical environments (e.g., clean water) as well as from their own personal reserves (e.g., personal optimism)."* (Korotkov, 1998 p. 54)

Similar notions of adaptation to stressful environments are now becoming a central discourse among climate change scientists (Folke et al., 2003; Nelson et al., 2007). Adaptation can be seen as a stream of activities, actions, decisions and attitudes about all aspects of life that reflect existing and changing social norms and practices. The capacity to adapt to change is related to access to resources such as knowledge, skills, institutions, social capital and the capacity for social learning (Nelson et al., 2007). Antonovsky was interested in exploring the role of stressors on health, noting that stresses occur everywhere, but that not everyone is affected in the same ways. As part of his research, he found that Jewish women who had survived the concentration camps employed psychological resources and beliefs to maintain their health in the face of the overwhelming stresses of their lives (Lindström and Eriksson, 2006). He wrote that *"The stimuli bombarding one from the inner and outer environments were perceived as information rather than as noise"* (Antonovsky, 1996 p.15) suggesting that they were used to generate learning and adaptation. He termed the ability to make sense of and understand the external world as a "sense of coherence"(SOC) which he defined as:

> *"a generalized orientation toward the world which perceives it, on a continuum, as comprehensible, manageable and meaningful. The strength of one's SOC, I proposed, was a significant factor in facilitating the movement toward health."* (Antonovsky, 1996 p. 15)

The SOC has been extensively used throughout the world (Lindström and Eriksson, 2010) and found to be positively related to healthy patterns of behaviour in a range of social groups (Wainwright et al., 2007; Binkowska-Bury and Januszewicz, 2010; Stigsdotter et al., 2010; Mattila et al., 2011).

SOC has also been used at a community level as a measure of wellness (Eriksson et al., 2007), but this begs the question of how we can bridge between the fundamentally individual way in which salutogenesis is articulated and the collective focus of the notion of assets for health? More than a description of the personal, salutogenesis is a way of thinking, an approach to health which can be thought of at a number of levels from the individual to the global. As Korotkov (1998)says people look for inputs (or GRR) from the social and the environment, as well as from personal resources, so that it is important to look at how people participate in the construction of shared resources, that is those related to groups or to place, as means of coping with stresses and making sense of the world. From other research (Harrop et al., 2005), there is evidence that characteristics of location and the availability of professional support are resources that can help entire communities.

Resilience

The connections made between salutogenesis and adaptation link it also to resilience, indeed resilience is one of a number of overlapping concepts cited by authors in discourses related to salutogenesis (Almedon, 2005; Lindström and Eriksson, 2010; Shirani, 2011). Others mentioned include hardiness, self-efficacy, flourishing, connectedness, adaptation and empowerment. Lindström and Eriksson (2010) place them all under a salutogenic umbrella, a high level concept, a way of thinking which brings together ideas.

Theories of resilience have much in common with salutogenesis (Taylor, 2004) and Antonovsky argued that the successful management of stress relied on the application of internal and external tools which he termed 'generalised resistance resources ' (GRR) (Antonovsky, 1987). Resilience is a term that is used across many fields, including engineering and environmental studies as well as in the social sciences. It can be understood as the capacity for a system to successfully adapt and maintain functioning or competence despite pervasive or severe adversity (Stewart et al., 1997; Adger, 2000). Evidence suggests that adaptation occurs through complex and continuous processes of person-environment interaction, which in turn suggests the importance of considering context and meaning in studies of the process (Harrop et al., 2005).

At community level, there has been significant recent work on the development and fostering of resilient communities. Both Dynes (2005)and Aldrich (2011) cite the notion of social capital as central to community level resilience in the case of natural disasters. The Young Foundation (Sellick et al., 2010) stresses the importance of strong networks and 'bonding' social capital in respect of community resilience and coping in social economic adversity (The Young Foundation, 2009), although they also caution that social capital of this type which enhances resilience within the group may also reduce the capacity or aspiration to change through what they term 'passive resilience' (The Young Foundation, 2009). By contrast, 'bridging social capital' which they refer to as 'adaptive resilience', encourages the formation of heterogeneous networks and can enable people to employ social supports in the absence of material supports (Sellick et al., 2010).

Resilience is a dynamic process which can be fostered though education, the family and social capital within the community (Berkes and Jolly, 2001). It is highly influenced by protective factors, which

include competencies, skills and abilities that the individual or community can access from within or from their social and physical environment (Dyer and McGuinness, 1996; Luthar et al., 2000; The Young Foundation, 2009). Crona and Bodin (2010) also highlight the importance of power asymmetries as a potential barrier to the development of resilient communities which can be compromised or enabled by institutional and structural power which can act to shape and limit the desires and expectations of the disempowered (Crona & Bodin 2010)

The capacity to resist and adapt to system disturbances is governed by availability of, and the ability to access resources such as knowledge, institutions and networks, social capital and the capacity to learn (Nelson et al., 2007). The Egan Review (2004) for the UK Government identified the components of sustainable and flourishing community, emphasising involvement in community life, access to services and inclusion. Marmot (2008) recognized reducing power inequities as central to addressing inequality. Folke and colleagues (2003)see promoting resilience as a vital component in maintaining socio-economic systems at times of crisis and identify 'social memory' as embodied within social and human capital as a resource for building adaptive capacity, so that resilience at community level can be related to social cohesion, which requires active development and social learning. (Adger et al 2005).

It is also a quality central to the sense of coherence and salutogenic thinking. Antonovsky's concept of creating health through supporting individuals to understand and manage their social environment seems an important mechanism for reducing stress and increasing resilience at a personal and a community level.

Social capital

Social capital represents an important theoretical model for understanding community resilience as the characteristics of resilient communities incorporate core dimensions of social capital: such as the centrality of networks and social relationships (connections for groups to work collaboratively) and norms of trust and reciprocity (essential for networks and collaboration to exist) (Shirani, 2011).

The role of community organisers working within communities in generating social capital may be one approach to building resources for health (Shirani, 2011). In community development, the aim is to support the construction of resources which can both enable or improve access to services and develop social relationships which sustainably support them. In his book 'Bowling Alone', Robert Putnam charted the decline of community life in America over 30 years and assessed its importance (Putnam, 2001) and thus generated a view that supporting and building new resources for bringing people together could benefit communities. This 'social capital', which according to Putnam, refers to the features of social organization including networks, norms, and trust which, facilitate coordination and cooperation for mutual benefit. Social capital can contribute considerably to the well-being of an area and enables the kind of social networking that has been shown as vital to maintaining good health (Holt-Lunstad et al., 2010). Dale and Newman link the creation of social capital through community development to community level resilience (Dale and Newman, 2006).

Putnam recognized that high levels of social capital were linked with engagement in public issues, mutual trust and lawfulness, though like the Young Foundation, he emphasised that both the 'bonding' capital that came from good social networks within a community and the 'bridging' capital

that enabled connections to wider society were necessary for positive change (Putnam, 2001; The Young Foundation, 2009).

According to Islam (Islam et al., 2006)bonding relationships are the primary means for the transmission of behavioural norms within social networks. Bonding social capital is important for establishing and promoting healthy behaviour, controlling anti-social behaviour and for generating individual level support to protect vulnerable people. However the strength of bonds can also have a 'darker side', promoting insularity or normalising health-harming behaviours (Volker and Flap, 2001; Borlatti and Foster, 2003).

Bridging social capital on the other hand is more outward facing, making important connections to wider civil society and creating resilience at community level (Dale and Newman, 2006). Furthermore, it may be a source of other benefits for individuals, communities, and societies, offering people opportunities for participation in groups of people from diverse backgrounds. Volker and Flap (2001) found that the absence of bridging ties in East German communities greatly reduced the ability to work across different groups and to generate impact within hierarchical power structures. These communities were strongly connected internally, but lacked access to outside networks which might extend their reach and build pressure on power structures.

A third form, 'linking' social capital alluded to in Volker and Flap's work (2001) works within social hierarchies, presenting opportunities to voice concerns and contribute to social change. Few studies have explicitly measured or tested the bridging or linking forms of social capital and its relationship to health (Islam et al., 2006) although both Dynes (2005) and Aldrich (2011) have studied the impact of both bridging and bonding forms on communities in the aftermath of disaster and other research has shown a beneficial impact on mental health (Mitchell and LaGory, 2002).

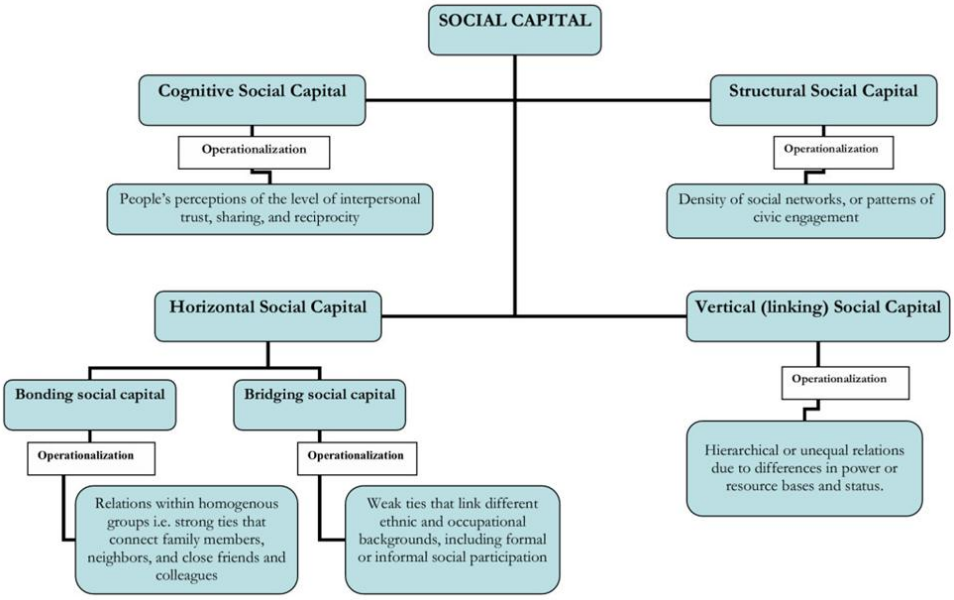

Figure 3: Forms of Social Capital (Islam et al., 2006)

Islam et al (2006) chart the forms of social capital, extending and clarifying the links and functions (see Figure 3). They theorise a divide between formally constituted (structural) forms of social capital including civic engagement and the density of social networks and 'cognitive forms' including

trust, sharing and reciprocity. At another level, they conceptualise 'bonding' and 'bridging' forms as horizontal social capital, occurring within communities, while adding the notion of vertical or 'linking' social capital, as a form which connects local groups to powerful interests. Some authors have identified the failure to take account of power inequities, the absence of linking social capital and the access it might give to political and governance systems as a significant barrier to building strong and resilience communities (Navarro, 2002; Crona and Bodin, 2010).

An explanation of how social capital might be constructed and function is offered by Bourdieu, for whom social capital is built through social interaction, rooted in the social structure (Bourdieu, 1986). He offers a more critical view, noting the importance of networks and shared experiences that buttress privilege and forcing consideration of not only the existence of social networks in the community, its resources and individuals' abilities to make use of them, but also the unequal access that individuals and neighbourhoods have to social capital resources (Shepherd, 2010). Social capital is seen as a product of individual involvement, which changes relationships, into lasting obligations for example feelings of gratitude, respect and friendship enabling individuals to substitute social for economic resources (Bourdieu, 1986). Such a functional approach is also taken by Coleman (1988) who defines social capital as a variety of different entities sharing two characteristics: some aspect of social structure; facilitating certain actions of individuals who are within the structure (Coleman, 1988).

Modern approaches to measuring social capital draw on social surveys (Onyx and Bullen, 2000), observation of key indicators such as meetings with friends, network membership and civic participation (Isham and Kähkönen, 1999; Krishna and Uphoff, 1999; Fiorillo and Sabatini, 2011) or more specific approaches designed for individual studies (Crowther et al., 2008). Crowther et al (2008) adopt a structured interview technique that focuses on developing relationships, problem solving, interaction with authorities and social interaction with people from different backgrounds. The World Bank has developed two assessment tools (The World Bank, 2012), while most helpful perhaps is the the Office for National Statistics who have recently released a review of measurements of social capital (Foxton and Jones, 2011).

Five dimensions of social capital form the basis of this work:

- civic participation
- social networks and support
- social participation
- reciprocity and trust
- views about the area

These dimensions have been used by ONS to formulate a set of questions for use in gathering data on core elements of social capital.

Community cohesion

The notion of community cohesion is closely linked to social capital, indeed some authors (Stafford et al., 2004)define it in very much the same terms, relating to networks and interactions. However community or social cohesion has emerged over the last few years as an issue of interest, partly as a result of perceived breakdowns in the relationships between groups in society which have led to urban unrest rooted in ethnic or racial differences. According to David Cameron, society is

fragmented (or 'broken'), without the obligations and sense of responsibility that brings people together (Finlayson, 2010). A similar, if distinct argument is made from the soft left who argue that the atomisation of society results from a range of pathologies though which trust has been replaced by self-interest, social activity by consumerism (Finlayson, 2010). What right and left agree on is that society is less cohesive than it has been in the past, an idea that appears to be resonant with politicians and the public.

The origins of the search for a shared sense of belonging and core can be seen in communitarian texts and discussion of commonality in difference (Etzioni, 1996; McGhee, 2005; Robinson, 2005), however it was thrown into focus by concern resulting from divisions between ethnic communities in several northern English towns in 2001, which exploded into civil unrest (Worley, 2005), the discourse has since widened to encompass other issues while maintaining a presumption of the need for a shared narrative of citizenship. Research for the previous UK government (Department for Communities and Local Government, 2007) suggests that the public recognise community cohesion as a multi-faceted concept which concerns encouraging positive relationships and meaningful interaction between diverse groups.

Government reports following the disturbances talked of polarisation and 'parallel lives', highlighting the separation of the white and Asian communities in the areas affected (Cantle, 2001), while another strand of discourse blames the impact of neoliberal economics and the decline of heavy industry (Bennett et al., 2000; Forrest and Kearns, 2001; McCartney et al., 2011). Subsequent to the disturbances in 2001, policy options searched for a way to achieve positive relationships between communities although running the risk of problematizing certain places and groups who express values at odds with the dominant moral order (Robinson, 2005; Blake et al., 2008). Another way to look at this might be in terms of the predominance of bonding social capital over bridging or linking social capital. The importance here of linking social capital might be analysed as an allegiance to a narrative of meaningful citizenship in which people, regardless of background feel they have a stake in national identity by virtue of shared values, collective interests and inclusion, what Fieldhouse calls a *'common national identity based on common values and symbols'* (Fieldhouse, 2008 p. 22).

Buck and colleagues (2002) offer an analysis of social cohesion, identifying three dimensions: social inequality, social connectedness and social order. Other writers (Forrest and Kearns, 2001; Turok et al., 2006 see table below) have discussed the concept in the same way, with classifications tending to include elements of shared values, inequities and attachment to people and places.

Domain	Description
Common values and a civic culture	Common aims and objectives; common moral principles and codes of behaviour; support for political institutions and participation in politics
Social order and social control	Absence of general conflict and threats to the existing order; absence of incivility; effective informal social control; tolerance; respect for difference; intergroup co-operation
Social solidarity and reductions in wealth disparities	Harmonious economic and social development and common standards; redistribution of public finances and of opportunities; equal access to services and welfare benefits; ready acknowledgement of social obligations and willingness to assist others
Social networks and social capital	High degree of social interaction within communities and families; civic engagement and associational activity; easy resolution of collective action problems

Place attachment and identity	Strong attachment to place; intertwining of personal and place identity

Though expressed positively by the authors, their analyses are in the context of why cities in particular(or nation-states) appear to be experiencing a disintegration of social ties problematizes this trend and the implication for policy makers is that these are descriptions of what might be lacking in communities (Morrow, 1999). One way to understand the social cohesion might be to see it as in a reciprocal relationship to the three forms of social capital, perhaps as an outcome of social capital formation.

Operationalising an Assets-based approach

Building an assets-based approach to public health means a commitment to building skills, or re-building skills within communities which have been subject to deindustrialisation, disempowerment, and deeply ingrained inter-generational health and social problems. These can also be communities where there are strong families and close social networks, which retain a sense of place and commitment to place. It will be necessary to promote and foster people's assets and capacities for health and wellbeing. Health assets include people's aspirations and sense of control and social and community factors.

It also means embedding a salutogenic approach to health within public policy. Morgan and Ziglio (2007) have pointed out that approaches to the promotion of population health have been based on a deficit model. That is, they tend to focus on identifying the problems and needs of populations. The organisational response to these problems is to provide professional resources and interventions which produce high levels of dependence on hospital and welfare services. We do things to people rather than doing things with them. We reinforce their dependency and encourage passivity in the face of problems.

These deficit models are important and necessary to identify levels of needs and priorities. But they need to be complemented by some other approaches as they have many adverse consequences. Deficit models tend to define communities and individuals in negative terms, disregarding what is positive. Deficit approaches miss opportunities to allow individuals and communities to react positively to the problems they encounter. Instead of taking control, they are encouraged to remain passive as others try to do things for them.

In contrast, asset models tend to accentuate positive capability within individuals and support them to identify problems and activate their own solutions to problems which they themselves identify. They focus on promoting health generating resources that promote the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services. In effect, by concentrating on the strengths of individuals and communities, their sense of control over their lives is enhanced and they experience less of the chronic stress which leads to a range of health consequences.

Morgan, Davies and Ziglio (2010) have developed this argument into one which may offer a more concerted approach to tackling health inequities. They suggest that by developing the stock of key assets necessary for promoting health within individuals and communities it should be possible to rebalance assets and deficit models for improving their health. By developing assets which support

health in individuals and communities rather than by doing things *to* them, thereby undermining a sense of control and self-esteem, it may be more likely that a positive attitude to health and wellbeing would be enabled. Failing to develop the assets which allow people and communities to be resilient in the face of the stressors which can damage their health may well be one factor which has limited the effectiveness of many well intentioned health improvement programmes in the past. Turning to policies that offer demonstrable openness from government at all levels; alongside policies which actively develop community capability might then enhance wellbeing and ultimately improve health status.

Asset based health improvement in action

There are many examples of interventions which have been successful in improving wellbeing but which have, usually inadvertently, done so through involving and empowering local people and developing assets, rather that filling perceived deficits. Most of these are small scale, which are acknowledged as successful but not replicated widely (Ewles et al., 2001; Anderson et al., 2006; Cropper et al., 2007). Broader programmes like Health Action Zones(Judge and Bauld, 2006) and Sure Start (Reading, 2006; Hutchings et al., 2007) have had mixed success which has been put down to the complexity of addressing health inequities (Judge and Bauld, 2006) however the learning from such early attempts may be that the need is for bottom up action, rather than top down policy. The role for government then is to enable, rather than specify activity. Achieving this, within constrained budgets and without the kind of control that often accompanies national strategies is a significant challenge for government, but there are approaches that may make it possible.

'Normalising' the salutogenic model

The construction of health in terms of deficits is deeply ingrained, particularly in policy terms and with professionals from all disciplines. A public health policy based on the assets model requires recognition of the evidence base and a reorientation to positive views of health across public service and within civil society (Glasgow Centre for Population Health, 2011).

Many commentators now agree that a new approach to delivering public services is needed to address deep seated, long-standing and increasing inequities (Marmot, 2010; Christie, 2011). Like Burns (Burns, 2010) these experts agree that it is time for change and refer to the importance of building on people's strengths and involving them in decision-making and governance to a far greater extent than before.

The deficit model of health is not only relevant to health care and public health, it is evident throughout government and at all levels and it is the default position for most people. On the positive side, there is a widespread recognition that deficit models are themselves problematic and that new approaches to mental health (Jacobson, 2001) and disability (Harry and Klingner, 2007)as well as public health (Burns, 2010; Foot, 2012)which emphasise assets, abilities and resources are becoming more influential. Marmot et al (2008) conclude that action on the social determinants of health requires change in the training and practice of professionals, including inclusion of social determinants of health in the curricula of health practitioners (and we might add other public servants). In addition, orienting policy makers and other stakeholders to health, rather than health care, is essential.

Assessing Assets

Assets can be described as the collective resources which individuals and communities have at their disposal, which protect against poor health and promote better health. These assets might be social, cultural, financial, physical, environmental, or psychological and may be located within the individual, the neighbourhood or shared across many communities (Glasgow Centre for Population Health, 2011).

Everyone has health assets, but they are not necessarily used purposefully or mindfully, however they can be brought to bear on challenging situations by individual or group action to (Rotegård et al., 2010).

Asset mapping is central to the approach, it is a process of building an inventory of the strengths and resources of people and places before deciding on ways forward. Asset mapping estimates the resource level for the entire community in terms of the physical (parks, community centres, shops, etc) and personal assets (experience, knowledge, passion), rather than identifying problems to be addressed. It highlights connections between people, between people and organisations and between the assets themselves. In itself, it can have a positive impact by promoting a positive view of the community and the people who live there (Glasgow Centre for Population Health, 2011).

Foot and Hopkins (2010) list types of health assets as including:

- the practical skills, capacity and knowledge of local residents;
- the passions and interests of local people that give the energy to change;
- the networks and connections in a community;
- the effectiveness of local community and voluntary associations;
- the resources of public, private and third sector organisations that are available to support a community;
- the physical and economic resources of a place that enhance wellbeing.

Assessments of health assets need to be locally driven and focus on the experience of life for people who live in the community. Achieving an inventory might use a range of participatory approaches which will offer access to people. Approaches such as action research (Minkler, 2000; Cropper et al., 2007), appreciative inquiry (Cowling, 2004; Cooperrider and Whitney, 2005), participatory appraisal (Chambers, 1994) and qualitative GIS (Wridt, 2010) might be used. These approaches connect building an assets map to action for change in health status, they help individuals and communities to gain confidence, build linking social capital and a stronger voice with which to engage with hierarchies and they might also identify where resources such as educational opportunities or transport are needed to help tackle the structural causes of health inequities (Glasgow Centre for Population Health, 2011).

Nelson et al (2011) propose that asset mapping should include professionals and policy-makers as their capacities and knowledge represents an important resources for the community. They also point out that high level buy-in from institutions such as the local council and health administrations is an essential part of building an assets approach and can open the door to ‘whole system’ buy-in, which would include broad based support for and involvement in the approach (Nelson et al., 2011)

Acting on the assessment

An asset based approach is community led, long term, open ended and has less certain, measurable or predictable outcomes, which are likely to take time to emerge. This approach is not 'one size fits all', it is a bottom up way of working, with each community recognising and combining their assets and defining their ambitions in a very local way. Key aspects of the process such as values, tools and working practices may be shared, but outcomes may still vary from place to place. Bottom up working requires careful negotiation on an individual basis when working with communities and the building of trust with and between community members (Glasgow Centre for Population Health, 2011).

In designing actions, it will be important to distinguish between change that can be led by or involve family, friends and social networks, those that will be best met through cooperation and co-production with services, and those that can only be delivered through mainstream services. This will not happen without support from local and national government; it will need to be enabled, perhaps commissioned. Assets based approaches may help to address inequities, but are unlikely to lead to significant change on their own. They will need to be embedded alongside traditional health promotion practices (with which they are compatible) but if the necessary shift in thinking takes place, chances of successful change will be improved.

Involvement in planning and decision-making as well as in providing services fits within the action research approach. Participatory action research (Minkler, 2000; Baum et al., 2006)is a ground-up process of planning, action and reflection which embeds action within a particular context and aims to empower participants to create change and increase control over their lives. Participatory action research (Minkler, 2000) engages communities in action to benefit their health and build capacity for problem solving, it is based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health (Baum et al., 2006). It is not so much a research method as an orientation which recognises co-learning and mutual respect between partners. Community members are involved in the process from start to finish, and have a major role in the governance and direction of the process (Minkler and Wallerstein, 2008). It shares with the assets-based approach a participatory approach and social learning about health and change and represents an approach involving co-learning between professionals and citizens, as well as co-production of health or other valued community outcomes.

Central to the process is the resulting empowerment and the potential for a clash between central decision-making (at local government level for example) and local community action. A mobilised and empowered community will not necessarily choose to act on the same issue that health services or local councils see as the priorities (Foot and Hopkins, 2010). However, this tendency towards dissent and animosity may be mitigated or managed through high level champions within the centralised hierarchy (Sánchez et al., 2011). A critical issue in community based action research is trust, which has to be earned by professionals working with communities (Lantz et al., 2006). Professional staff and services have to be willing and open to sharing power rather than doing things to or for people, they have to help a community do things for itself. However, struggling communities cannot be expected to achieve change on their own and the reframed role of the professional remains crucial (Glasgow Centre for Population Health, 2011).

Measuring outcomes

The evaluation of assets approaches may be problematic for policy-makers used to particular indicators of success. Central to assets based approaches are collaboration across agencies and the participation of citizens as co-producers of health. In systematic reviews assessing the contribution of these to change in health status, little evidence of change as measured in terms of mortality and morbidity have been found, in other words according to a deficit approach (Evans et al., 2010; Hayes et al., 2011). As Marmot concludes, the hierarchy of evidence which dominates biomedical research is inappropriate for work focused on the social determinants of health (Marmot et al., 2008). An assets model should lead to reformulation of indicators to ensure that they changes in access to health resources and sense of coherence as well as changes in health status. A role for the Welsh Government in developing an assets-based approach might include leading the agreement on definitions and understandings of key assets and related concepts, such as connectedness, sense of purpose, social capital, community cohesion and community empowerment, to ensure consistency across the evidence base and allow transferability of research findings and approaches (Glasgow Centre for Population Health, 2011).

Given the importance of participatory research approaches and context, it is perhaps not surprising that there is no controlled research which shows the impact of an assets-based approach on health and wellbeing outcomes. Taking up Marmot's (2008) point, adopting a social-ecological approach means that we should initially view outcomes not in terms of changes in the incidence of disease, but as changes manifested in improvements in the social determinants such as: the quality of the community environment; in the quantity and quality of social engagement; in employment or in access to social networks as health outcomes. Such approaches might be seen through measures of wellbeing (such as sense of coherence (Antonovsky, 1987)). Such work is already in evidence within organisations such as ONS and the new economics foundation (Office for National Statistics, 2008; Stoll et al., 2012).

There are already many case studies of how the approach has been successfully implemented and which include supportive comments from those who have been involved. In Wales, the seven SHARP projects (Cropper et al., 2007) developed a community focused approach to health improvement, using action research to ensure the participation of local residents in both the health improvement process and the accompanying research. This evidence, sponsored by the Welsh Government is available to draw on, as are case studies from across the UK and around the world.

Conclusions and recommendations

Health assets or resources represent a way to assess and address inequities in health status through local action. The assets model of health begins with a reconceptualization of health from a focus on disease and deficits to a focus on wellbeing and assets or resources. This salutogenic approach moves health promotion away from traditional public health, toward broader conceptions of community, sustainability and social action.

Adopting an assets-based approach requires re-thinking not only health, but the approach to the evaluation of health improvement activity. To ensure that such an approach is leading to positive change, we need to revise the language we use in assessing and reporting success to emphasise the

resources and strengths of communities, rather than recording their levels of morbidity and mortality.

The assets model draws significantly from community development, focussing on developing self-efficacy and social capital within communities in disadvantage. Bonding, bridging and linking social capital all have an importance to wellbeing, while the outcome of efforts to build social capital may be increases in inclusion and social cohesion in local communities. It is essential that efforts are made to monitor the growth of all forms of social capital and the wellbeing of individuals and the community to ensure the continued development of community cohesion at the local level.

- Health assets approaches have the potential to begin to address inequities in health and improve the health of the population of Wales. A high level commitment is needed to an assets approach to public health will be needed if it is to be successful, such a commitment should include expressed support and involvement from broad spectrum of representatives at local and national level and across disciplinary boundaries. Reiteration of the importance of the social determinants of health and their role in addressing inequities should be accompanied by wider discussion of the salutogenic framework among policy-makers across Wales.
- The Welsh Government should work with Public Health Wales and local authorities to identify approaches to building social capital through community leadership and development. The appropriate skills are already available within PHW, local government and the voluntary sector in Wales, they require nurturing and developing. Efforts should be made to ensure that they are available and accessible to those working in and with communities.
- The Welsh Government should initiate an on-going programme to measure, monitor and publish levels and changes in social capital and wellbeing across the country.
- A programme of research involving Public Health practitioners and academic partners, taking broad approach to evidence, should be commissioned. It would require generating learning from participatory action research and qualitative work as well as social surveys and controlled research. Additionally, an overarching evaluation, utilising measures of wellbeing as well as more traditional outcome measures would add enormously to the public health evidence base and should be commissioned.
- The Welsh Government should work closely with other administrations in the UK, in Europe and across the world on the development of the assets approach. The model of action in Scotland is of particular interest, but activity in England and in other countries should be utilised to help increase the knowledge base.

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Appendix: Potential Contribution of Public Health Wales to Developing a Health Assets Based Programme

The WHO Health 2020 draft framework 1 recognises the need for effective strategies to reduce the health divide in times of economic constraints on government action. The framework advocates joint investment between health and other sectors, and highlights approaches aimed at improving resilience, cohesion and assets for wellbeing. This will involve promoting community strengths that protect and promote health and setting year on year targets for reducing health inequalities. The WHO paper also mentions the importance of sustainable funding measures. Community cohesion projects which rely on short-term funding tend to suffer from lack of continuity and the negative effect this can have on staff and potential beneficiaries.

Public Health Wales already has links with the WHO European Office for Investment for Health and Development, and these links could be helpful in planning a programme aimed at reducing health inequities by strengthening health assets. As discussed in the literature review, Scotland is attempting to address the failure to make progress in reducing health inequalities by exploring the potential of the health assets approach and it would be beneficial for Wales to make links with this work.

All work on health assets and community cohesion should link in with the Sustainable Communities Pathfinder project and with the collaboration with Sir Michael Marmot's Institute of Health Equity.

The Public Health Wales workforce has theoretical and practical experience of the health assets approach in disadvantaged communities, so could advise on training, initiation and evaluation. The Observatory is involved in discussions regarding the measurement of wellbeing, which should be considered in the evaluation of a health assets/community cohesion approach.

Public Health Wales can contribute to the development and evaluation of a health assets approach by:

1. Developing proposals for a Sustainable Communities Pathfinder project
2. Furthering links with the WHO European Office for Health and Development
3. Initiating links and working with those in Scotland who are developing a health assets approach
4. Working with Sir Michael Marmot's Institute of Health Equity.
5. Collaborating in the planning and evaluation of a health assets/ community cohesion programme
6. Involvement in the training of lay and professional participants in the programme.

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