

**Title: Putting the public (back) into public health - leadership, evidence and action**

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Figure 1: The family of community-centred approaches for health and wellbeing, Public Health England & NHS England, 2015. This image is made available through the Open Government Licence (<http://www.nationalarchives.gov.uk/doc/open-government-licence/>) which is a non-exclusive licence.

## **Abstract**

There is a strong evidence-based rationale for community capacity building and community empowerment as part of a strategic response to reduce health inequalities. Within the current UK policy context, there are calls for increased public engagement in prevention and local decision-making in order to give people greater control over the conditions that determine health. With reference to the challenges and opportunities within the English public health system, this essay seeks to open debate about what is required to mainstream community-centred approaches and ensure that the public is central to public health. The essay sets out the case for a reorientation of public health practice in order to build impactful action with communities at scale leading to a reduction in the health gap. National frameworks that support local practice are described. Four areas of challenge that could potentially drive an implementation gap are discussed: (i) achieving integration and scale (ii) effective community mobilisation (iii) evidencing impact and (iv) achieving a shift in power. The essay concludes with a call to action for developing a contemporary public health practice that is rooted in communities and offers local leadership to strengthen local assets, increase community control and reduce health inequalities.

**Key words** community engagement; health inequalities; empowerment; policy; public health practice

## Introduction

In 2002, Heller and colleagues argued that the public should be put back into public health, advocating extending beyond a population orientation (the health of the public) to include engagement of the public in partnership with professionals(1). More than a decade on this challenge, which goes beyond narrow forms of consultation on professionally determined topics, has still not been met. In 2010, the Marmot strategic review of health inequalities in England gave emphasis to 'creating the conditions for people to take control over their lives' within a strategic response to reducing health inequalities(2). This paper examines why participatory approaches can no longer remain peripheral to actions on the key health challenges in England today.

While we have been experiencing continuous improvements in life expectancy, these improvements have slowed in pace and the health inequality gap remains (3,4). Male life expectancy is now 79.5 years compared with 70.8 years in 1980-82(3), but the gap between those in the most affluent decile of the population and most deprived decile now stands at 9.2 years(5). Furthermore, the gap in healthy life expectancy (years lived with self-reported good health) between the top and bottom deciles is much greater with gaps of 19 years for men and 20.2 years for women. There have been many contributions to the improvement in health over previous decades including the quality of healthcare and actions on key risk factors such as smoking. Changes to important determinants such as educational attainment, housing and income are also likely to have been contributory factors(2). But inequalities have persisted and there are ever greater pressures on the health system from an ageing population with growing number of years lived in poor health(6). This has been recognised in the NHS Five Year Forward View for England(7,) which highlights the necessity for prevention, public health and community empowerment. Devolution and democratic renewal are now key themes in the public health response to inequalities, with calls for increased citizen influence on decision making and allocation of resources(8).

The strategic direction towards greater community empowerment requires a reorientation of public health programmes to move beyond the rhetoric of 'community' to impactful action at scale. Critical analysis of participation levels suggests this has to go beyond narrow forms of engagement or consultation, towards the higher levels of empowerment(9). Public Health England uses the term 'community-centred' to describe prevention approaches that involve active participation, build on local assets, address inequalities and increase individual and community control(10). This essay opens the debate about mainstreaming these approaches in public health - what it means, what the challenges are and what infrastructure and leadership are needed.

### **Why community-centred public health and why now?**

A broad consensus on the importance of communities and community-level determinants for population health and wellbeing exists(2, 11, 12). England's National Institute for Health and Care Excellence (NICE) now provides a strong mandate for community engagement, which is viewed as encompassing a range of approaches to involve and empower communities within local efforts to improve health and wellbeing and reduce health inequalities(13). In the past, adoption of community empowerment interventions has been undermined by perceptions of a relatively weak evidence base(14), alongside the various cultural, political and organisational barriers to forming and sustaining equal partnerships with communities(15). The current impetus for change, to 'put the public back into public health', reflects an ambition to rebalance public health towards greater recognition of community assets(16) and having a stronger evidence base on the effectiveness of community engagement (13, 17).

The evidence base on protective factors that support good health and buffer against risks, many of these operating at a community-level, is growing. Systematic review evidence shows the importance of social relationships and the detrimental health effects of social isolation and lack of social

support(18,19). Morgan and Ziglio(16) argue that public health should be moving away from a deficit-based model, focused exclusively on needs and unhealthy behaviours, towards a focus on health assets. This involves mobilisation of collective resources within communities that protect health and can support prevention efforts, such as individuals' knowledge, skills and commitment, social networks, informal support systems and environmental assets. More recently, Crisp and colleagues set out a manifesto for a health creating society built on a society-wide approach where community mobilisation is valued as a means to build healthy, thriving communities(20).

Justifications for a community orientation in public health rest on an understanding that community control and connectedness are major determinants of health, yet can be eroded through poor social and economic conditions(2,11). The heterogeneity of communities, the importance of social context and power imbalances driven by socio-economic differences should be acknowledged. Participatory methods promote health equity by increasing individual and collective control, reducing social exclusion and facilitating collaborative action to address the conditions that drive poor health(21). Additionally, the active involvement of those most affected by health inequalities can improve the reach of interventions and remove barriers for marginalised groups(22), thereby countering any 'inverse prevention law'(23).

In summary, there is an evidence-based rationale for adopting community-centred solutions within a strategic approach to reduce health inequalities. An extensive range of approaches can be used to translate theory into practice(10, 24), and there is a body of knowledge on community engagement barriers and facilitators(15, 25). However, evidence alone is rarely sufficient to achieve change, and this essay now considers what is needed to mainstream community-centred approaches within a 'whole-of-government, whole-of-society' approach to health (12,26). In this essay, we reflect on opportunities and challenges in the context of the public health system in England, because this is a point in time where many actors within that system are attempting to move this agenda forward.

## **A national framework for practice**

As the national agency for public health in England, PHE is uniquely positioned to provide leadership and contribute to an infrastructure that supports more engaged, empowered and socially connected communities. In setting out national health priorities, PHE highlighted 'the importance of place and the strength of building on all of a community's assets' as an underpinning theme (27:14). In 2015, PHE and NHS England published a guide to community centred approaches for health and wellbeing(10). This summarises the case for greater community empowerment and the vital roles that local government, NHS and third sector organisations can play. The guide offers a framework for public health leaders, planners and practitioners to navigate the multiple ways of working with communities and access relevant evidence. A family of community-centred approaches is presented (Figure 1) with interventions grouped across four strands:

- Strengthening communities - approaches that build community capacity to take action on health and the social determinants of health
- Volunteer/peer roles – approaches that enhance individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- Collaborations and partnerships - approaches that involve partnership working with communities to design and/or deliver services and programmes
- Access to community resources - approaches that connect people to community resources, information and social activities (10).

Recent NICE guidance incorporates the guide as a framework for selecting community engagement approaches(13). The best outcomes are most likely to occur when action is taken across all four strands as part of a whole system, place-based approach to improving health and reducing health inequalities.

The guide sits alongside other national and regional initiatives that are building capacity in the public health system to use community-centred approaches. These include the PHE National Conversations initiative supporting public dialogue on inequalities(28), the national mental health workforce development framework with competencies around working with communities(29), and collaborations that focus on tackling regional and local health inequalities(8). These frameworks complement the portfolio of PHE products to support local action on health inequalities across the six domains of the Marmot review (Supplementary file A). In 2016, an alliance of national bodies involved in health and social care, including PHE, published a shared commitment and call to action for community capacity building at scale(30).

### **Implementation and impact – what are the challenges?**

So far this paper has argued that there is a solid national platform to build evidence-based action with communities. Perhaps for the first time, there is alignment of intersectoral commitment, evidence and practical models. We are poised on the brink, looking forward to a public health system more oriented to communities and part of a movement to build a health creating society(20). But there are risks that this ambition will falter and we will fail to make the necessary shifts in practice. In a systematic review of participatory approaches by UK public health units 1974-2007 (31), Evans and colleagues concluded that there was a gap between policy rhetoric, which was broadly positive in that period, and practice, where there was limited evidence of uptake and impact as reported in peer reviewed publications. If community-centred approaches are to achieve broad impact, then there needs to be debate about overcoming factors that could drive an implementation gap. In seeking to open up that debate, four areas of challenge are now examined, which we consider priority areas for action: integration and scale, enabling people to get involved, evidencing impact and achieving a shift in power.



### *Integration and scale*

The first challenge is how to mainstream community-centred approaches at sufficient scale to achieve impact. This requires broadening out from engaging communities as a means of improving intervention delivery, to a systems orientation where community-centred approaches underpin all areas of public health. In the US, the value of a systems approach to community-based prevention is well established(32) and an upstream focus on community conditions and effective coalition building are critical elements(33). In England, the move of public health to local government has provided the impetus for some areas to adopt whole system, place-based approaches to health improvement with community action at the core (Table I). The ambition is that community empowerment becomes integral to local public health practice, with implementation across the four strands of the family of community-centred approaches(10). Strengthening communities is an integral part of a 'Health in all Policies (HiAP)' approach, which promotes building community capacity to enable informed community participation and engagement with decision-making(26,34). HiAP is both a 'whole- of-society' and 'whole-of-government' approach and assessing the impact that potential policies across sectors have on the empowerment of communities, as well as their social connectedness, inclusion and sense of belonging, is vital to mainstreaming.

What is proposed here is a reorientation of public health practice and this can be in conflict with more traditional, top-down approaches(35). It vital that public health action remains rooted in communities and shaped by communities. Evidence points to the long-term, relational nature of change(25, 32), which may be at odds with short-term policy cycles. Public health leadership is needed to advocate for ongoing investment focused on local priorities and building community capacity. Defined interventions are, of course, needed to pilot innovation or to focus efforts, however an upstream approach will also be about creating good places to meet or a volunteering

infrastructure to support pro-civic action(36). Table 1 provides some examples that illustrate a reorientation towards community-centred public health at scale using transferable approaches.

### *Enabling people to get involved*

A whole-of-society approach to health requires effective strategies for community mobilisation(12). Experience from the UK indicates that given the right opportunities, members of the public prove to be interested stakeholders in public health. Methodologies such as participatory budgeting(37) have seen significant numbers participating in local government priority setting around health. Many volunteers already contribute to community wellbeing(38); for example, in 2013 there were estimated to be 10,000 volunteer health walk leaders in England(39). There is scope for expanding opportunities for the public to contribute to public health; however, the challenge is to ensure that inequalities are not widened and that professionals are prepared to give away power. Multiple barriers and facilitators may influence community engagement(25) and the effects of social exclusion can be powerful even when opportunities to participate are presented(40). Working towards greater community empowerment cannot therefore be seen as a quick technical fix, but as a long term process bringing greater critical awareness of power dynamics within communities and between communities and statutory services. The public health role is to consider health equity issues and actively mitigate barriers to participation for groups at risk of poor health, who often have least control. As well as addressing practical issues around communication, training and support(13), evidence points to the need to combine community capacity building with organisational change, including investment in the necessary infrastructure, workforce development and developing supportive organisational cultures(15,25).

### *Evidencing the impact*

A further challenge concerns improving the underpinning evidence base for community-centred prevention. The recent updated NICE guideline on community engagement notes the significant increase in evidence on this topic, but also the scope for further research to unpick the effectiveness and cost-effectiveness of different components and to compare interventions(13). As community-centred approaches are more widely implemented, there is additional practice-based evidence to be garnered about what works well and what does not in different local contexts and with different populations.

The conceptual and methodological challenges of developing an evidence base in this field are well versed(32) and this can undermine political and professional support(14). Community-centred approaches are usually complex interventions, developmental in nature and sensitive to social context, with outcomes occurring over time(41). Realistic evaluation may offer an alternative to more traditional experimental designs(42). We welcome The Academy of Medical Sciences call for greater spend on prevention research that is collaborative, transdisciplinary and focused on wider determinants of health(43). Developing robust evaluation frameworks and indicator sets for community-centred approaches that can be applied in local areas to capture individual and community-level impacts is a priority. Academic-practice collaborations are needed to increase research capacity and improve measurement in this field.

### *Achieving a shift in power*

The final, and possibly biggest, challenge is about power and powerlessness. Community-centred approaches for health and wellbeing involve shifts in power, as the practice of public health becomes joint action routinely designed and delivered with, not done to, people. Conversely, community engagement that is tokenistic can be damaging and lead to disillusionment for those

involved(44). The implications are to focus on the quality of community-statutory relationships, building trust over time. This is not easy when the pressure is often for short-term results or where resources are stretched in the current context of austerity. PHE recognises the importance of investing in workforce development to prepare public health professionals to work in empowering ways and to value lay knowledge and skills(29).

Redressing power imbalances that underpin health inequalities requires action at a societal level including democratic renewal(45). Yet inequalities in democratic engagement and influence are linked to disadvantage and this represents a significant challenge for public health(8). The Marmot review gave specific recommendations on building community capital and reducing barriers to community participation(2). The review identified that increasing control may result in communities acting to change their social, material and political environments.

In the context of a commitment in England to devolve more power for local services, some devolution deals such as in Greater Manchester explicitly reference empowering local communities as part of health plans(46). The NHS Five Year Forward View advocates engaging with communities and citizens in new ways, involving them directly in decisions about the future of health and care services(7). Calls for community empowerment in an era of austerity can be interpreted as synonymous with the retrenchment of public services(47). These are contested issues and more debate is needed about the impacts of austerity on the public's capacity and confidence to participate. The Due North Inquiry responded to these challenges by integrating national policy recommendations on poverty and inequality with recommendations on devolution of power and resources from national to local, and from local to community through integrating communities into local decision making(8). Public health can advocate that those most affected by health inequalities

gain a greater say in determining the conditions that create good health. It is vital that community-centred approaches are not uncoupled from matters of social justice.

## **Conclusions**

Engaging communities in actions that improve health and increase community control and connections should be core to public health. As a significant resource in the efforts to reduce health inequalities, community-centred approaches have been overly neglected and underutilised. Steady gains in life expectancy have not narrowed the gaps between communities and are hindered by the attendant inequalities in healthy life expectancy. Leadership for public health in the 21<sup>st</sup> century is confronted by the challenges of new risk factors, shifting economic climate and the social changes brought by new technologies. This calls for a responsive leadership and skills to match the challenges of the day. To build more equitable and empowered communities, we have highlighted four priority areas for action: integration and scale, enabling people to get involved, evidencing impact and achieving a shift in power.

Public health experts are aware they do not have all the solutions, and may even miss the right problems to focus on. With the right opportunities, communities can be in a position to define issues of importance to them and be core to designing and delivering the solutions, as the lessons from participatory planning and volunteer/peer roles can show(13). Moreover, community-centred approaches to health require a reset of normal thinking, a reconfiguration of public health processes. Empowering communities does not mean a loss of power for professionals, but a new sharing of power and knowledge that can bring greater rewards for all. Collaborative leaders are needed who are willing to take risks, and are able to share knowledge, power and credit(48).

In taking the next steps, local leaders, commissioners and public health teams can consider how community-centred approaches can become an essential part of local health plans, embedding them systematically through the planning and delivery phases(10). By involving those at risk of social exclusion in designing and delivering solutions, we will be better able to address inequalities in health, but this needs doing at sufficient scale to achieve noticeable impact on physical and mental health. In facilitating and supporting community-led action, there is a need to counter the impacts of austerity on community capacities to organise. We must together learn from experiences, evaluate impact and share learning that will enhance the wider knowledge base.

A contemporary public health system embraces change, new learning and technology, but remains rooted within the communities it serves. Acting in partnership with those communities will reap significant rewards. Conversely, not leveraging the capacities of communities is a failure to utilise and strengthen available assets for health. Putting the public back into public health needs to be at the heart of everyday practice, planning and delivery.

## **Acknowledgements**

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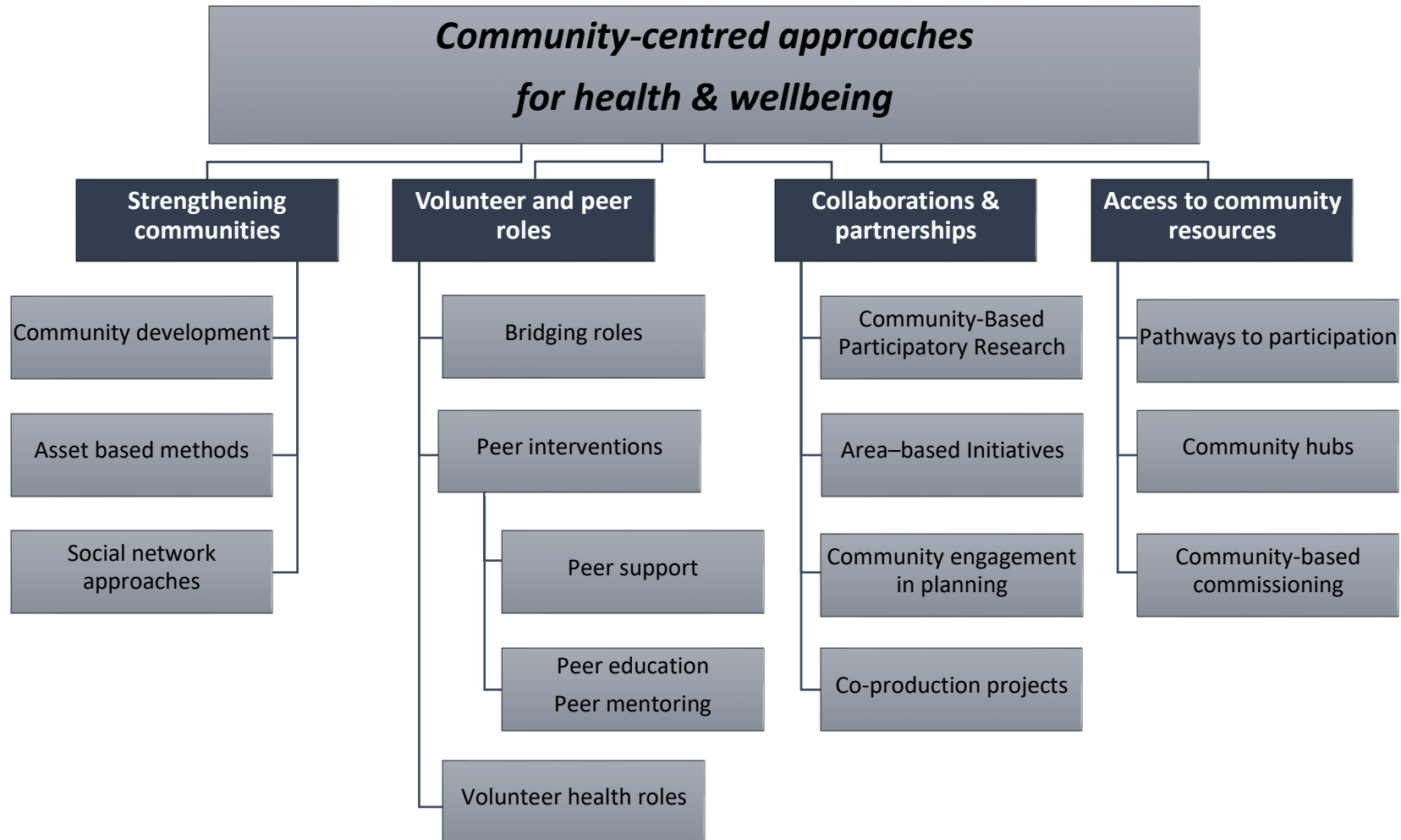


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**Table 1: Examples of whole system community-centred approaches**

<b>Level</b>	<b>Example</b>	<b>Summary</b>
National programme	Young Health Movement	<p>A network aiming to empower young people and support them as peer health advocates(49)</p> <p>The YHM is coordinated nationally by the Royal Society of Public Health with PHE</p> <p>Some 2000 young people aged 14-24 years have qualified as youth health champions</p>
Local government – regional devolution	Greater Manchester Health Plan	<p>GM Health Plan 2017-2021 aims to improve health and reduce health gap across the ten combined local authorities as part of devolution deal(46)</p> <p>Investment in person and community-centred approaches is integral to the strategic framework for health</p> <p>Objectives to build local capacity and system leadership to adopt these approaches, alongside ambitions to develop a network of 20,000 cancer champions</p>
Local government – local authorities	North East – network of districts using community and asset-based approaches	<p>Local authorities across the North East of England are implementing community-centred, asset-based approaches</p> <p>The local PHE centre provide learning and networking opportunities to help services align practice with evidence</p> <p>Councils use the PHE family of community-centred approaches as framework to map practice and strengthen community action across their district(50,51)</p>
Neighbourhood	C2 Connecting Communities	<p>An asset-based approach to neighbourhood community development (52)</p> <p>Aiming at transformative change in a locality, residents and local services work together on seven step process addressing the determinants of health</p> <p>C2 is a transferable model that has been successfully adopted in a number of disadvantaged communities across the UK</p>
Community and Voluntary Sector	Wandsworth Community Empowerment Network	<p>A community-led network in South London that addresses health issues through advocacy, co-production and skills development (53)</p> <p>Community members develop health and wellbeing activities and use faith settings to reach out to people</p> <p>An annual Black mental health conference highlights inequalities around mental health and draws in statutory services to identify solutions.</p>

**Figure 1: The family of community-centred approaches for health and wellbeing (source: PHE and NHS England 2015:17)**



**Supplementary Table A: Public Health England Products for local action on Health Inequalities**

<p>1. Best Start in Life</p> <ul style="list-style-type: none"> <li>• Increasing access to good quality parenting<sup>i</sup></li> <li>• Building children and young people’s resilience in schools<sup>ii</sup></li> </ul>	<p>2. Maximise Capabilities</p> <ul style="list-style-type: none"> <li>• Reducing the number of young people not in education, employment or training (NEET)<sup>iii</sup></li> <li>• Adult learning services<sup>iv</sup></li> </ul>	<p>3. Good employment</p> <ul style="list-style-type: none"> <li>• Increasing employment opportunities and improving workplace health<sup>v</sup></li> <li>• Promoting good quality jobs to reduce health inequalities<sup>vi</sup></li> </ul>
<p>4. Healthy Standard of Living</p> <ul style="list-style-type: none"> <li>• Health inequalities and the living wage<sup>vii</sup></li> <li>• Using the Social Value Act to reduce Health Inequalities<sup>viii</sup></li> </ul>	<p>5. Healthy Places</p> <ul style="list-style-type: none"> <li>• Working together to promote active travel<sup>ix</sup></li> <li>• Improving access to green spaces<sup>x</sup></li> <li>• Fuel poverty and cold home related health problems<sup>xi</sup></li> </ul>	<p>6. Better Prevention</p> <ul style="list-style-type: none"> <li>• The CleaR model. Excellence in tobacco control<sup>xii</sup></li> <li>• Health matters: harmful drinking and alcohol dependence<sup>xiii</sup></li> </ul>

<sup>i</sup> PHE/IHE. Increasing access to good quality parenting. September 2014.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/355764/Review1\\_Early\\_intervention\\_health\\_inequalities.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/355764/Review1_Early_intervention_health_inequalities.pdf)

<sup>ii</sup> PHE/IHE. Building children’s and young people’s resilience in schools. September 2014.

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<sup>iii</sup> PHE/IHE. Reducing the number of young people not in education, employment or training (NEET). September 2014.

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<sup>iv</sup> PHE/IHE. Adult learning services. September 2014.

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