COMMUNITY DEVELOPMENT IN HEALTH

A LITERATURE REVIEW

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1 INTRODUCTION

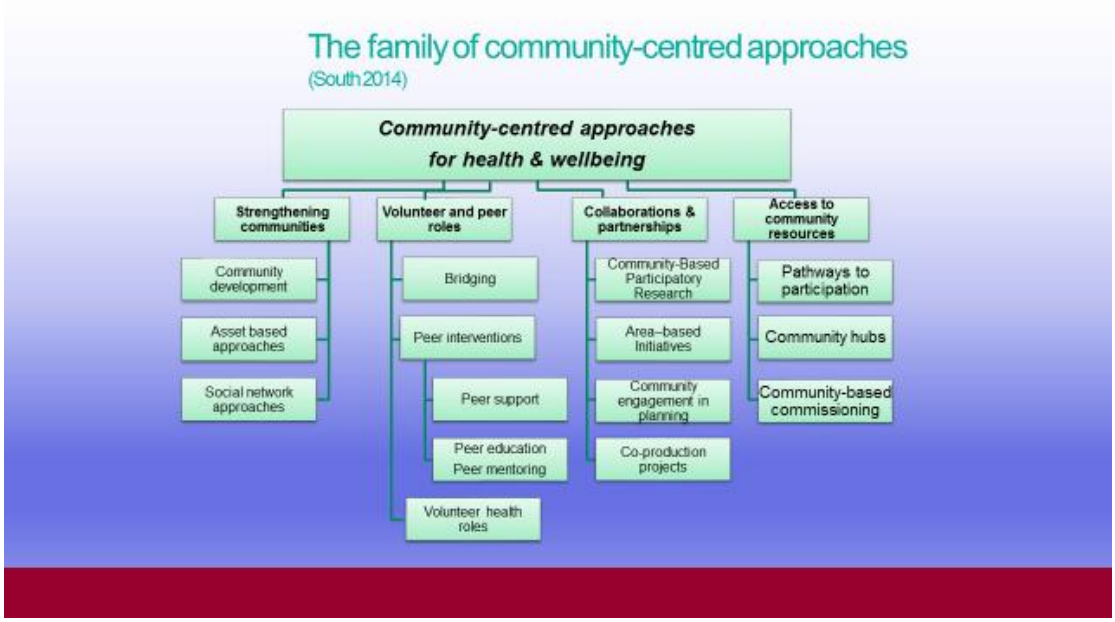
This literature review aims to offer relevant definitions, a brief background to the current state of play in the statutory services, the nature of community development, its relationship to community health and to enhancing the responsiveness of commissioning. It also touches on the evidence on CD and behaviour change.

In addition, it will outline approaches to business cases and how a business case can be constructed for such a complex situation as area-based community development.

The aim is to bring together a broad sweep of evidence that comes from disparate sources but which all illuminate the way in which communities can be supported to develop their own strengths and their own trajectories of development. It also tries to examine the evidence for health benefit from community engagement of various kinds. Although the story appears to be a consistent and successful one, we have highlighted limitations of studies and evidence that suggests poor outcomes or risks.

Since this project has a commitment to examine the business case for community development, and this discipline is relatively unknown to many in the NHS, we have tried to explore the field in outline and look at what is already known of costs and benefits in relation to community development.

This paper should be read in conjunction with the Public Health England report “A guide to community-centred approaches for health and wellbeing” by Jane South and others [1].This explores a range of interventions and locates community development as one of a range of interventions, as in this chart:



Some interpretations of community development would see it as occupying a more pivotal role in relation to some of the other elements, but different accounts of its scope need not concern us in reviewing the evidence which we have collected here. We need only assert that as well as being important in itself, CD can at times have a catalytic effect in relation to some of the other elements.

A summary of the conclusions of each section

SECTION 2
Community Development (CD) and Community Organising (CO) are techniques that support and increase social networks and that support and enhance participation. This increases social capital and assists associational life. CD and CO can support the process of co-production.

SECTION 3
There is a developing constellation of ideas that more flexible, place-based services are likely to offer more effective and efficient outcomes. To achieve this, statutory services will need to change and share power.

SECTION 4
There is strong evidence that strong social networks (SNs) protect people against the impact of stressors mental or physical. That is, strong SNs confer resilience. This appears to span a range of conditions, stressors and populations.

SECTION 5
Social networks have been shown to result in multiple beneficial outcomes, apart from health. These include improvements in crime rates and anti-social behaviour.

SECTION 6
The evidence seems clear that CD can improve community health through building social capital by means of building social networks. Such activity spreads to other aspects of civil life. Government can support this process.

SECTION 7
The evidence is clear that involvement of local people can make significant impact on the responsiveness of local services. CD is one of these effective approaches.

SECTION 8
It appears that community engagement and development are likely to have wide-ranging impacts on behaviour change.

SECTION 9
There are a variety of approaches to expressing a business case. So far as CD and community involvement is concerned, the difficulties are compounded because it is so difficult to express costs and benefits in monetary terms. Nonetheless, effective though complex techniques do exist. However, benefits can be problematic as they may take time to accumulate, impact on different stakeholders differently and also may benefit budgets other than those whose costs they are.

SECTION 10
The evidence available strongly supports the case that CD offers good value for money.

2. DEFINITIONS – COMMUNITY DEVELOPMENT AND OTHER RELATED CONCEPTS

The arena of empowerment is burdened with a number of key concepts which often overlap and on occasion, can confuse. This review does not explore these in any detail, but this section is intended to help navigate meaning in the rest of this paper.

Community Development (CD)
CD is defined within the National Occupational Standards for CD [2] as: a long term value- based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion. The process enables people to organise and work together to:

- identify their own needs and aspirations
- take action to exert influence on the decisions which affect their lives
- improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

Key roles in the field of health could include:

- Developing social networks
- Developing and supporting groups
- Developing an agenda for change from the views and recommendations of local people and decision-makers
- Bringing people together to respond to those needs themselves, so far as possible, while at the same time:
- Working with decision-makers in health to ensure that local views are taken into account and responded to.
- Impacting on entrenched Health Inequalities nationally

NICE uses the terms 'community engagement' and 'community development' almost interchangeably[3]. However, the terms can be distinguished by saying that community engagement is the *top-down* effort to involve people in a given agenda, while community development is the *bottom-up* stimulus and facilitation for people to become involved through their own priorities. Both are necessary.

Asset-based approaches, in contrast to deficit approaches

The WHO European Office for Investment for Health Development uses the term "health assets" to mean the resources that individuals and communities have at their disposal which protect against negative health outcomes and/or promote health status. These assets can be social, financial, physical, environmental or human resources; for instance education, employment skills, supportive social networks, natural resources, etc. [4]

Working together, asset based approaches complement the conventional model by:

- Identifying the range of protective and health promoting factors that act together to support health and wellbeing and the policy options required to build and sustain these factors.
- Promoting the population as a coproducer of health rather than simply a consumer of health care services, thus reducing the demand on scarce resources.
- Strengthening the capacity of individuals and communities to realise their potential for contributing to health development.
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

Morgan recommends an asset-based approach to responding to health inequalities. [5]

Co-production

Co-production is said to be a simple idea: it's about individuals, communities and public service organisations having the skills, knowledge and ability to work together, create opportunities and solve problems. The central idea in co-production is that people who use services are hidden resources, not drains on the system, and that no service that ignores this resource can be efficient [6]

Key ideas within the concept are:

- People as assets, not problems to be solved
- Neither government nor citizens have access to all the necessary resources to tackle problems on their own
- Individuals, organisations and statutory services working together to improve civil life
- Both local people and statutory services have skills that need to be combined for maximum effectiveness.

Coproduction is seen to be an approach distinct from traditional responses to social problems: voluntarism, paternalism or managerialism. [7]

Edgar Cahn, who defined the concept of Time Banking expressed it pithily "No society has the money to buy, at market prices, what it takes to raise children, make a neighbourhood safe, care for the elderly, make democracy work or address systemic injustices... The only way the world is going to address social problems is by enlisting the very people who are now classified as 'clients' and 'consumers' and converting them into co-workers, partners and rebuilders of the core economy." [8]

Social networks

Social networks are a simple concept for a universal phenomenon that underpins much community development practice. Social networks are the sum of the links between you and the people you know. These people can be family, friends, the bowling club, parents chatting outside the primary school, and connections that people make through more formal kinds of volunteering and association and through work.

The reason that social networks are so important for health is that evidence links them with substantial health and participatory benefits for individuals and the community.

Associational life

While social networks are the links between people, associational life refers to the collective activities that people do together as part of a community. This might include: being a member of a community group, a tenants' association or a trade union; supporting the local hospice by volunteering; and running a study group on behalf of a faith organisation. Others have variously called this kind of activity social engagement, social participation, collective action, or civil, horizontal or community participation. [9]

McKnight places this in a wider context: "At the heart of the democratic faith is an idea that reaches beyond equality. It is the idea that every person has unique skills, capacities, and gifts and that a good society provides an opportunity for those gifts to be given and shared…... In this sense, associations are a democratic society's

primary vehicle for identifying, combining, and manifesting the unique gifts of citizens for the common good. An association is the structure we have uniquely created to provide a means of coalescing the capacities of each to create a synthesis, making each participant more powerful and the group's power greater than the individual power of each member. …..In addition to being a principal means for citizens to be powerful and create power, associations provide a vital resource for creative problem-solving." [10]

Community Empowerment

IDeA defines the term as follows: "Community empowerment is the outcome of engagement and other activities. Power, influence and responsibility is shifted away from existing centres of power and into the hands of communities and individual citizens." [11]

The "Communities in control: real people, real power" white paper [12] defined empowerment as 'passing more and more political power to more and more people, using every practical means available' This is no doubt intended to link individuals and communities to decision making processes but it tends to suggest that power is a commodity in the gift of government rather than an inherent and existing attribute of citizens. [13]

Social Capital

Putnam describes social capital as the "connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them" He draws together a wide range of research showing that joining and taking part in local organisations helps to foster trust in others and a sense of shared values, broadening participants' 'sense of self' and enhancing 'participants' "taste" for collective benefits' and that these processes correlate widely with better health [14].

Social capital is disputed research territory. However, broadly, the literature says that:

- it is possible to build social capital in the short term through capacity building [15]
- social capital can be enhanced by supportive action by government, nongovernmental organizations, local societal actors and external actors in the civil society, both in combination and in isolation [16] [17] [18]

The literature suggests different types of social capital: bonding (ties between people who are similar); bridging (ties between people who are different), and linking (ties between citizens and those in authority [19]

The social capital module of the UK General Household Survey (GHS) 2000/2001 defined it as a combination of:

- Civic engagement
- Neighbourliness (reciprocity and trust in neighbours)
- Social networks (friends and relatives)
- Social support
- Perceptions of local area [20]

The National Indicator Set – the single set of 198 performance indicators used for the comprehensive area assessment (CAA) between 2006 and 2010 – included a

number of indicators of well-being and social capital. Collected by the Place Survey – carried out by every local authority – these asked whether people:

- feel they can influence local decisions (NI 4)
- feel they belong in the neighbourhood (NI 2)
- feel they get on well together (NI 1)
- participate in regular volunteering (NI 6).

Other indicators asked about the condition of the third sector in the locality (NI 7), self-reported health and mental well-being (NI 119) and whether people with long-term conditions are supported to be independent and in control of their conditions (NI 124). [21]

Community capital

An action research initiative on 'community capital' from 2010-2015 in seven disadvantaged but otherwise very varied neighbourhoods across England combined a survey of, in total, 2,840 residents with locally-designed interventions around health and related issues. Preferring the term community capital to social capital, the report shows that people's satisfaction with their neighbourhood, their health, their lives as a whole and their access to social support are all linked: 'Causality may run in several directions concurrently' (p46).'People who said there was something stopping them from taking part in the community,and those who did not know anybody in their network who could put them in touch with somebody in a position of local influence, tended to report lower subjective wellbeing... People who were mentioned in other people's social networks had significantly higher subjective wellbeing' (p51). Interventions to boost people's social networks largely had marked beneficial effects on health and associated issues, but 'it takes engaged, deliberative, sometimes difficult work to release value from community capital' (Foreword). The report identifies four kinds of 'dividend' from investment in such work: a wellbeing dividend, a citizenship dividend, a community capacity dividend and an economic dividend, including savings where participation in a community-based programme reduced the extent to which people had recourse to health agencies.[22]

Community Organising

Community organising is a particular approach to building communities, strengthening ties between social groups and helping people come together to address common challenges. Community organisers identify, recruit and develop community leaders, and help them to develop new relationships within and between communities. They develop local campaigns, based on local concerns and priorities, to encourage people to come together and make a difference in their area. [23] In 2011 the Coalition government engaged Locality to create a training system for community organisers as part of the 'big society' agenda (www.locality.org.uk).

Big Society

This was initially a key concept underlying Coalition government policy (2010-2015). Commentators have struggled to define it, and many regard it as having lost credibility, but some key components appear to be the following:

- Reduced state provision providing only 'core' services
- Social justice taking extra steps where necessary to empower local communities
- Increased accountability reinvigorating local accountability, democracy and participation through Community Organising
- Transparency: letting local people know how money is spent

- Enhancing public sector markets to examine opportunities for involvement by private and voluntary sectors in service delivery
- Leadership by frontline providers including decisions on commissioning
- Funding based on social investment, giving and philanthropy, not from the State
- Improved local commissioning creating a level playing field for the voluntary sector
- Formation of neighbourhood groups, mutuals and cooperatives
- Including a new right for public sector workers to form employee owned cooperatives
- Charitable giving philanthropy to replace public sector spending where possible and encouraging business to focus activity in their local area
- Volunteerism, National Citizens Service and Social Action Day to be the centre piece of a large drive to increase social action.

There are echoes of CD in some of these ideas. [24]

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3. STATUTORY SERVICES NEED TO FIND A NEW WAY TO WORK

Although significant aspects of the NHS are improving, with reduced waits and improved outcomes, there is a strong sense that the NHS and statutory services in general need to act and react differently.

What needs to be different?

Many commentators feel that these services have inappropriate characteristics for effective delivery. In particular, that services are inflexible and treat people as ciphers, often as a response to requirements for increased efficiency. One theme is that statutory services rely too heavily on a narrow concept of citizens as rational actors able to choose between providers, assert their rights and voice their dissatisfaction. [25]

Dier suggests that this approach is not only inefficient but alienates: The common response has been to "reinvent government" to be more like a business with a greater emphasis on "efficiency" and "customer service." ….. To the extent that government treats citizens only as customers, citizens think of themselves only as taxpayers and feel that much more alienated from their government. [26] Indeed there is good evidence that citizens want public services to be different from normal retail/supermarket experiences.[27]

Commentators feel that we need to “reject both old statist models of universal service delivery and the new public management models of consumerism.” [28] This is particularly relevant now in the financial crisis. To meet commitments, public spending in the UK would need to rise above 50 per cent of GDP by 2028.Tax receipts have never risen above 40 per cent. [29]

One response is to involve people in the design and planning of services. Evidence is strong that this is essential for effectiveness.

- Coproduction often improves outcomes – evidence shows that interventions that adopt this approach have a big impact on outcomes
- The public frequently want to be partners– the public want to be more involved when public services relate directly to them and their family – we usually underestimate people's willingness to help others
- The value citizens contribute is significant – the scale and value of the resources that the public contribute is enormous – families and communities generate a huge amount of economic value that is currently unmeasured and unrecognised by public services
- Coproduction can improve value for money – evidence also shows that the economic benefits of coproduction approaches outweigh the costs [30]

Characteristics of a new approach

Good public services enable and encourage people to maintain social relationships, but badly provided ones can create social isolation. Evidence suggests that characteristics of services profoundly affect the degree of resilience they foster in the populations they serve. These mostly have to do with the quality of human relationships, and with the quality of public service responses to people with problems. These two factors, in turn, are closely related to each other.

Resilience-enhancing services should have the following evidence-based characteristics:

Trust and respect: provision must be non-judgemental, where people in hard-pressed neighbourhoods feel they are welcome.. This involves building up trust and creating social spaces for participation in activities with people who share similar experiences. Provision must also be on the basis of respect – in deed as well as in word.

Recognising and releasing capabilities: services must rid themselves of the legacy which sees those in hardship and poverty as being in deficit, and of less moral and social worth. Services that provide opportunities for clients to build self esteem and confidence, and identify skills and aptitudes that would otherwise have gone unrecognised, are essential for improving life.

Listening to and involving people: the needs and perspectives of clients and front-line staff should be at the core of service provision and design. Treating user groups and individual clients as a legitimate source of 'welfare wisdom 'and incorporating their views is essential. User involvement plays a key role in acknowledging and releasing the often hidden capabilities of users, sometimes leading to employment, as well as enhancing the responsiveness and sustainability of services.[31]

Critical success factors to enable people to feel involved appear to include, in descending order of importance:

- Feeling informed and consulted
- Outcomes from specific incidents – personal and family experience
- Attitudes to local agencies
- Experience of responsiveness of public services
- Feeling part of the community
- Involvement in decision making

This suggests that individual experiences of good (or bad) services are key to participation.

The World Bank offers a simple description of the difference between approaches that are likely to empower users and those that offer routine responses: [32]

Table 1
Agency Outreach Mechanisms
Differences Between Extension and Empowerment Approaches

	Extension Approach	*Empowerment Approach*
Purpose	Information dissemination, delivery of inputs, demand creation, advocacy	Local capacity building; strengthening existing groups to achieve self-management
Nature of Task	Supply of inputs, education	Coordinated action over a prolonged period of time
Role of Field Agents	Channel of information and inputs, liaise with technical agencies	Facilitator, catalyst, organizer;
Control over Decisions	Control stays with agency	Parameters established by agency; decisions made and owned by community through process of negotiation
Role of Information	Since information dissemination is a primary function, mass media and social marketing are used	Organization of goal oriented groups takes precedence; technical information introduced as needed
Accountability of Field Agent	To agency	To clients, community groups
Characteristics, Skills of Field Agents	Technical specialists, information specialists	Community organizers, facilitors with limited technical know-how
Outcomes	Use of inputs, increased demand for services, effectiveness, efficiency	Empowered groups managing services they did not manage before, group cohesion, cooperation, empowerment, effectiveness, efficiency

It is not easy to change

However, current services have difficulty delivering such an approach. Popay suggests the following barriers:

- the capacity and willingness of service users and the public to get involved;
- the skills and competencies of public sector staff;
- the dominance of professional cultures and ideologies;
- the organisational ethos and culture;
- the dynamics of the local and national political system. [33]

A key corollary of this approach is localism. However, there are few services that have mastered this approach either. Blocks to working locally include lack of understanding of how best to engage with communities; lack of flexible budgeting and public sector finance; lack of mechanisms to attract private sector finance; lack of skills in the private, public and third sectors [34]

Brodie reminds us of the importance of power relationships that can undermine all the good ideas and nice phrases. [35] NICE, in its evaluation of community engagement, identified fourteen good quality studies identifying the (mis)use of power by officials and elected members of local authorities as a key constraint on the process and outcome of community engagement initiatives. [36]

Making the effective approach the more likely
Incorporating empowerment approaches into performance management is likely to make such characteristics more likely to emerge and to be sustained. Public services should be judged by the extent to which they help citizens, families and communities to achieve the social outcomes they desire. Criteria to judge appropriate culture could include:

- Helping to create social value for citizens and communities.
- Enhancing citizen autonomy, capability and resilience.
- Unlocking citizen resource.
- Supporting existing social networks and building collective community capacity.[37]

This is echoed by a Cabinet Office discussion suggesting that greater weight be given to the quality of partnerships between staff and service users in performance management frameworks**.** [38]

There are also many suggestions for how to improve, including training for organisational change, with processes that look very like community development. [39] In addition, Cabinet papers suggest structural changes to budgets, with more control passed down to individual users and frontline professionals; support for civic society and mutual help; performance regimes; and professional training and culture. [40]

Examples of local services which have changed towards co-production
Diers describes an institutional policy shift in Atlanta's services for regenerating community, creating a space for the "citizen centre" to grow, a policy that shifts from prescription to proscription, from "How we will fix them" to "What we won't do to limit them." The shift of approach includes:

> From a focus on deficiencies to a focus on assets
>
> From a problem response to opportunity identification
>
> From a charity orientation to an investment orientation
>
> From grants to agencies to grants, loans, contracts, investments, leveraging dollars

The Joseph Rowntree Foundation describes "citizen-centred governance". Opportunities are created for local people and service users to shape policy choices, decide on services and allocate resources. They provide an alternative to traditional methods of government through local authorities, although councils themselves are often the main players in creating these forums. [41]

Developing place-based budgets is likely to make coordination of services and involvement of the local population easier. It also holds the promise of savings [42] Those wishing to design public services around people and places should begin by analysing the social networks, assets and resources of the community and the existing patterns of public service structure and delivery [43] .

In Northern Ireland, community development is an integral part of public health policy. "We will build on our existing policy Mainstreaming Community Development, to ensure that a sustainable programme of community development is at the heart of our services. This will include actively examining the scope for increasing the number and type of services that

are delivered through the community and voluntary sector " [44]

SUMMARY OF SECTION 3
There is a developing constellation of ideas that more flexible, place-based services are likely to offer more effective and efficient outcomes. To achieve this, statutory services will need to change and share power.

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4. SOCIAL NETWORKS, SOCIAL CAPITAL, RESILIENCE AND HEALTH

We have seen that CD can enhance social networks (SNs), participation and co-production. We can also see that one way of seeing social capital is an accumulation of SNs perhaps of different kinds with different kinds of connections. We now turn to the link between SNs and health.

Mortality
Low levels of social integration, and loneliness, significantly increase mortality. People with stronger networks are healthier and happier. [45] Social networks are consistently and positively associated with reduced morbidity and mortality. [46] [47] [48]

In a study in Chicago, neighbourhood social capital--as measured by reciprocity, trust, and civic participation--was associated with lower neighbourhood death rates, after adjustment for neighbourhood material deprivation. Specifically, higher levels of neighbourhood social capital were associated with lower neighbourhood death rates for total mortality as well as death from heart disease and "other" causes for White men and women and, to a less consistent extent, for Black people. However, there was no association between social capital and cancer mortality [49]

An important meta-analytic review [50] was conducted to determine the extent to which social relationships influence risk for mortality, which aspects of social relationships are most highly predictive, and which factors may moderate the risk.

Data across 308,849 individuals, followed for an average of 7.5 years, indicate that individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The magnitude of this effect is comparable with quitting smoking and it exceeds many well-known risk factors for mortality (e.g. obesity, physical inactivity). The overall effect remained consistent across a number of factors, including age, sex, initial health status, follow-up period, and cause of death, suggesting that the association between social relationships and mortality may be general, and efforts to reduce risk should not be isolated to subgroups such as the elderly.

To draw a parallel, many decades ago high mortality rates were observed among infants in custodial care (i.e., orphanages), even when controlling for pre-existing health conditions and medical treatment [201]–[204]. Lack of human contact predicted mortality. The medical profession was stunned to learn that infants would die without social interaction. This single finding, so simple in hindsight, was responsible for changes in practice and policy that markedly decreased mortality rates in custodial care settings. Contemporary medicine could similarly benefit from acknowledging the data: social relationships influence the health outcomes of adults.

The authors suggest that multifaceted community-based interventions may be an effective way of intervening. These have a number of advantages because such interventions are socially grounded and include a broad cross-section of the public. Public policy initiatives need not be limited to those deemed “high risk” or those who have already developed a health condition but could potentially include low- and moderate-risk individuals earlier in the risk trajectory.

Mental health
Several longitudinal studies have shown that social networks and social participation appear to act as a protective factor against dementia or cognitive decline over the age of 65. Social networks are weaker in more deprived areas.

The most powerful sources of stress are low status and lacking social networks, particularly for parents with young children.

National surveys of psychiatric morbidity in adults aged 16-64 in the UK show that the most significant difference between this group and people without mental ill-health problems is social participation. [51] There is strong evidence that social relationships can also reduce the risk of depression. [52]

Life Satisfaction
What seems to be more important, however, for life satisfaction is being happy at work and participating in social relationships. Job satisfaction and being in a relationship are important influences on life satisfaction. Income and occupational status are far less important. [53]

Responding to stress
Bartley studied different communities examining the links between social networks and resilience. Strong communities with good networks of social relationships also appear to have helped areas cope in the face of economic problems. It does not appear to matter what ‘the glue’ is which holds a community together: there are examples of a common ethnic or religious identity, and of a shared industrial history, such as being a mining or car-building area. All the resilient areas studied both had protective social networks and benefited from new initiatives designed to help in the face of economic decline. [54]

The elderly
Social support helps older people to maintain their quality of life if they develop an illness. Involvement in family and community is a source of resilience during older age.

Link-Age Plus is an approach to capacity building that recognises older people as independent and active citizens, participating in and shaping their local communities. A number of sites could demonstrate involvement and health improvement. [55]

Cardiac Disease
A number of studies are consistent with the idea that areas with poor social capital have higher rates of cardiovascular disease[56] in general and recurrence of acute coronary syndrome in particular among lower-income individuals [57].

There is also evidence UK general practices working with CD can improve cardiac indices, such as attendance at cardiac rehab and BP reviews. [58]

Resilience

Bartley's research shows that there are common factors that make resilience possible and increase people's capability. These mostly have to do with the quality of human relationships, and with the quality of public service responses to people with problems…….. It is social relationships that are most effective in maintaining resilience in the face of adversity. [59]

Health Inequalities

It has been unclear why income inequality leads to poorer health. Kawachi's data suggests that the growing gap between the rich and the poor affects the social organization of communities and that the resulting damage to the social fabric may have profound implications for the public's health. Data support the notion that income inequality leads to increased mortality through reduced social capital. [60]

SUMMARY OF SECTION 4

There is strong evidence that strong SNs protect people against the impact of stressors mental or physical. That is, strong SNs confer resilience. This appears to span a range of conditions, stressors and populations.

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5 SOCIAL NETWORKS AND NON-HEALTH BENEFITS

Improving links between people has other beneficial outcomes too. There is a large literature on this. We only pick out a few highlights. Those areas with stronger social networks experience less crime [61] and less delinquency[62]. SNs influence employment and employability [63]

Social cohesion and informal social control predict a community's ability to come together and act in its own best interests. These derive, at least in part, from participation in local associations or organizations. [64]

For example, networks of friends are associated with reduced crime and social disorder. Wesley Skogan, a noted criminologist, notes that "when residents form local social ties, their capacity for community social control is increased because they are better able to recognize strangers and more apt to engage in guardianship behavior against victimization." [65]

Social cohesion, informal social control, and trust are directly related to a community's ability to come together and act collectively to combat violent crime and other antisocial behaviour. [66]

SUMMARY OF SECTION 5

Social networks have been shown to result in multiple beneficial outcomes, apart from health. These include improvements in crime rates and anti-social behaviour.

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6. COMMUNITY DEVELOPMENT, SOCIAL NETWORKS, SOCIAL CAPITAL AND HEALTH

We have presented evidence that SNs and SC have significant impacts on health and on health protection or resilience. We now examine to what extent CD can develop and support SNs and whether, in turn, CD has an impact on health outcomes.

In general, the evidence suggests that empowerment and engagement initiatives can produce positive outcomes for the individuals directly involved including: increased self efficacy, increased confidence and self esteem, personal empowerment, improved social networks; a greater sense of community and security and improved access to education leading to increased skills and paid employment. Research also reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life [67] [68]

Petersen [69] and Schmid [70] agree that it is possible to enhance social capital by intervention.

CD and building social networks.
Minkler is quite clear that CD builds social networks [71] while Falk and Harrison suggest that social capital building can be equated with capacity building through community development. [72]

Evidence from seven studies suggests that community engagement may have a positive impact on social capital and social cohesion. [73] There are many examples of CD promoting SNs. [74]

Through the Healthy Communities Collaborative, there was also evidence of an improvement in social capital within the communities involved in the reducing falls programme, resulting in:

- 12% increase in people's perception of whether their area was a good place to live
- 12% increase in people's perception of whether individuals show concern for each other
- 22% increase in the number of people who knew where to get advice about falls
- 48% increase among participants in the proportion who thought they could change and improve things in their communities. [75]

The RSA's Connected Communities Report is clear that community organisers build SNs which improve health. They also suggest that a range of other kinds of people can do the same job. [76]

CD, health improvement and protection
Seattle Partners for Healthy Communities (SPHC) was a multidisciplinary collaboration of community agencies, community activists, public health professionals, academics, and health providers who conducted research aimed at improving the health of urban, socioeconomically marginalized Seattle communities. SPHC used a community-based participatory research approach to address social

factors that affected the health of these communities. Projects successfully addressed proximal social factors affecting health, but with difficulty. [77]

Time banks improve mental health through their social networking. [78]

The NICE guideline on community engagement offers a wide range of examples of how community engagement can promote health improvement. For instance evidence from six studies suggests that community coalitions used in the planning and design of an intervention may contribute to reducing the number of alcohol-related crashes, and contribute to improving a number of alcohol-related behaviours as well as improving the prevention of injuries to children, and in promoting a healthy diet in children. In terms of changing bicycle helmet use in children, community coalitions contribute to effective use; although girls are twice as likely as boys to wear helmets. Community coalitions also appear to contribute to effective promotion of physical activity through walking. [79]

Solid scientific knowledge and practical experience that can guide policy in many areas already exists. Promising, knowledge-based directions to explore include a range of collaborative community-focused initiatives that can lead to healthier communities, both by attracting additional resources and by building on and developing community strengths. [80]

Collective efficacy--the willingness of community members to look out for each other and intervene when trouble arises-- reduces BMI, being at risk of obesity, and overweight status when levels of neighbourhood disadvantage had been taken into account. This suggests that future interventions to control weight by addressing the social environment at the community level may be promising. [81] This supports community development workers' experience that health behaviour such as smoking can only improve when people feel better about themselves and each other.

Kim's research suggests modest protective effects of community bonding and community bridging social capital on health. Interventions and policies that leverage community bonding and bridging social capital should be considered as means of population health improvement. [82]

It's not easy

Seattle Partners for Healthy Communities (SPHC) successfully addressed proximal social factors affecting health. However, influencing more distal underlying factors proved more difficult. [83]

But it can be done

The Beacon project in Cornwall employed CD on a deprived estate. Significant change resulted both in the short and long term. Key success factors appear to be starting with an agenda designed by the community and building confidence from there.

It was not an academic exercise, however, and the data used below draw on everyday primary care statistics, collected by GPs and health visitors. Some of the data are not as robust as would be gleaned from a scientifically designed evaluation, but they do provide a strong indication of success.

An independent evaluation found major improvements between 1995 and 2000 in education, health, employment and crime [84] [85] Attempts to substantiate these statistically remain uncertain since numbers were small and chains of cause and effect complex, but improvements appeared to outstrip national trends at the time,

and the sense of an overall positive momentum of development driven by the project was attested in successive meetings of residents and service providers.

The complexity of effects is illustrated by the project's relationship to a regeneration grant. The creation of the neighbourhood partnership opened the way to applying for a national 'Capital Challenge' grant of £1.2m. Having a credible residents' organisation was a condition of the grant, which was then matched by a further £1m by the local authority. The resident-led partnership negotiated successfully for a leading role in how the grant was used. The resulting improvements to the estate's housing were therefore felt as 'owned' by residents, reinforcing all that they were doing through a plethora of new community groups, social projects and volunteering. The dynamic interaction of the physical and social improvements was undoubtedly of great benefit to the estate and provided an impetus to self-generated improvement which is still reaping rewards in 2011.

Comparable results have been seen in Balsall Health, an estate in Birmingham that independently developed a similar method [86]

Links between community participation and other health determinants
In a public housing neighbourhood in San Francisco where a community-based pilot programme was started to prevent tobacco use [87] In addition to being energized to address tobacco-related problems, residents were empowered such that they successfully advocated for general neighbourhood improvements including improved street lighting and speed bumps.

There is some evidence that community development expertise is associated with better outcomes for empowerment/engagement interventions particularly in the housing field e.g. tenant management initiatives. These are confirmed by NICE. [88]

Consideration should be given to public funding of community development approaches to health inequality reduction. However, it is important that the groups who are the targets of interventions are able to 'control' the remit and work of any community development workers, not the public sector professionals, and there is also scope for increasing the community development skills and competencies of local activists rather than committing the majority of funding to professionals whatever field they are in. [89]

The state increasing Social Capital
Evidence suggests that government can increase social capital through community based interventions and indirect social capital building. [90] [91] The World Bank agrees. [92] Marmot suggests that the state can intervene to create and deepen social networks and capital. Ideally, intervention needs to be local activity in a national context. [93]

Similar evidence can be seen in developing countries. In Tamil Nadu, India, a community based nutrition outreach programme in 9,000 villages resulted in a one third decline in severe malnutrition. A group of twenty women interested in health issues was hired in each village as part time community workers accountable to the community. The women's groups, formed initially to "spread the word," subsequently branched off and started food production activities on their own. Earlier programmes focusing only on the creation of health infrastructure were unable to make any difference in the nutritional status of children. [94]

The POPP initiative was set up to provide improved health and well-being for older people through involvement of older people themselves. These services were to be person-centred and integrated with local voluntary and community organisations, to promote health, well-being and independence. POPP services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact [95]

SUMMARY OF SECTION 6
The evidence seems clear that CD can improve community health through building social capital through building social networks.. Such activity spreads to other aspects of civil life. Government can support this

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7. CD AND SERVICE CHANGE

In this section we explore whether there is evidence that CD can influence local service change. If so, it could be a useful approach for consortia to use as a way of supporting services to be more responsive to the needs of the communities they serve.

The Department for Communities and Local Government suggested in 2007 the following typology of possible changes that might be seen:

- Changing corporate policies and practices – changes in the way that a provider operates that are likely to bring about benefits to the neighbourhood, such as reconfiguring the area that a service covers to coincide with the neighbourhood.
- Re-allocating mainstream service resources – increasing mainstream expenditure that benefits the neighbourhood, such as providing additional police patrols.
- Joining up mainstream service provision – improving the linkages between two or more mainstream services in ways that improve the quality, targeting, responsiveness and/or efficiency of those services.
- Reshaping mainstream service provision – making changes in the way that a service is designed and delivered, to improve its quality, targeting, responsiveness or efficiency.
- Improving service access to increase take up – increasing awareness amongst potential clients of the relevant services available to them and how they can be accessed, for example improving the signposting of services offering health advice and treatment through the use of outreach workers. [96]

The co-production literature offers many examples of more efficient and responsive services [97] Loffler offers a taxonomy of the ways in which co-production can assist in supporting services to become more efficient and responsive. [98]

Neighbourhood Management is a process which brings the local community and local service providers together, at a neighbourhood level, to tackle local problems and improve local services. The 35 Pathfinder pilots attempted to harness community engagement as a key tool. Community safety and environmental services, as well as health and children's services showed impacts. Impact varied by the effectiveness of the manager and the pressures on services. [99]

The Link-Age Plus initiative demonstrated the following outcomes: older people having new opportunities to socialise through involvement in social, training, leisure and networking activity; creation of employment, self-help and volunteering opportunities which developed new skills and social capital through the engagement and empowerment of older people; market development resulting in new organisations being created to work with, and for, older people by partnerships of statutory, third sector and private organisations; market development resulting in new preventative services being created by statutory, third sector and private organisations either individually or in partnership to work with, and for, older people; multiplier effects, where older people, either individually or collectively, have been at the centre of policy development and service design and empowered to identify outcomes and create innovative solutions; [100]

The Healthy Communities Collaborative to reduce falling in the elderly was based on enabling and incentives which lead to empowerment. The average age of team members was 65 and 70% of participants were local community members. The average reduction in the incidence of falls was 31%.

Some examples of successfully completed work are as follows:

- Joint work with local authority has improved street lighting within a sheltered housing complex and improved natural lighting within sheltered housing by changing the style of the front doors
- 10,000 elderly residents had a “message in a bottle” which is kept in the fridge to provide essential information for emergency services in the event of a fall or medical emergency
- Use of older people’s drama groups have helped to convey information on hazards and risks of falling
- Work has taken place with schools to include children in awareness campaigns
- Provision of battery powered night-lights in areas prone to frequent power cuts
- Work with voluntary agencies has provided home handyman schemes for older people, with particular reference to hazards in the home and garden.
- Work with residential care providers has led to a review of polypharmacy in residents.
- Provision of group exercise classes to improve balance, strength and stamina.
- Joint working with Highways Agency has led to a review of walkways around older people’s homes, eliminating existing poor surfaces.
- Joint working with local pharmacists, ophthalmologists and chiropodists has ensured that regular reviews and interventions on personal risk factors take place e.g. domiciliary eye checks and ‘sloppy slipper’ exchanges for older people.

Social capital indicators demonstrated that the model encouraged teams to apply the improvement techniques to improve other services. [101]

All local POPP projects involved older people in their design and management, to varying degrees. Improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs.

Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person. A practical example of what works is pro-active case coordination services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced

by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10% [102]

A community development intervention in Lewisham, SE London [103] has also shown some clear health and cost-benefits, partly perhaps because it made good links with GP practices in the area. Overall, it generated a high level of community capital and capacity with both lay and professional synergy. Many volunteering and training opportunities were created and many community groups received practical and financial support.

A variety of outcomes were tracked. There was a 9% increase in local people saying that they:'Definitely agree that we can influence local decisions' and an 11% increase in local people saying that they 'Definitely enjoy living in neighbourhood'.

So far as health behaviour was concerned, there was a 62% increase in stopping smoking, while at the same time, there was an 7% increase in the rest of Lewisham. There was a 22% increased consumption of fruit andvegetables and a 33% increase in levels of physical activity.

Improved physical and mental health outcomes were also found. A 13% increase in those saying they 'Feel very/quite happy with life in general' and increased confidence and self-esteem. There was a 24% increase in 'those not feeling anxious or depressed'.

There were also changes in the way primary care behaved. There was increased uptake of and improvements in services; a large increase in the recording of BP for people with hypertension; a 4 times increase in people expressing concern or referred with suspected cancer symptoms and 3 times the number of cancer referrals per month. There was evidence also of improved management of chronic problems like diabetes and back pain.

Local Authorities find community engagement and empowerment, in good and difficult times, saves time and money, creating more satisfied communities.[104] Once people in an area take charge of their destiny, they can negotiate new relationships with statutory agencies which can then, in turn, develop new, improved and appropriate forms of service delivery. [105]

Making resources available to address the association between poor health and poor social networks and break the cycle of deprivation can also decrease costs of health care.[106]

SUMMARY OF SECTION 7

The evidence is clear that involvement of local people can make significant impact on the responsiveness of local services. CD is one of these effective approaches.

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8. COMMUNITY DEVELOPMENT AND BEHAVIOUR CHANGE

In this section we examine the evidence for CD influencing behaviour change in the populations with which it works. All the evidence presented here comes from the evidence base on which the NICE guidance on community engagement is based. [107]

The evidence from six studies suggests that community coalitions used in the planning and design of an intervention may contribute to reducing the number of alcohol-related crashes, and contribute to improving a number of alcohol-related behaviours as well as improving the prevention of injuries to children, and in promoting a healthy diet in children.

In terms of changing bicycle helmet use in children, community coalitions contribute to effective use; although girls are twice as likely as boys to wear helmets.

Community coalitions also appear to contribute to effective promotion of physical activity through walking. The evidence from one study indicates that community coalitions appear to be associated with the integration of a healthy lifestyle into a community norm.

The evidence from two studies suggests that peer educators may be effective in delivering health promotion related education/support in improving vaccination uptake, and decreasing unsafe sex and increasing safe sex practices.

The evidence from one study suggests that peer educators would seem to be ineffective in changing injury prevention behaviours in high-risk adolescents.

The evidence from three studies indicates that neighbourhood/community committees used in the planning/design of an intervention may be effective in contributing to improving diet and reducing alcohol-impaired driving, related-driving risk, traffic deaths, and injuries.

Evidence from four studies suggests that indirect community engagement initiatives may have a positive impact on environmental and socioeconomic indicators such as employment, education and training, income, and crime.

SUMMARY OF THIS SECTION 8
It appears that community engagement and development are likely to have wide-ranging impacts on behaviour change.

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9. WHAT IS A BUSINESS CASE?

In this section, we explore the various approaches to developing a business case. In particular we focus on the complexities of trying to describe non-monetary benefits. We also explore the costs and risks of CD.

HM Treasury's guidance defines value for money as "the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the good or service to meet the user's requirement".

The Treasury Green Book goes on to emphasise that "value for money is not the choice of goods and services based on the lowest cost bid", but that "wider social and environmental costs and benefits for which there is no market price also need to be brought into any assessment".[108]

A useful summary of approaches is found in a Turning Point paper:

Cost-effectiveness analysis
Cost-effectiveness studies assess the cost per unit output, i.e. the analysis compares the costs and health effects of an intervention to assess the extent to which it provides value for money In cost effectiveness analysis, the outputs are measured in 'natural' units such as number of cases or number of sessions delivered. For example, a cost effectiveness study would consider the immediate results or outputs of a particular intervention.

Cost-benefit analysis
Cost-benefit analysis assesses the cost per unit outcome, and enables decision makers to know whether the programmes concerned are 'worth while' when compared to alternative ways of doing things. Costs and benefits are measured in monetary terms, allowing the financial value of the costs to be compared with the financial value of the benefits. For example, a cost benefit study would consider the impacts of an intervention further along the line such as hospital admissions avoided or number of deaths of avoided.

Cost-utility analysis
A particular type of cost benefit study is cost utility analysis. In a cost utility analysis the outcome is measured in a common currency such as Quality-Adjusted Life Years (QALY), which allows the cost-benefit of interventions to be compared. [109]

These broader models also take into account wider benefits to citizens, which can be perceived as non-economic benefits, such as

- Enhanced community leadership;
- Better accountability; and
- Increased public confidence. [110]

Four specific types of benefits that need to be measured in the case of co-production are identified in the literature:

- **Reduced agency inputs** resulting in greater economy and efficiency in delivery services or achieving outcomes;
- **Increased agency outputs** which refer to the services delivered by an agency and which are typically easy to specify and measure (Alford, 2009: 19);
- **Increased service quality** as the user or communities bring in resources, in particular expertise and information not available by professionals. Furthermore, active involvement in the delivery process may change subjective perceptions of quality – an issue which will be discussed in more detail later; and
- **Improved outcomes** – this refers to the impact of agency inputs on target groups (i.e. individual users or communities) which is typically more difficult to measure and often hard to link casually to outputs. But as Alford points out (2009:19), it may be the case that co-production has the objective of economising on agency outputs by contributing directly to a particular desired outcome. For example, if in the case of a local fire brigade the desired outcome is to reduce the damage of objects and people from fire, increased prevention activities of local residents (e.g. by installing fire alarms and checking them regularly) may reduce the number of emergency and rescue services a fire brigade has to provide (see also Audit Commission, 2008a).

The Social Return on Investment (SROI) framework helps organisations understand and manage the social, environmental, and economic value that they create. The approach combines, cost-benefit analysis and social auditing, taking into account the social benefits to all stakeholders. There are often different outcomes for different stakeholders

The stages of an SROI analysis include:

1. Establishing scope and identifying stakeholders

2. Mapping outcomes

3. Evidencing outcomes and giving them a value

4. Establishing impact

5. Calculating the SROI

6. Reporting, using, and embedding [111]

There are many examples comparing SROI with more conventional business cases [112]

Because an economic analysis can be so difficult, many business cases in local government and the NHS measure outputs against policy requirements. [113]

In the kind of holistic CD work across many departments it can be a problem to decide to which budget benefit accrues. Jason Lowther director of policy and delivery at Birmingham City Council, has said: "Parenting classes have been shown to work, and for every £1 spent by council, £4 comes back to public sector. But only £1 of this comes back to the council itself, so we spend £1 to save £1 – that's OK, but not exciting. And the other partners get £3 back, for no action. So we are starting to have conversations about how we can get more payback."

The timeframe over which success is currently measured can be a major barrier to progress that can only be addressed nationally. Lowther recognises that "the existence of short-term financial horizons make expenditure impossible if savings are only accrued in several years' time. So we need to talk to the Treasury about looking longer – can we look over a three or five year period, or 10 or 15 year periods? [114]

In the financial evaluation of community-based initiatives, it may be necessary to add up retrospectively the benefits of individual initiatives based on evidence from elsewhere. For instance, a community group may develop play or exercise space such as a park which can lead to behaviour change and more exercise. It is possible to find reasonably robust evidence about the SROI for open spaces. [115]

IDeA has offered much advice on developing a business case for community empowerment for community groups. [116]

SUMMARY OF SECTION 9

There are a variety of approaches to expressing a business case. So far as CD and community involvement is concerned, the difficulties are compounded because it is so difficult to express costs and benefits in monetary terms. Nonetheless, effective though complex techniques do exist. However, benefits can be problematic as they may take time to accumulate, impact on different stakeholders differently and also may benefit budgets other than those whose costs they are.

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10. WHAT DO WE KNOW ABOUT THE COST-BENEFITS OF CD?

This section explores research data on cost-benefit analyses of CD in health and other sectors. As we have said above, there are few costed examples of CD and therefore few cost-benefit studies but there is more material if we widen the net to include quasi-CD projects such as targeted outreach projects which support a particular section of the population whilst also seeking to empower them to take independent group activity.

Making resources available to address the association between poor health and poor social networks and break the cycle of deprivation can also decrease costs of health care. [117]

The World Bank (1999) has also brought together a range of statistics to make the case for the social and economic benefits of social capital and they present a strong defence for CD. [118]

The technique of SROI has been used to examine four examples of CD [119]. This report tracks the cost benefit of a CD worker in each of four local authorities, identifying, supporting and nurturing volunteers within their areas to take part in local groups and activities, and thereby indirectly improving the lives of people in the wider community. Research identified outcomes for three types of beneficiaries:
1) individuals who volunteer to deliver community projects
2) those who participate in the activities of community projects
3) members of the wider community who do not participate.

The results indicated that for an investment of £233,655 in community development activity by the four CD workers the social return was approximately £3.5 million, a return of 15:1. The time invested by members of the community in running various groups and activities represented almost £6 of value for every £1 invested by a local authority in employing a community development worker. If the volunteering is counted as a cost *input*, the return is reduced to 2.16:1

36% of the value created by community development work is manifested in the form of an improvement to the supportive relationships enjoyed by volunteers, participants in community activities, and the wider community. This equates to £1,273,215 in terms of the value of improved relationships.

28% of the value created by community development work is manifested in the form of an improvement to the feelings of trust and belonging fostered among volunteers, participants in community activities, and the wider community. This equates to £992,213 in terms of the value of trust and belonging.

The greatest changes in well-being were evidenced for those who volunteer to deliver community projects worth £395,358 in social value. For those either delivering or participating in community development projects and activities, the biggest impact on well-being was in relation to positive functioning: feeling competent, engaged and living life with meaning and purpose. The element of well-being most impacted for those in the wider community is around personal resilience, optimism and self-esteem.

These findings support the conclusion that community development met the needs it had identified, namely: a need for social and organisational structures in a locality which allow for residents to engage with one another, trust and respect each other, and effectively influence the provision of services, facilities and activities to their community.

Other examples

The Healthy Communities Collaborative reduced falls in older people through combining CD with targeted outreach to this section of the community. . In three sites, covering a population of 150,000, there was a 32% reduction in falls (730 fewer falls over two years). This is estimated to represent a reduction in hospital costs of £1.2m, in ambulance costs of £120,000 and in the costs of residential social care by £2.75m.

The SROI for CD in heart disease is estimated by Lomas [120] He estimates, based on available evidence from elsewhere, to what extent CD activities would reduce cardiac disease and compares those outcomes with those from more conventional approaches. He compares potential heart disease deaths in men prevented per 1000 exposed to each``intervention'' per year:

- Social cohesion and networks of associations would prevent 2.9 fatal heart attacks or heart failure
- Medical care and cholesterol-lowering drugs would prevent 4.0 fatal heart attacks in screened males
- Routine access, free care would prevent 2.1 all cause deaths in high-risk males over 50 years old [121]

Time banks use hours of time rather than pounds as a community currency: participants contribute their own skills, practical help or resources in return for services provided by fellow time bank members. The cost per time bank member averages less than £450 per year but could result in savings and other economic pay-offs of more than £1300 per member. In addition, time banks can have wider impacts than those estimated so far, so additional economic pay-offs are probable. [122]

Befriending services – many run by voluntary and community organisations and heavily reliant on volunteers – aim to reduce social isolation, loneliness and depression, particularly among older people. The economic impacts are estimated to be typically about £80 per older person but savings could be about £35 in the first year alone because of reduced need for treatment and support for mental health needs. [123]

Plus probable future savings as found in the POPPs pilots showed quality of life improvements as a result of better mental health, valued at £300 per person per year. [124]

Community navigators: volunteers trained to reach out to vulnerable people. Provide emotional, practical, social support; information; signposting. Typically work at interface between the community and public services. Economic impacts are estimated as follows: when working with hard-to-reach individuals to provide benefit and debt advice, cost is less than £300 per person, but economic benefits from less time lost at work, savings in benefits payments, contribution to productivity and fewer GP visits could be £900 per person in the first year. There are likely to be other pay-

offs such as quality of life improvements from better mental health have economic value [125]

A wide overview by NESTA [126] exploring a range of interventions, of which CD was one, concluded that social action can, through reductions in A&E attendance, planned and unplanned hospital admissions, and outpatient attendances, release savings of 7 % for CCGs, that is an average of £21m per CCG.

Integrated health and well-being services can realise significant financial benefits. In particular, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1 spent (POPPs, LinkAge Plus, Supporting People, self care schemes). Furthermore, for every £1 spent on balance/Tai Chi classes by the taxpayer in LinkAge Plus areas there is a health and social care saving of £1.35. This suggests that balance classes are a highly effective way to reduce the incidence and associated costs of falls, leading to fractures, hospitalisation and operations).[127]

Evaluations of the El Salvador community organization and FUNDASAL housing projects for the poor found that the unit cost of houses was less than half that of the least expensive standard government dwelling. The FUNDASAL housing unit also had a superior benefit-to-cost ratio compared to any other housing program in either the formal or informal housing sector. [128]

Engagement leads to less complaints and saves money[129] Having an engaged community can also avoid delays or issues such as vandalism. On a £2.2m housing redevelopment project for the Shoreditch Trust, consultants estimated that the additional costs saved from community engagement were about £500,000.

For similar reasons, corporate business uses CD [130]

A strong community relations programme involving ongoing community consultation, dialogue and a community development programme helped Shell Prospecting and Development in Peru identify and address a potentially significant community issue. Shell had been using hovercraft to transport supplies. Local indigenous communities objected because they were noisy, frightening and were believed to carry demons. Through a culturally sensitive public consultation programme, the company was able to address these concerns by altering important aspects of their transport services.

Effective public consultation and positive community development help minimize risks of added cost that come from poor community relations. In an atmosphere of poor community relations, minor disputes can escalate into major disagreements that may do damage to a company's bottom line. [131]

Costs

From a local authority perspective, costs to be considered include:

- **Agency professional staff inputs** to induce service users or communities to contribute their time and effort to the co-production of public services. For example, expensive public campaigns or even 'grass-roots working by neighbourhood managers' and a direct financial incentive which means reduced public income.
- **Agency managerial inputs** to induce public service professionals to change traditional ways of providing services or to provide different services. Some service professionals may resent working more closely with non-professionals and require extra incentives or sanctions.

- **User-related inputs** to train service users and communities make co-production work. For example, citizens acting as environmental champions have to undergo 'risk, health and safety' training.
- **Professional-certification inputs** to train professionals to the standards necessary to make co-production work. This applies, in particular, when co-production involves work with citizens who lack capacity.

The key efficiency gain through user or community-led co-production only comes if these co-production-caused costs are outweighed by the costs savings in actual service provision, as users and communities provide more inputs and decrease the need for the service through their increased preventative activities. [132]

Giving citizens more control over resources may reduce the effectiveness of traditional cost control. New ways of enabling the public to control costs are needed. Equity can be threatened where people have unequal levels of resources to contribute. Coproduction is also limited where citizens lack capacity e.g. dementia or where there are large knowledge asymmetries e.g. pharmacy. Waste and failure becomes more transparent – encouraging more risk management, more responsiveness and faster learning and evaluation [133] [134]

Poor community development practice can cause problems of its own. Fourteen good-quality primary studies suggest that common practices in community engagement may create significant barriers. These problematic practices include the organisation, style and timing of meetings, a lack of diversity in methods for engagement, inflexible funding regimes, discriminatory practices, failure to accommodate cultural diversity, formidable time demands leading to consultation fatigue, the complexity of structures and processes for engagement and the public sector's failure to develop effective and transparent mechanisms to translate community expertise into action and ensure feedback. [135]

SUMMARY OF SECTION 10

If we widen our definition to include various approaches that have many similarities to CD or which demonstrate at least some aspects of CD, the evidence available from different cultures and including the private sector, strongly supports the case that CD offers good value for money.

CONCLUSION

This literature review was started before the HELP project began. The data from the HELP project [136] contributes to the conclusions we can draw from this literature review. Social capital is a way of describing the multitude of social networks in a community. There is good evidence that social capital is closely linked to health, both mental and physical. In essence, the review shows that CD helps to strengthen and multiply social networks – the connections, the associational life we all have – and so build up social capital. These contribute significantly to individual and to community health and resilience. Existing data suggests that community development in health is cost-effective. The cost-benefit literature is limited and the HELP project adds significantly to it.

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