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

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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.

#### Keywords:

Community; health; participation; governance; policy; asset based community development; regeneration

#### 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

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3 health inequities and examines the potential role of statutory organisations that seek to  
4 incorporate participative approaches to community development.  
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### 7 **Health, social justice and economic imperatives**

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10 Health inequalities are fundamentally tied to social justice. It is not simply that different  
11 people experience variations in health, wellbeing and quality of life; these different  
12 experiences are patterned along a socioeconomic gradient. Such systematic inequalities of  
13 experience and outcome are intersectional, as those who in already disadvantaged social  
14 circumstances are likely to be further disadvantaged with regard to their health (Braveman  
15 and Gruskin, 2002; Marmot, 2005). The roots of these differential outcomes lie in the social  
16 determinants of health – that is, the social, economic and political circumstances in which  
17 people live, including poverty, employment, housing, transport, diet, education and welfare  
18 system, amongst others (Dahlgren and Whitehead, 1991). The impact of social determinants  
19 can be seen most starkly in mortality rates. How long someone might be expected to live  
20 varies radically on the global scale, with estimates of male life expectancy at birth ranging  
21 from just over fifty years of age in the most troubled areas of west and central Africa to just  
22 above eighty years on in some of areas of Europe, North America, South-East Asia and  
23 Oceania (UN, 2018). However, even within more affluent countries, significant differences  
24 can be seen at a micro level: within Glasgow, Scotland's largest city, male life expectancy  
25 varies from 68.3 years old in the most deprived quintile to 80.2 years in the least deprived  
26 quintile (NRS, 2018). The systematic nature of these variations in mortality, patterned by  
27 economic and demographic factors as well as social and policy context, renders them  
28 inequities rather than simply inequalities. Furthermore, the issue of inequity is, of itself,  
29 problematic for health and wellbeing. Beyond material deprivation, what might be  
30 considered 'soft', factors including how we are treated and how we feel about ourselves,  
31 can all have impacts on health, through the mechanisms of relative status, stigma and the  
32 psychosocial environment (Clark and Kearns, 2012; Marmot, 2005; Wilkinson and Pickett,  
33 2009). Amenable to intervention, health inequities are 'unnecessary and avoidable as well as  
34 unjust and unfair' (Whitehead, 1992: 431).  
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39 In the UK, the issue of social justice in relation to health inequities has recently been given  
40 additional force by economic imperatives in different guises. Dahlgren and Whitehead's  
41 widely accepted conceptualisation of the social determinants of health (1992) shows the  
42 living and working conditions that underpin or undermine health as framed by wider  
43 socioeconomic, cultural and environmental conditions. An extended period of austerity,  
44 dating from the financial crisis of 2008, has an entrenched discourse of necessity around  
45 welfare reform, which, functions as an ideological 'cover' for public sector spending  
46 reductions (Lavalette, 2017: 31). This putative economic imperative, to reduce the deficit by  
47 cutting public expenditure, stands in tension with public health. The withdrawal or  
48 contraction of opportunities and services has seen more deprived local authorities suffering  
49 greater cuts (Bhattacharyya, 2015; Milne and Rankine, 2013). Over the longer term, growing  
50 stress on the suite of factors that both directly and indirectly support health and wellbeing  
51 will add to economic pressures, through increased levels of social exclusion and poorer  
52 population health. The immediate economic imperative, in relation to health and social  
53 justice, then is that statutory bodies, the third sector and our most vulnerable communities  
54 are required to do more with less.  
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### 59 **How might we drive health equity forward?**

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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 scarce resources as effectively as possible, which incorporate local residents and facilitate community-led action and, in England, Health and Wellbeing Boards (Lyll, 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 users, 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,

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3 salutogenic approaches emphasise individual and community agency and the determinants  
4 of health, rather than illness (Friedli, 2012). Asset Based Community Development (ABCD) is  
5 gaining traction as a model for supporting improved community health (McLean et al, 2017).  
6 An ABCD approach promotes:  
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9 '...focus on identifying and utilising the assets of a community – which include the  
10 skills of local residents, the power of local associations, the resources of public,  
11 private and non-profit institutions, and the physical and economic resources of local  
12 places so the community itself can respond to its own needs and issues' (Kretzmann  
13 and McKnight, 2005:3).  
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16 The signature characteristics of asset-based approaches to supporting health include  
17 recognising and valuing existing individual and community resources (including skills,  
18 networks, knowledge and potential) that promote health and protect against negative  
19 outcomes, and involving communities as co-producers of services in ways which suit their  
20 self-defined needs and priorities (GCPH, 2011). In theory, the participative dimension of  
21 asset-based approaches to public service provision has the potential to support health  
22 equity along two axes. First, as a 'bottom-up' approach, by marshalling soft power, ABCD has  
23 the flexibility to address health inequities by engaging with people in terms of protected  
24 characteristics, as well as in relation to clusters of poverty and material deprivation, so  
25 serving both equalities and inequalities agendas. As discussed above, more syndicalist  
26 approaches can benefit health and wellbeing by supporting both personal and community  
27 empowerment, ultimately reducing healthcare costs and, if appropriate, potentially seeing  
28 people move into the labour market. Second, it could mitigate the impact of the hard  
29 choices that austerity policies have forced on service providers. Collaborative planning can  
30 reduce costs by ensuring that expenditure is more effectively targeted, with services  
31 delivered how and where required, in ways that are most useful to those who need them  
32 (GCPH, 2012).  
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### 36 37 **ABCD and Fostering Soft Power**

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39 Several examples of ABCD can be found within what has been described as Scotland's  
40 'receptive policy landscape' (Isserman, 2014; McLean et al, 2017: 5). These are generally  
41 community-based or relating to one specific programme, albeit in some cases the  
42 programme-based intervention may be citywide. However, since the end of 2017, the IJB of  
43 one of Scotland's larger local authorities has also been developing ambitious plans to build  
44 community capacity and resilience by transitioning to a more asset-based mode of health  
45 and social care service delivery. A series of interviews conducted in 2018 offers useful  
46 insights into the potential and challenges of adopting ABCD approaches on a larger scale.  
47 This comprised small group interviews with twelve Health and Social Care Partnership  
48 practitioners, who were selected purposively for their operational insights, supplemented by  
49 nine in-depth key informant interviews with senior members of the Health and Social Care  
50 Partnership who were engaged in the strategic development of the initiative, including  
51 executive managers, senior practitioners and third sector partners.  
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### 54 55 ***Good news, if not new***

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

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3 perception that strengths-based approaches were already in widespread use in some  
4 quarters. However, rather than expressing any frustration, along the lines of *reinventing the*  
5 *wheel*, the Partnership's turn towards ABCD was broadly welcomed. However, even for  
6 others who lacked clarity on the terminology or considered the proposed introduction of  
7 ABCD as more of a change of practice, there was consistent and clear support for a more  
8 strengths-based, rather than deficit focused orientation. The core characteristics of the  
9 proposed new approach to health and social care were identified by interviewees as being  
10 community-led, empowering and anti-paternalistic, fostering relationships and ensuring that  
11 everybody was at the table.  
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14 In part, the endorsement of ABCD in the Partnership was derived from three areas of  
15 consensus, apparent across the interviews. First, that the Partnership covered very diverse  
16 communities and that all of those communities included multiple assets that could be drawn  
17 upon to support health and wellbeing. Although Scotland is a relatively small country, many  
18 local authorities cover varied geographies, which might include islands, a sizeable rural  
19 hinterland, or villages and towns along with significant urbanised areas. A second area of  
20 consensus, relating to the shifting economic base of many of these areas as well as the  
21 context of austerity outlined above, was that those communities are under considerable  
22 pressure, in particular, from poverty and from demographic change, mostly relating to  
23 ageing populations. Third, local communities have been, simultaneously, over-consulted yet  
24 under-involved with regard to the provision and management of services; a historic top-  
25 down approach and lack of community agency has limited the potential for realising long-  
26 term positive change in health and social care. A more collaborative approach is needed.  
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30 However, leadership and timing were also important influences in interviewees' enthusiasm  
31 and the strong level of consensus about the nature and value of promoting asset-based  
32 approaches throughout partnership practices. In respect of leadership, outreach and  
33 engagement between health, social care and the third sector was identified as an important  
34 feature during the conception and a process of consensus building at the strategic level  
35 during the early development phase, as early as September 2016. Timing, as a further  
36 positive contributory issue, related to both push and pull factors. Interviewee  
37 interpretations of rationale underpinning the shift included, on the one hand, constrained  
38 resources, making self-management at individual and community levels a necessity. The  
39 logic of asking people what help they would like, rather than making assumptions, and  
40 fostering an environment in which they were more likely to help one another, was seen as a  
41 cost effective solution in difficult times. However, the positive connections between  
42 wellbeing and more asset-based approaches to health improvement and health care,  
43 suggested by some of the research base, also featured strongly. Empowerment and  
44 supporting resilience were considered, of themselves, health enhancing by all groups of  
45 interviewees. Finally, the planned turn towards ABCD was viewed as strongly aligned  
46 towards partnership strategy, having scope to advance existing statutory priorities in  
47 relation to health and wellbeing outcomes, clinical excellence and the integration of health  
48 and social care priorities by better meeting community needs.  
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### 52 ***Challenges to Theory, In Practice***

53 Although economic pressures are in part a motivator, it must unequivocally be  
54 acknowledged that there is an underlying conviction that a more syndicalist approach to  
55 managing services will benefit communities. Promoting practices that prioritise community  
56 needs, as perceived by local communities themselves, and greater levels of flexibility and  
57 creativity in removing barriers to mutual support in the community are considered pathways  
58 to improving outcomes, as well as ultimately securing more sustainable health and social  
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3 care services. However, as observed in a Glasgow Centre for Population Health briefing on  
4 ABCD, moving away from ‘the deficit mind-set adopted in traditional mortality and disease  
5 prevalence measures’ may present a challenge (GCPH, 2012: 2). At this stage in the process  
6 of adopting a more strengths-based orientation, three particular challenges are evident.  
7

8  
9 First, although they are partnerships, Health and Social Care Partnerships are partnerships  
10 between large, hierarchical bureaucracies, jointly managed by a Local Authority and the  
11 National Health Service. This necessarily complicates two key shifts that will be required in  
12 the relationship between the health and social care teams and the wider community: an  
13 increasing emphasis on delivering support in a more bespoke manner, at the request and to  
14 the requirements of local communities; and acting as a prompt and support, so that  
15 communities can set and fulfil their own agendas in terms of health and social care –  
16 concerning communication, responsibility, and empowerment. Additionally, internal politics  
17 in a crowded policy landscape can override a focus on communities and community  
18 priorities. An additional area of possible tension will be in ensuring that the implementation  
19 of an asset-based approach is not diluted or confused by overlapping agendas within an  
20 already crowded policy landscape, such as with Community Planning teams. Coordination  
21 across all aspects of the partnership, communication with relevant external bodies, and  
22 demarcation of roles is likely to be needed to ensure a successful culture shift.  
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25  
26 Second, this issue of responsabilisation is a concern (Scourfield, 2007). A hallmark of  
27 austerity has been an increasingly hollowed out social support system, with an accelerated  
28 transfer of responsibility and risk from collective authorities to relatively vulnerable  
29 individuals and communities (McKendrick et al, 2016). Interviews identified a tension  
30 between, on the one hand, having unrealistic expectations of a new approach and, on the  
31 other hand, anxiety that there is genuine substance to the change. While interviewees are  
32 enthusiastic about an asset-based approach, there are also concerns that the proposed shift  
33 is meaningful, with participants stressing the need to avoid a tokenistic application of ABCD,  
34 where *business as usual activities* are simply rebadged, rather than any meaningful change  
35 in practice being enacted. Terminology can be a problematic issue, clouding rather than  
36 clarifying objectives. Based on long experience of working in large bureaucracies, the risk of  
37 adopting new language, rather than a new approach, was raised more than once and  
38 practitioner interviews favoured more intuitive language than the jargon of ABCD as  
39 signalling an intention to adopt a community-led approach to health and healthcare.  
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43 A third and allied concern is one of resources. This issue encompasses both the capacity  
44 required to incorporate and embed ABCD in the day-to-day practices of the partnership and  
45 the cultural shift required. As one third sector interviewee put it:  
46

47 ‘...senior management are 100% on board. Middle management are getting there.  
48 The workers on the ground, its very much a postcode lottery at the moment on who  
49 you get as your worker - pressure of work and the amount of work they’ve got. And  
50 they seem to pile work on, and they get more and more work and its very, very  
51 difficult for them to prioritise’  
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53  
54 Though ethos of ABCD has been warmly received as a concept, there is a lack of clarity about  
55 how that can be put in to practice, particularly given the constraints of the day-to-day  
56 pressures in the working environment. Moving away from a ‘target culture’, which can  
57 disguise the realities of health inequities, was recognised as one of the potential benefits of  
58 ABCD. However, staff must still deliver within their existing target frameworks. Making  
59 meaningful connections with the public is a particularly significant issue when considering  
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3 the ways in which terminology and bureaucratic practices can act as barriers to public  
4 engagement. These challenges are also likely to be exacerbated in the case of people who  
5 are suffering from consultation fatigue or are easier to overlook, by virtue of being isolated  
6 and less socially engaged or perhaps having other issues with mobility or connectivity. While  
7 the aspiration of senior management is towards a more grassroots, community-led  
8 approach, front-line staff must be in a position to facilitate this. An expectation of significant  
9 change in practice without significant support is not tenable.  
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### 13 **Still a hard choice**

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15 Health inequities are a manifest injustice. Although a global concern, their impacts are  
16 profoundly personal, with impacts evident at local, community and family levels. Radical  
17 changes of policy approach are needed to address this. Participative public policy practices  
18 that prioritise and valorise citizen needs – as defined by people, themselves – have great  
19 potential to support health and wellbeing. The soft power of community assets can be  
20 mobilised, acting across the full range of the social determinants of health, from housing to  
21 food production. Likewise, well-supported participative processes support psychosocial  
22 benefits, associated with positive mental wellbeing. For people of working age, envisioning  
23 assets as opposed to deficits reveals untapped resources for the labour market. Further, as  
24 well as being empowering for participants, a shift towards more asset-based conceptions of  
25 our communities offers the hope of more effectively utilising public sector budgets,  
26 responding to and mitigating pressure on resources within existing systems.  
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30 Any statutory organisation taking bold steps in this direction should be applauded. However,  
31 although economic imperatives may be a driver, promoting asset based community  
32 development as a quick or inexpensive fix is a significant error of judgement. Historically,  
33 statutory organisations work within hierarchical structures that struggle, as one interviewee  
34 put it to 'step outside of service land' and the world of fixed targets in order to reshape itself  
35 around citizen agendas. Without adequate resourcing for staff time, training and support,  
36 syndicalist and co-operative models of health promotion risk dilution. Given that none of  
37 this is cheap, marshalling soft power must still be considered a hard choice.  
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