Debate & Analysis

Social action for health gain:

the potential of community development

INTRODUCTION

Community engagement is mission critical for clinical commissioning groups (CCGs) and practices that need to understand and respond to the communities they serve. The NHS can find this difficult. Community development (CD) may help and has a long history with recent evidence of contributions to health gain.

COMMUNITY DEVELOPMENT

CD enables people to organise and to identify shared needs and aspirations, improve lives through joint activity, address imbalances in power, bring about change founded on social justice, equality, and inclusion,[1] and influence the agencies whose decisions affect their lives. An 'asset-based' strand builds on positives; leaders, skills, and the strengths of individuals and communities, rather than need: 'build on the strong not on the wrong'.

CD is best carried out by specialist workers, but existing NHS staff can also be trained to do it. CD is usually geographically-based, but can address communities of interest, for instance, people with diabetes, or with disabilities.[2]

In 1995, a 7-step process was developed and repeated elsewhere over a number of years. Beginning with involving residents in community meetings, it usually leads to a resident-led partnership between active residents and public services, which develops an increasing range of community activity, and influences services. This is one of many techniques: CD is a 'broad church'.

COMMUNITY DEVELOPMENT AND HEALTH GAIN

The Marmot Review sees community empowerment as key to tackling health inequalities[3] through strengthening social networks — the connections we have with other people — friends, relations, acquaintances, colleagues. Areas with stronger social networks experience less crime, less delinquency, and enhanced employment and employability.[4]

Strong social networks appear to act protectively against cognitive decline in people aged >65 years, and are associated with reduced morbidity and mortality.[5] Social relationships can reduce the risk of depression. Low social integration and loneliness significantly increase mortality.[6] A meta-analysis shows 50% increased survival for people with stronger social relationships, comparable with reducing damaging health behaviours and consistent across age, sex, and cause of death.[7]

CD builds social networks[8] to improve health and enable communities to work with public agencies and exert influence. CD in Cornwall and Balsall Health[9] has shown sustained changes in community activity, with improvements in housing, education, health, and crime. The 'Linkage plus' programme developed social networks for older people while collaboratively redesigning services, with improvements in health and independence. Overall, therefore, CD may contribute to:

- improving health protection and community resilience;
- tackling health inequalities;
- effective patient and public involvement in service change; and
- individual behaviour change.

Many questions remain. To what extent can CD increase community activity and result in more social networks? Can we be clearer about the links between CD and health gain? We need objective cost–benefit measures over time.

CASE STUDIES

The Beacon Estate, Falmouth: C2

The partnership secured and jointly managed a regeneration package which was linked to significant changes within 5 years.[10] These included reducing childhood asthma attacks, reducing postnatal depression, reducing child protection registration, and reducing crime. Numbers were small, but improvements appeared to outstrip national trends.

The Health Empowerment Leverage Project (HELP)

Building on C2, HELP supported a resident-led partnership in Townstal, Devon, bringing many agencies together. Within 6 months satisfaction with services increased and police reported crime dropping as a result of the partnership. New groups began and attracted funding for new projects. Results included a new dental service, a playpark, a planned GP surgery, improved relations with housing, and a plan for social renewal agreed between community and agencies.

Estimating cost–benefit

The HELP experience suggests about £80 000 a year per neighbourhood. Two years' work should leave a self-renewing resident group, supported by existing front-line workers. The Beacon project is 15 years old.

An internal HELP analysis[11] suggested an NHS saving of £558 714 across three neighbourhoods over 3 years, based on cautious but evidence-based estimates of improvements in health factors by 5% annually as a result of increased community activity and social networks: a return of 1:3.8 on a £145 000 investment in CD, with additional savings through reductions in crime and antisocial behaviour of £96 448 a year per neighbourhood.

These calculations are difficult and open to criticism. However, the results are similar to estimates obtained by others.[12]

THE CUT AND THRUST OF COMMUNITY DEVELOPMENT

The process begins with identifying key issues most relevant to residents prepared to take local action. These may not be NHS related, antisocial behaviour being a common theme. As social networks expand, most relevant health issues emerge.

As agencies work with communities, confidence grows, leaders appear, social capital improves, and the benefits to health become apparent.[8] For residents deeply involved it can be life changing, finding new skills and influence; others gain confidence, sometimes increasing employability. For the majority, the benefit may be a service change or an improving neighbourhood.

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The process may benefit or be thwarted by strong personalities in the community. Other problems include public agencies not listening or imposing solutions fitting organisational convenience rather than residents' concerns. CD workers need to persuade agencies to involve their front-line workers, learning to see local residents as sources of solutions and not merely as presenting needs. This can challenge the traditional public health approach of identifying areas with poor health and offering a series of unrelated interventions. In both of the case studies, health and primary care were only peripherally involved.

Statutory agencies worry about the unpredictability of outcomes, as the key issues for the community are largely unknown at the beginning. Also, funding may come from one agency and benefits accrue to another. Community budgets may be particularly useful, through which local funding may be shared.

COMMUNITY DEVELOPMENT, POWER, AND PRIMARY CARE

GPs often see the impact of the social determinants of health. It is difficult for practices and practitioners to intervene at a social or political level. CD not only makes a dialogue with communities easier, but offers an avenue to tackling social determinants.

GPs or practice staff are not expected to do CD themselves. However, practices can reap the benefit and contribute to developments. Practices for instance, refer to voluntary groups or offer rooms for their use. Housing issues, often frustrating, can be raised through CD.

CD is a support and, by challenging the pre-eminence of the professional gaze, a challenge to GPs, commissioners, and sometimes councillors. However, by sharing power with the communities we serve, CCGs, and practices will gain substantially.

NHS POLICY CHANGES

The NHS can help create conditions that maximise the contribution of communities to better health and service redesign.

- Each Health and WellBeing Board and CCG should have a CD strategy.
- Joint Strategic Needs Assessments should become Joint Strategic Needs and Assets Assessments, a profile of the strengths of the local community.
- Social networks and/or social capital should be routinely measured as an outcome of health commissioning.
- NHS England should support investment in community development through the Social Value Act.
- Health Education England should develop relevant CD training.
- Public Health England should include asset-based CD in guidance and develop a CD work programme.
- Local area teams should promote CD.
- Asset-based CD should be included in discussions on integration of health and care.

CONCLUSION

CD can boost social networks and contribute to health improvements and participatory accountability. Relationships can improve between health agencies and communities by sharing power. Support from the centre would help. Costs are not prohibitive, but the work can be difficult, and a skilled workforce needed, to work with existing staff in health and local authorities.

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Provenance
Freely submitted; externally peer reviewed.

DOI: 10.3399/bjgp15X683641

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