EDITORIAL
Promoting health and wellbeing through the asset model

An asset approach to public health policy, research and practice aims to support individuals communities and organisations to secure the skills and competencies that can maximise opportunities for health and wellbeing[1]. The approach is characterised by 2 main ideas. Firstly, it focuses on solutions not problems. In other words, it encourages health programmes to create the conditions for health so that the capacities and capabilities of individuals and communities can be released. The approach thereby, supports populations to be less dependent on health and welfare services. Certainly in today's economic climate, this means that the limited resources that are available can be targeted towards those in most need. Secondly, it places people at the centre of the health development process. The more health programmes are developed with and by local people, the more likely they are to be successful and sustainable[2]. Effective ways of involving people include: a commitment by policy for long term investment; openness to organisational and cultural change to understand what supports or inhibits community engagement; a willingness to share power, as appropriate, between statutory and community organisations; and the development of trust and respect among all those involved[3].

The asset approach whilst not a new idea has been re-energised in recent years in the context of continued political and policy goals to reduce health inequalities. For example, at an international level, the World Health Organisation (WHO) Health 2020 policy framework[4] for health and wellbeing, highlights the importance of creating resilient communities and strengthening people-centred health systems. At a country level, there are numerous examples of the asset approach being taken seriously by government. For example, Sir Harry Burns, Chief Medical Officer for Scotland, in his 2009 annual health report[5], argued that '*we need to develop an approach to health improvement which does more to unlock the assets within individuals which create a sense of control and wellbeing'.* In Spain, the Andalucian Public Health Law[6] supports the development of the discipline of health promotion by ensuring that all health plans, projects and services are framed by the health asset approach. Most recently, a motion by the Spanish Parliament recognised that the adoption of the asset approach and the inclusion of salutogenesis in the health dialogue can help to overcome some of the most difficult challenges in society[7].

Whilst policy commitment sets the imperative for change, the appeal of the asset approach will only be retained if the benefits of delivering it can be demonstrated both in population health and economic terms. There remains a challenge therefore to consolidate the knowledge and enthusiasm about why the approach works into a robust evidence base that can make the case for longer term investment.

THE ASSET MODEL

The Asset Model (AM) developed by Morgan and Ziglio (2007)[1] sets out a systematic framework for how this evidence base could be achieved. A revised model by Morgan, Hernan and Ziglio is shown in Figure 1[8].

The AM aims to add value to a range of existing concepts and ideas that have the potential to promote positive notions of health. It does this by bringing them together into a coherent framework that encourages a more systematic approach to assembling and applying knowledge for health solutions. It uses a 3 phase public health approach to support a wide range of professionals to think and act differently about the way they deliver health programmes. Further details of these concepts can be found in *Health Assets in a Global Context*[9]

Phase 1, is framed by an 'epidemiology of health' (in contrast to the traditional needs based approach which assesses the disease burden and problems of populations). That is, it assesses which protective factors (or 'health assets') are critical for helping individuals and communities thrive, achieve health, wellbeing and other personal goals. It draws on Antonovsky's[10] theory of salutogenesis as an intermediary step along the health and wellbeing pathway. Salutogenic thinking challenges us to ask: what are the key sources of health and what causes some to prosper, and others to fail or become ill in similar situations? The asset model asserts that the more people have the opportunities to experience and accumulate the positive effects of a range of health assets across the life course, the more likely they are to achieve health goals[11]. In salutogenic terms, the

accumulation of health assets develops the 'sense of coherence' required by individuals and communities to understand and manage the world they live in[12]. Those with high levels of coherence are much more able to make the right health choices and to thrive even when faced with difficult circumstances. The evidence to demonstrate the links between sense of coherence and health and wellbeing is beginning to emerge[13].

Findings from phase 1 provide a starting point for the action phase (phase 2) of the model. Evidence accumulated during phase 1 provides an itinerary of those health assets that can be protective; as well as a better understanding of how the assets identified can link together to formulate a pathway to positive outcomes. Phase 2 then becomes the testing ground to understand whether the hypotheses generated during the first phase make sense in real life. Core to the implementation of phase 2 is the building of trust and respect between professionals and local people. It makes use of 'asset mapping' a well-established technique pioneered by Kreztmann and McKnight[14] to identify and make best use of individual skills, physical and organisational resources that together can be mobilised to help achieve a vision for health within a particular community context. In the words of the Asset Based Community Development (ABCD) Institute '*building community has always depended upon mobilising the capacities and assets of a people and a place*' (see www.abcdinstitute.org for further information). There are numerous Spanish examples of how asset mapping is being implemented to ensure that health is secured through a process of co-production with the local community. The RIU project in Comunitat Valenciana[15], the Asturias Health Observatory[16] and the work of the Escuela Andaluza de Salud Pública [16, 17] are worthy of note.

Fundamental to this phase is that asset identification starts at a community level through a process

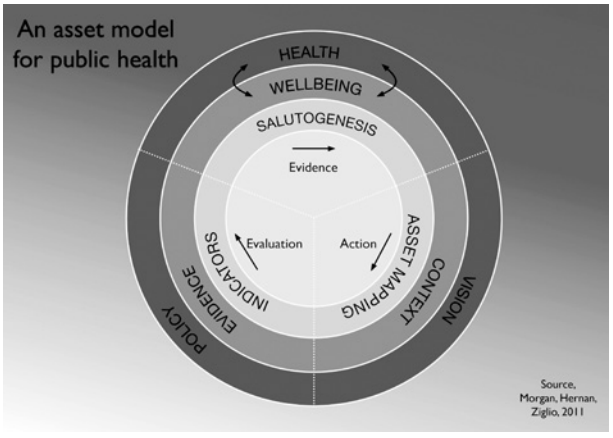

Figure 1

of visioning and mobilisation. By this we mean, that communities are given the opportunity to set their own priorities for health (their vision) and the support required for them to identify and acquire the assets to fulfil that vision (mobilisation) [14]. These may or may not match those already identified in phase 1. This is important as it recognises the dynamic process of health and that populations change over time with new demands, challenges and opportunities[4]. The iterative process used by the AM allows the itinerary identified in phase 1 to be kept up to date.

Phase 3 supports a more systematic approach to documenting why the participatory actions used in phase 2 have been successful. Evaluation is essential to advance the evidence base for the approach. Evaluation frameworks can: help professionals engaging with local communities consider the theory of change required to achieve success; ensure outcomes match the resources available and the time to invest in the activity; and select indicators that reflect positive notions of health and wellbeing[3].

Evaluation often instils an unnecessary fear in those who already have the tacit knowledge of why and how things work at a community level. Phase 3 aims to demystify research by encouraging technicians to work alongside those taking action to ensure that the knowledge base of successful asset approaches can be made more explicit and transferable. A starting point for this task is to think about evaluation as a narrative. This narrative describes what was done and why and how the actions involved in delivering initiatives can be deemed successful. Success can be demonstrated through testimonials from community members; case studies; qualitative interviewing or through more ambitious quantitative means[18]. The rigour of the process comes via three main principles of collecting and synthesising evidence[19]. They are: transparency (being clear about what, how and why things were done); systematicity (contextualising the work into a broad theoretical framework to make explicit the different questions being asked and the methods chosen to answer them); relevance (contextualising evidence so that information about the population; place and social structures is given to allow an assessment about how generalizable and transferable the findings are).

WHY ASSETS WHY NOW?

There are a number of reasons why we should take the opportunity to advance the theory and practice of the approach.

Firstly, many of the assets found to be protective of health lie within the social context of people's

lives and therefore the approach offers much potential to contribute to the persistent health inequalities that exist between and within countries worldwide. As highlighted above there is a growing policy impetus to adopt the approach as one of the solutions to unlocking some of the barriers to tackle these inequalities.

Secondly, the knowledge of how to construct an evidence base around the social determinants of health is strong[20]. The AM recognises that whilst new knowledge is required we need to make the most of what we already have. Those already working with the principles and values associated with the asset approach need to collaborate with research to make explicit the learning from asset based practice so that we can make stronger the argument about why it makes a difference to people's health and wellbeing.

Thirdly, it has already been demonstrated that investing in public health interventions is cheap thereby affirming that prevention is preferable to cure[21]. In addition, many of the barriers to achieve behaviour change such as reductions in smoking and alcohol; or in adopting healthy eating are the same and relate to external pressures often outside an individual's immediate control. By nature, the asset approach works horizontally to seek solutions that have a positive impact on all these behaviours simultaneously. In so doing, it has the potential to acquire even more economic gains to public health. Although this has yet to be proven!

THE CAVEATS

When new approaches emerge (or re-emerge), there is always a simultaneous emergence of critics who refute the ideas presented. It is important to engage with the criticisms to ensure that the clarity of message about why the approach is important can be more firmly understood. Since the publication of the AM a number of questions have arisen. For example, some ask: is it not a bit naïve to think that we can live in a world free of risks? The asset approach aims to help people move beyond their status as passive recipients of services. It seeks to identify how we can maximize the benefits of a range of assets that counteract risk thereby minimizing their impact on health and wellbeing. That said it recognizes that there may be times in all of our lives when vulnerabilities and risk accumulate such that individuals and communities are in need of immediate services. Therefore it is true that asset and deficit (based on need) approaches are both required to maximize life chances and access to services when they are most needed.

Another question that arises is: so if we implement the asset model effectively there will be no need for Government intervention as communities can look after themselves? This is absolutely not the case. However what is often true is that asset based approaches often become more popular in times of crisis when there is less resource and money available to deliver effective services. The idea of communities looking after themselves may at this point seem attractive to Governments. Key to the success of any asset initiative is the ability of policy makers, practitioners and researchers to play their part in optimizing the conditions for health. This includes the ability to work with local communities in such a way as to build the trust and respect that facilitates an equal share of the power required to make effective people centred decisions.

Finally, most often the approach is seen as a revamp of community development. Although many of the principles of community development are central to the asset approach, it is equally important to work at the level of the individual. Integrating the individual with community and broader society and understanding how to do this across the life course becomes the added value of the approach. Asset acquisition ideally starts early on in life and accumulates as we move through each key life stage. Prominent assets in this regard, are the skills and competences required to navigate life's stressors along with a set of values that promote a desire to participate in and contribute to community life and goals.

The life course approach is particularly useful, as it recognises that at any point in a person's life things may go wrong. The asset approach then provides a process for understanding what is required to rebuild the confidence and self-esteem necessary for individuals to regain the motivation for doing well. The article by Paredes et al in this issue of RESP '*Sentido de coherencia y activos para la salud en jóvenes internos en centros de menores'* provides an example of how we can start to build an evidence base that demonstrates how re-offending can be minimised and assets released so that the skills and talents of young people foster healthy and productive lives. Closed environments, such as juvenile detention centres or prison settings, are an opportunity to access a population with inequalities and from where abilities or health assets can be developed in a participatory manner[23].

In sum the asset approach is helping to revitalise the paradigm of health promotion by ensuring that health and wellbeing is secured through a wider lens of understanding. As such it draws on the fields of social medicine and behavioural sciences, political and economic disciplines and the field of human learning. In this way our understanding of how to create the conditions for improving the quality and quantity of

life becomes a reality for individuals and communities irrespective of their race, culture, gender or socio-economic position and indeed at any particular stage in the life course.

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REFERENCES

1. Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. Promotion and Education. 2007; Suppl 2: 17-22
2. Popay J. Community empowerment and health improvement: the English experience. In: Morgan A, Davies M, Ziglio E. Health assets in a global context: theory methods action. New York: Springer; 2010. p. 183-195
3. National Institute for Health and Care Excellence[Internet]. Manchester: NICE; 2008-2013 [updated 2013 march 15; cited 2013 Sept 08]. Community engagement guidance; [about 2 screens]. Available from: http://www.nice.org.uk/PH9.
4. World Health Organisation. Health2020: the european policy for health and wellbeing. Copenhagen: WHO; 2012.
5. Burns H. Health in Scotland 2009: time for change. P15. Edinburgh: The Scottish Government; 2010.
6. Ley de Salud Pública de Andalucía 16/2013, de 23 de diciembre.(Boletín Oficial de la Junta de Andalucía nº 255, de 31/12/13).
7. Proposición no de ley relativa a la promoción de activos para la salud y salutogénesis 161/001724, de 3 de junio de 2013. (Boletín Oficial de las Cortes Generales, Congreso de los Diputados Serie d núm. 282 de 3-6-2013).
8. Morgan A, Hernan M, Ziglio E. In Morgan A. Young people and health: social capital for the asset model today. Advanced seminar: Health promotion, health assets and salutogenesis – experiences in Andalusia and Europe; 2011 Jan 27-28; Granada: Escuela Andaluza Salud Pública; 2011.
9. Morgan A, Davies M, Ziglio E. Health assets in a global context: theory methods action. New York: Springer; 2010.
10. Antonovsky A. Unravelling the mystery of health. How people manage stress and stay well. San Francisco: Jossey-Bass; 1987.
11. Morgan A. Social capital as a health asset for young people's health and wellbeing. Journal of child and adolescent psychology 2010; suppl 2: life contexts; 19-42.
12. Antonovsky A. The structure and properties of the sense of coherence scale. Social Science and Medicine 1993; 36; 6; 125-733.
13. Eriksson M, Lindstrom B. Antonovsky's sense of coherence scale and the relation with health: a systematic review. Journal of Epidemiology and Community Health. 2006; 60; 376–81.
14. Kretzmann J, McKnight J. Building Communities from the Inside Out: a path to finding and mobilising a community's assets. Illinois: ABCD Institute; 1993.
15. Paredes-Carbonell JJ, Aviñó D, Peiró R, Bosch C, Ramo I, Palop V et al. Projecte RIU: Un riu de cultures, un riu de salut. Una propuesta de intervención en salud en entornos vulnerables. Comunidad. 2011; 13: 34-7.
16. Botello B, Palacio S, García M, Margolles M, Fernández F, Hernán M, Nieto J, Cofiño R. Metodología para el mapeo de activos de salud en una comunidad. Gac Sanit. 2013; 27(2): 180-3.
17. Hernán M, Morgan A, Mena A. Formación en salutogénesis y activos para la salud. Granada: Escuela Andaluza de Salud Pública; 2013.
18. Pettigrew M, Roberts M. Evidence, hierarchies and typologies; horses for courses. Journal of Epidemiology and Community and Health. 2003;57; 527-9.
19. Swann C, Falce C, Morgan A, Kelly M, Powell G, Carmona C et al. Process and Quality Standards for Evidence Briefings. 3th ed. London: Health Development Agency; 2003.
20. Bonnefoy J, Morgan A, Kelly M, Butt J, Bergman V. Constructing the evidence base on the social determinants of health: a guide. A report to the WHO Commission on the Social Determinants of Health. London: WHO; 2007.
21. Owen L, Morgan A, Fischer A, Hoy A, Ellis S, Kelly M. The cost effectiveness of public health interventions. Journal of Public Health. Mar; 2012; 34(1); 37-45.
22. Paredes-Carbonell JJ, Agulló-Cantos JM, Vera-Remartínez EJ, Hernán-García M. Sentido de coherencia y activos para la salud en jóvenes internos en centros de menores. Rev Esp Sanid Penit. En prensa 2013.
23. Paredes-Carbonell JJ. Promoción de salud en el medio penitenciario. En: Colomer C, Alvarez-Dardet C. Promoción de salud y cambio social. Barcelona: Masson; 2001. p. 173-89.