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In Perspective Paper

Soft Power and Hard Choices: A critical perspective on health and inclusion in disadvantaged communities

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Abstract
The potential of area based initiatives as a mechanism for addressing health inequities is coming increasingly to the fore within local policy and planning. The need to move beyond 'bricks and mortar' in order to mitigate and reverse concentrations of disadvantage is now well established within academic and policy discourse, yet plans to stimulate economic development may be of limited benefit to local communities without addressing poor population health. Drawing on attempts to introduce assets-based community development made by a health and social care partnership in Scotland, UK, this paper explores the opportunities, risks and tensions that arise when statutory organisations seek to incorporate 'bottom up' approaches to community development within hierarchical organisational cultures. Those working within such structures frequently welcome more participatory approaches. However, syndicalist and co-operative models of health promotion risk dilution, as statutory organisations supporting more radical approaches to addressing the social determinants of health are forced to function within a context of increasingly strained public sector budgets.

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Introduction

In an era of straitened budgets and hard choices for the public sector, promoting social inclusion and mitigating socioeconomic disadvantage has never been more critical. Across the world, the realpolitik of inequality is evident in diverging length and quality of life. We must not forget that, even in more affluent nations, striking inequities, the clustering of disadvantage in place is further complicated and exacerbated by unequal treatment relating to their personal characteristics. Although questions remain about the evidence, asset based community development (Russell, 2015) has potential as a community development strategy which might support health equity by fostering the soft power of communities. However, to happen at scale this must be driven and supported by relatively rigid bureaucratic structures. This paper explores the challenge and importance of addressing

health inequities and examines the potential role of statutory organisations that seek to incorporate participative approaches to community development.

Health, social justice and economic imperatives

Health inequalities are fundamentally tied to social justice. It is not simply that different people experience variations in health, wellbeing and quality of life; these different experiences are patterned along a socioeconomic gradient. Such systematic inequalities of experience and outcome are intersectional, as those who in already disadvantaged social circumstances are likely to be further disadvantaged with regard to their health (Braveman and Gruskin, 2002; Marmot, 2005). The roots of these differential outcomes lie in the social determinants of health – that is, the social, economic and political circumstances in which people live, including poverty, employment, housing, transport, diet, education and welfare system, amongst others (Dahlgren and Whitehead, 1991). The impact of social determinants can be seen most starkly in mortality rates. How long someone might be expected to live varies radically on the global scale, with estimates of male life expectancy at birth ranging from just over fifty years of age in the most troubled areas of west and central Africa to just above eighty years on in some of areas of Europe, North America, South-East Asia and Oceania (UN, 2018). However, even within more affluent countries, significant differences can be seen at a micro level: within Glasgow, Scotland's largest city, male life expectancy varies from 68.3 years old in the most deprived quintile to 80.2 years in the least deprived quintile (NRS, 2018). The systematic nature of these variations in mortality, patterned by economic and demographic factors as well as social and policy context, renders them inequities rather than simply inequalities. Furthermore, the issue of inequity is, of itself, problematic for health and wellbeing. Beyond material deprivation, what might be considered 'soft', factors including how we are treated and how we feel about ourselves, can all have impacts on health, through the mechanisms of relative status, stigma and the psychosocial environment (Clark and Kearns, 2012; Marmot, 2005; Wilkinson and Pickett, 2009). Amenable to intervention, health inequities are 'unnecessary and avoidable as well as unjust and unfair' (Whitehead, 1992: 431).

In the UK, the issue of social justice in relation to health inequities has recently been given additional force by economic imperatives in different guises. Dahlgren and Whitehead's widely accepted conceptualisation of the social determinants of health (1992) shows the living and working conditions that underpin or undermine health as framed by wider socioeconomic, cultural and environmental conditions. An extended period of austerity, dating from the financial crisis of 2008, has an entrenched discourse of necessity around welfare reform, which, functions as an ideological 'cover' for public sector spending reductions (Lavalette, 2017: 31). This putative economic imperative, to reduce the deficit by cutting public expenditure, stands in tension with public health. The withdrawal or contraction of opportunities and services has seen more deprived local authorities suffering greater cuts (Bhattacharyya, 2015; Milne and Rankine, 2013). Over the longer term, growing stress on the suite of factors that both directly and indirectly support health and wellbeing will add to economic pressures, through increased levels of social exclusion and poorer population health. The immediate economic imperative, in relation to health and social justice, then is that statutory bodies, the third sector and our most vulnerable communities are required to do more with less.

How might we drive health equity forward?

There has been a shift within the UK towards understanding equalities in terms of protected characteristics, including age, disability, sex, and ethnic or national origins. However, poverty and economic inequality remain as the preeminent policy concern, one which is most visible and, therefore, frequently conceptualised in spatial terms (Clark et al, forthcoming). In recent years there has been a retreat of explicitly badged 'urban' programmes in favour of Local Economic Partnerships, increasingly regional-level initiatives intended to boost economic growth, including City Deals and Regional Growth Deals (Harding et al., 2015). For people of working age, 'decent' work has important role to play in addressing inequalities in both health and poverty (Stuart et al, 2016). However, for all the Scottish Government's commitment to inclusive growth, aspiring to combine increased prosperity with greater equity, these are primarily economic development vehicles and economic growth can stand in tension with greater equity. Furthermore, plans to stimulate economic development may be of limited benefit to local communities without addressing poor population health; a baseline survey of people in a regeneration area in Glasgow found that 45% of participants reported having a longstanding illness, disability or infirmity, while 33% had concerns with mental wellbeing, having sought medical support with stress, depression or anxiety in the preceding year (Clark and Kearns, 2015). The need to take a holistic approach and move beyond 'bricks and mortar' in order to mitigate and reverse concentrations of disadvantage is a well-established legacy of regeneration history. Led primarily by local authorities and Community Planning Partnerships, the potential of place-based initiatives as a mechanism for addressing health inequities is coming increasingly to the fore within local policy and planning in Scotland (Improvement Service, 2016). Nevertheless, a large scale longitudinal study of the impacts of regeneration in Glasgow has shown that some strategies generally assumed to support people into employment, such as participation in training, had no effect; rather, support with physical and mental health and increasing physical activity were significant factors, while the participative aspects of regeneration were associated with psychosocial benefits, such as feelings of status and control, that are allied to positive mental wellbeing (Kearns and Mason, 2018). Participative approaches, ensuring communities of place and of interest to successfully influence or manage change, can be seen as an entry point to increasing health equity for different people of working age, and beyond (see Clark and Wise, 2018).

Partnership for Asset Based Community Development

In the face of spending cuts and increasing socioeconomic inequalities following austerity, governance partnerships, have become increasingly important as a means of managing scare resources as effectively as possible, which incorporate local residents and facilitate community-led action and, in England, Health and Wellbeing Boards (Lyall, 2016). In Scotland, salutogenic approaches to supporting health and wellbeing have been particularly well received, with Community Health Partnerships and integration of health commissioning and provision being a feature of the landscape since 2004 (Bates, 2017; Friedli, 2012). From 2014 onwards, all but one of the 33 Scottish Local Authorities has adopted an Integration Joint Board (IJB) model for health and social care services; these have a specific remit to improve the wellbeing of service us, taking into account of their specific needs, circumstances and characteristics (Bates, 2017).

Historically, health care and service provision has been conceptualised within a deficit-based framework, which can be seen as disabling, insofar as local context is disregarded and communities are treated as passive recipients of care (Turner and Pinkett, 2000). In contrast,

salutogenic approaches emphasise individual and community agency and the determinants of health, rather than illness (Friedli, 2012). Asset Based Community Development (ABCD) is gaining traction as a model for supporting improved community health (McLean et al, 2017). An ABCD approach promotes:

> '…focus on identifying and utilising the assets of a community – which include the skills of local residents, the power of local associations, the resources of public, private and non-profit institutions, and the physical and economic resources of local places so the community itself can respond to its own needs and issues' (Kretzmann and McKnight, 2005:3).

The signature characteristics of asset-based approaches to supporting health include recognising and valuing existing individual and community resources (including skills, networks, knowledge and potential) that promote health and protect against negative outcomes, and involving communities as co-producers of services in ways which suit their self-defined needs and priorities (GCPH, 2011). In theory, the participative dimension of asset-based approaches to public service provision has the potential to support health equity along two axes. First, as a 'bottom-up' approach, by marshalling soft power, ABCD has the flexibility to address health inequities by engaging with people in terms of protected characteristics, as well as in relation to clusters of poverty and material deprivation, so serving both equalities and inequalities agendas. As discussed above, more syndicalist approaches can benefit health and wellbeing by supporting both personal and community empowerment, ultimately reducing healthcare costs and, if appropriate, potentially seeing people move into the labour market. Second, it could mitigate the impact of the hard choices that austerity policies have forced on service providers. Collaborative planning can reduce costs by ensuring that expenditure is more effectively targeted, with services delivered how and where required, in ways that are most useful to those who need them (GCPH, 2012).

ABCD and Fostering Soft Power

Several examples of ABCD can be found within what has been described as Scotland's 'receptive policy landscape' (Isserman, 2014; McLean et al, 2017: 5). These are generally community-based or relating to one specific programme, albeit in some cases the programme-based intervention may be citywide. However, since the end of 2017, the IJB of one of Scotland's larger local authorities has also been developing ambitious plans to build community capacity and resilience by transitioning to a more asset-based mode of health and social care service delivery. A series of interviews conducted in 2018 offers useful insights into the potential and challenges of adopting ABCD approaches on a larger scale. This comprised small group interviews with twelve Health and Social Care Partnership practitioners, who were selected purposively for their operational insights, supplemented by nine in-depth key informant interviews with senior members of the Health and Social Care Partnership who were engaged in the strategic development of the initiative, including executive managers, senior practitioners and third sector partners.

Good news, if not new

In common with other research (McLean et al, 2017), many of the more senior interviewees were keen to stress that asset-based approaches are not new, being a long-established framework within community development practice, in which several of the colleagues had a professional background or received early training. Indeed, for some, there was a

perception that strengths-based approaches were already in widespread use in some quarters. However, rather than expressing any frustration, along the lines of *reinventing the wheel,* the Partnership's turn towards ABCD was broadly welcomed. However, even for others who lacked clarity on the terminology or considered the proposed introduction of ABCD as more of a change of practice, there was consistent and clear support for a more strengths-based, rather than deficit focused orientation. The core characteristics of the proposed new approach to health and social care were identified by interviewees as being community-led, empowering and anti-paternalistic, fostering relationships and ensuring that everybody was at the table.

In part, the endorsement of ABCD in the Partnership was derived from three areas of consensus, apparent across the interviews. First, that the Partnership covered very diverse communities and that all of those communities included multiple assets that could be drawn upon to support health and wellbeing. Although Scotland is a relatively small country, many local authorities cover varied geographies, which might include islands, a sizeable rural hinterland, or villages and towns along with significant urbanised areas. A second area of consensus, relating to the shifting economic base of many of these areas as well as the context of austerity outlined above, was that those communities are under considerable pressure, in particular, from poverty and from demographic change, mostly relating to ageing populations. Third, local communities have been, simultaneously, over-consulted yet under-involved with regard to the provision and management of services; a historic top-down approach and lack of community agency has limited the potential for realising long-term positive change in health and social care. A more collaborative approach is needed.

However, leadership and timing were also important influences in interviewees' enthusiasm and the strong level of consensus about the nature and value of promoting asset-based approaches throughout partnership practices. In respect of leadership, outreach and engagement between health, social care and the third sector was identified as an important feature during the conception and a process of consensus building at the strategic level during the early development phase, as early as September 2016. Timing, as a further positive contributory issue, related to both push and pull factors. Interviewee interpretations of rationale underpinning the shift included, on the one hand, constrained resources, making self-management at individual and community levels a necessity. The logic of asking people what help they would like, rather than making assumptions, and fostering an environment in which they were more likely to help one another, was seen as a cost effective solution in difficult times. However, the positive connections between wellbeing and more asset-based approaches to health improvement and health care, suggested by some of the research base, also featured strongly. Empowerment and supporting resilience were considered, of themselves, health enhancing by all groups of interviewees. Finally, the planned turn towards ABCD was viewed as strongly aligned towards partnership strategy, having scope to advance existing statutory priorities in relation to health and wellbeing outcomes, clinical excellence and the integration of health and social care priorities by better meeting community needs.

Challenges to Theory, In Practice

Although economic pressures are in part a motivator, it must unequivocally be acknowledged that there is an underlying conviction that a more syndicalist approach to managing services will benefit communities. Promoting practices that prioritise community needs, as perceived by local communities themselves, and greater levels of flexibility and creativity in removing barriers to mutual support in the community are considered pathways to improving outcomes, as well as ultimately securing more sustainable health and social

care services. However, as observed in a Glasgow Centre for Population Health briefing on ABCD, moving away from 'the deficit mind-set adopted in traditional mortality and disease prevalence measures' may present a challenge (GCPH, 2012: 2). At this stage in the process of adopting a more strengths-based orientation, three particular challenges are evident.

First, although they are partnerships, Health and Social Care Partnerships are partnerships between large, hierarchical bureaucracies, jointly managed by a Local Authority and the National Health Service. This necessarily complicates two key shifts that will be required in the relationship between the health and social care teams and the wider community: an increasing emphasis on delivering support in a more bespoke manner, at the request and to the requirements of local communities; and acting as a prompt and support, so that communities can set and fulfil their own agendas in terms of health and social care – concerning communication, responsibility, and empowerment. Additionally, internal politics in a crowded policy landscape can override a focus on communities and community priorities. An additional area of possible tension will be in ensuring that the implementation of an asset-based approach is not diluted or confused by overlapping agendas within an already crowded policy landscape, such as with Community Planning teams. Coordination across all aspects of the partnership, communication with relevant external bodies, and demarcation of roles is likely to be needed to ensure a successful culture shift.

Second, this issue of responsibilisation is a concern (Scourfield, 2007). A hallmark of austerity has been an increasingly hollowed out social support system, with an accelerated transfer of responsibility and risk from collective authorities to relatively vulnerable individuals and communities (McKendrick et al, 2016). Interviews identified a tension between, on the one hand, having unrealistic expectations of a new approach and, on the other hand, anxiety that there is genuine substance to the change. While interviewees are enthusiastic about an asset-based approach, there are also concerns that the proposed shift is meaningful, with participants stressing the need to avoid a tokenistic application of ABCD, where *business as usual activities* are simply rebadged, rather than any meaningful change in practice being enacted. Terminology can be a problematic issue, clouding rather than clarifying objectives. Based on long experience of working in large bureaucracies, the risk of adopting new language, rather than a new approach, was raised more than once and practitioner interviews favoured more intuitive language than the jargon of ABCD as signalling an intention to adopt a community-led approach to health and healthcare.

A third and allied concern is one of resources. This issue encompasses both the capacity required to incorporate and embed ABCD in the day-to-day practices of the partnership and the cultural shift required. As one third sector interviewee put it:

> '…senior management are 100% on board. Middle management are getting there. The workers on the ground, its very much a postcode lottery at the moment on who you get as your worker - pressure of work and the amount of work they've got. And they seem to pile work on, and they get more and more work and its very, very difficult for them to prioritise'

Though ethos of ABCD has been warmly received as a concept, there is a lack of clarity about how that can be put in to practice, particularly given the constraints of the day-to-day pressures in the working environment. Moving away from a 'target culture', which can disguise the realities of health inequities, was recognised as one of the potential benefits of ABCD. However, staff must still deliver within their existing target frameworks. Making meaningful connections with the public is a particularly significant issue when considering

the ways in which terminology and bureaucratic practices can act as barriers to public engagement. These challenges are also likely to be exacerbated in the case of people who are suffering from consultation fatigue or are easier to overlook, by virtue of being isolated and less socially engaged or perhaps having other issues with mobility or connectivity. While the aspiration of senior management is towards a more grassroots, community-led approach, front-line staff must be in a position to facilitate this. An expectation of significant change in practice without significant support is not tenable.

Still a hard choice

Health inequities are a manifest injustice. Although a global concern, their impacts are profoundly personal, with impacts evident at local, community and family levels. Radical changes of policy approach are needed to address this. Participative public policy practices that prioritise and valorise citizen needs – as defined by people, themselves – have great potential to support health and wellbeing. The soft power of community assets can be mobilised, acting across the full range of the social determinants of health, from housing to food production. Likewise, well-supported participative processes support psychosocial benefits, associated with positive mental wellbeing. For people of working age, envisioning assets as opposed to deficits reveals untapped resources for the labour market. Further, as well as being empowering for participants, a shift towards more asset-based conceptions of our communities offers the hope of more effectively utilising public sector budgets, responding to and mitigating pressure on resources within existing systems.

Any statutory organisation taking bold steps in this direction should be applauded. However, although economic imperatives may be a driver, promoting asset based community development as a quick or inexpensive fix is a significant error of judgement. Historically, statutory organisations work within hierarchical structures that struggle, as one interviewee put it to 'step outside of service land' and the world of fixed targets in order to reshape itself around citizen agendas. Without adequate resourcing for staff time, training and support, syndicalist and co-operative models of health promotion risk dilution. Given that none of this is cheap, marshalling soft power must still be considered a hard choice.

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