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Thinking and acting differently – An asset model for Public Health

Overview

In this lecture Antony Morgan described an asset as "*Any factor which maximises the opportunities for individuals, local communities and populations to attain and maintain health and wellbeing".*

He outlined the relationship between the assets approach and other concepts like social capital and salutogenesis. In outlining the potential for asset based approaches to generate evidence to influence national policy guidance he suggested that the development of an assets model has three related phases: *the generation of evidence*, *an action phase* and *an evaluation phase*. He suggested that key questions remain about how to put such evidence into practice systematically. In concluding he set out some of the challenges of adopting asset based approaches for key groups such as researchers, policy makers and practitioners engaged in public health.

Summary

In introducing the subject Antony described the factors in his life and experience which drew him to the assets based approach. He included his previous interest in social capital, social action for health and wellbeing and diversity of experience, including work for the World Health Organisation in Venice and a personal interest in Flamenco as important factors. He also emphasised that the asset based approach is not simply about health but more about life and living.

He went on to say that much of the content of the asset based approach is not new. Rather, it attempts to synthesise material in new ways. This is held to be especially important in the formulation of material to contribute to the national discourse about the evidence base for public health, shifting it towards an asset based framework. This he hoped would have the effect of ensuring that much of what we already know about what supported the building of health in everyday life finds its way into national evidence based policy decision making represented by NICE guidelines. He cited the recent publication "Health Assets in a Global Context" as an attempt to elucidate the assets perspective together with some examples of the approach in operation.

He defined a health asset as;

"*Any factor which maximises the opportunities for individuals, local communities and populations to attain and maintain health and wellbeing"*

He suggested that there were assets for 'knowing' and assets for 'doing' – reading a book about riding a bike is not the same as riding a bike!

He summarised the approach thus:

- It is about *thinking differently* – refocusing our questions to the 'glass half full' view;
- It is *about identifying those protective factors that keep us well* so that they can help offset the risks that inevitably people will face in their lives;
- It is about *re-energising community based programmes* to activate solutions for health and wellbeing through *recognition* of individuals and organisations;
- It is about helping us to *understand, manage and be more involved in the worlds we live in*;
- It is *not a new concept* but a framework for bringing existing concepts and ideas together in a systematic way.

The approach at NICE drew upon Archie Cochrane's 1979 principles of evidence based medicine:

- universalism – the best care available to all;
- empirical means/evidence to determine what was best
- compassion – the importance of rooting out harmful or useless practice
- accountability – the necessity of ascertaining costs and benefits

He raised the question of the limits of systematic review as a way of providing policy guidance. While systematic review has been helpful in establishing the importance of evidence based policy decisions, some have argued that the emphasis from this process concentrates attention too much on descriptions of health situations and not enough on specific and successful actions for health.

Key questions in the shift to an asset based approach

He suggested that key questions remained around how action was effective, what is ineffective and which interventions might yield the best return on investment in the very short, short and long term. Gaps exist in the initial formulation of research studies about health and health inequality and between evidence and practice; with much more focus on the deficit/risk factor model of health than an asset or resource based approach.

He went on to say that much of the evidence base available to address inequalities is based on a deficit (pathogenic) model of health. This approach focuses more on identifying problems and needs of populations requiring professional resources. This results in high levels of dependence on hospital and welfare services (risk factors and disease).

In contrast, asset models tend to accentuate positive ability, capability and capacity to identify problems and activate solutions. This in turn promotes self-esteem of individuals and communities leading to less reliance on professional services and their definitions of the problem. Both of these approaches are needed, the difficulty is that the deficit model has come to dominate at the expense of the less well known and understood assets approach.

Salutogenesis and social coherence

The asset based approach calls upon a very wide range of concepts and ideas, for example social support and self-efficacy. A key underpinning concept, developed by Antonovsky, is that of salutogenesis. This focuses on sources of health and what generates this rather than on sources of illness and what generates that. Antonovsky's work suggests that individuals and communities which exhibit a sense of coherence tend to have more health than those which do not.

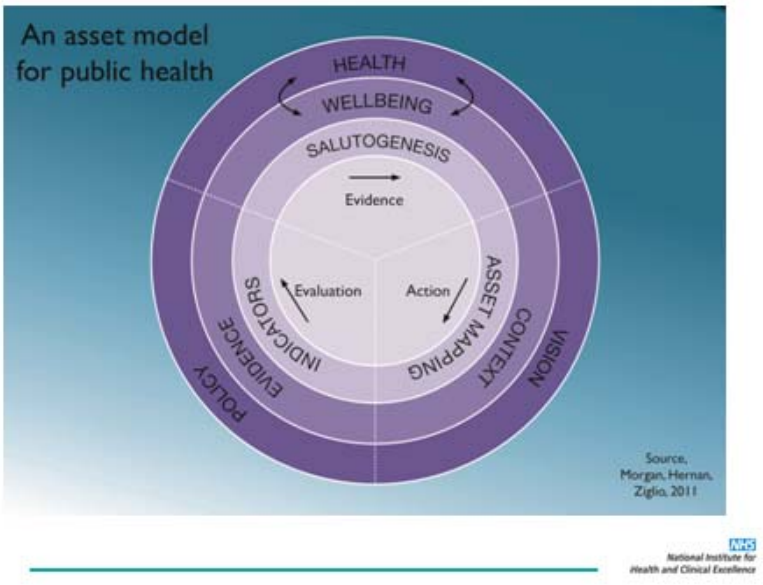
Social coherence suggests being able to make sense of, and demonstrate resilience across, a wide range of situations and disruptions. Such coherence is based upon a great many factors such as social capital, sense of identity and belonging, action competence, strong relationships, environments in which coherence has a chance to flourish etc. This amounts to being able to create a meaningful account of how the world is, why it is that way and how it might be changed and how to manage it. A difficulty in generating systematic understanding of these concepts at a national level is their complex nature and interaction across the life course.

To illustrate he drew upon perspective about young people. A dominant narrative in the public eye is about the misery of youth. Yet, research suggests most young people in Europe, when asked, say they are happy and in good health. Drawing on Scales (2001) work he highlighted personal assets for the healthy development of young people as support, empowerment and constructive use of time and external assets as commitment to learning, positive disposition towards social competence and positive identity. These assets are likely to be better developed in a supportive macro environment e.g. decent housing, environment, education and employment.

He suggested a key component in the development of community based asset approaches are the mapping of assets and ensuing guidelines. NICE developed such guidelines in 2010 which suggests a positive relationship between community control and health. The mapping of assets may well have the effect of encouraging professionals to see what communities have rather than what they do not have.

Asset based model

In this regard, he suggested that the assets approach consisted of three main phases, highlighted in the diagram.



Firstly, the gathering of evidence about what creates wellbeing. Secondly, a mapping of such assets in various contexts emphasising that such assets could be those of an individual or an institution or organisation. Here he drew on the work of John McKnight in identifying key assets in a community and building on these.

In setting this out he was careful to emphasise that the assets based approach needed to be framed in contexts which also have impacts on health, wellbeing inequality etc. The emphasis he drew was that of trying to move away from a risk factor driven context to one which asks what makes us stronger. He suggested that key concepts here are the idea of sense of coherence, resilience and connection. Here he argued that community work could be strengthened by engaging with the building of the public health evidence base for national policy.

Thirdly, evaluation of impact. He suggested that there were many possible ways of evaluating community based activity, both quantitative and qualitative, including story, and that these could be harnessed to provide sufficiently robust documentation for the effectiveness of this approach at the level of policy making at the national level. He suggested this was an area ripe for development and in which participatory process, narrative and case studies have a role to play.

What's next for the assets based approach

Antony saw some opportunities to highlight that many of the assets described above act protectively across risk factors. Many of these lie in social contexts and simply need a different, more positive perspective. Policy makers remain to be convinced about the economic case for investing in an assets based approach and so work remains to be done on how the model can assist in the process of guiding effective investment for health. Many questions remain:

- Are some assets more important/protective than others?
- What are the cumulative effects of multiple assets on wellbeing?
- How do different contexts social, economic, cultural – impact on the development of and benefits from assets based approaches?
- How can the balance between asset and deficit models be redressed?

He suggested too that challenges remain for various groups interested in health. For example in:

- *Policy* – how can those working in decision making positions can be stimulated to think differently about how they devise, monitor and evaluate health programmes which aim to promote wellbeing and to reduce health inequities?
- *Practice* – what are the prerequisites for effective asset based practice and how can its practice best be evaluated?
- *Research* – what types of research questions will support the development of a more systematic evidence base on asset approaches to health and wellbeing?

He went on to ask what needs to be done to encourage the policy, research and practice constituencies to work more closely together as a single 'us' working on (different and related aspects of) the same challenge? How can the benefits of permeable boundaries among these related fields be maximised so that the bonds within and across these groups are strong and positive?

Conclusion

Antony concluded by summarizing the key elements of the approach as:

- Focusing on positive health promoting and protecting factors for the creation of health.
- Emphasising the life course approach to understanding the most important key assets at each life stage.
- Being passionate about the need to involve people in all aspects of the health development process.
- Recognising that many of the key assets for creating health lie within the social context of people's lives and therefore links to health inequality agenda.
- Helping to reconstruct existing knowledge in such a way as to help policy and practice to promote positive approaches to health.