Professor Jennie Popay and Dr Emma Halliday – written evidence (CCE0149)

Introduction.
This submission is from Professor Jennie Popay and Dr Emma Halliday in our individual capacity. We welcome the opportunity to provide written evidence towards the Select Committee’s work as it considers issues related to citizenship and civic engagement. Our submission draws on research on the social determinants of health inequalities and in particular the potential positive impacts of civic engagement involving communities of ‘place’ (residents of a geographical area) within the UK context. We focus on evidence related to engagement approaches that seek to increase the ‘collective control’ residents of disadvantaged neighbourhoods have over decisions that affect their lives. Examples include initiatives that allocate funding to communities who take action around shared priorities in a geographical area (place based initiatives) or models of working that enable more equitable collaboration between communities and public sector and other organisations. In particular we provide evidence to contribute towards questions 9 and 12 of the evidence call.

Response to Q9.
Why so many communities and groups feel “left behind”:
1. Scale of health and social inequality in the UK: There is a very significant body of evidence documenting the scale and nature of the health inequalities associated with inequalities in social and economic living and working conditions. These inequalities are seen across almost all causes of mortality and many diseases including mental illness. However, perhaps the most profound dimension of these inequalities are those associated with life expectancy and healthy life expectancy (years without chronic illness) at birth between more and less disadvantaged areas of England. For example, based on figures for 2008-13 there is a 6 year difference in life expectancy and 20.2 year difference in healthy life expectancy between women living in the most and least deprived areas – the figures for men are 8 years and 19 years respectively. There are also significant inequalities between different regions, with health being worse on average in the north of England than in the south even when people are living in the same socio-economic circumstances. It is important to stress that these inequalities in health outcomes are not inevitable: as a recent paper in the BMJ has shown, the period of increased social investment between 1997 and 2010 across the whole of government, targeted at disadvantaged areas and groups, was associated with a decline in health inequalities.¹

2. Lack of control as a driver of inequality: The causes of health inequalities are complex and multifaceted but there is conclusive evidence that the social and economic conditions in which people live and work are primary drivers.² In this context, there is a growing body of evidence on the importance for health of the control people have over decisions that have an impact on their lives.³ Though much of the research has focused on control at the individual level, there is increasing interest in the social and health impact of ‘collective control’ by communities of interest or place which theory and some albeit limited research suggests may ‘work’ in the same way.⁴

³ Ibidem.
3. **Stigmatisation of economically deprived areas**: The impact of stigma associated with inequality presents significant issues for groups already experiencing considerable disadvantage. These processes of stigmatisation are shaped by the attitudes of those living or working outside an area, including journalists, as well as residents of other neighbourhoods and public officials working locally and nationally. Exploratory work during the Communities in Control study (see point 6) identified that residents perceived negative or stereotyped images connected to the areas where they lived, to affect life chances, investment into the area, social cohesion and wellbeing.\(^5\)

**Barriers to active citizenship:**

4. Existing research reviews have identified a range of factors acting as barriers to non-participation in decision making/civic activities by residents of disadvantaged areas, as well as challenges affecting on-going participation in programmes of engagement.\(^6\) These barriers include:

4.1. **(Mis)understandings of non-participation**: Professionals may misunderstand a lack of participation as resulting from apathy or a ‘lack of capacity’ among the community. Community members may, however, enact non-participation or be unwilling to engage with external agencies as a rational decision, which is based on poor experiences of previous engagement efforts by professionals or where communities perceive past funding (e.g. regeneration) to have had little impact.\(^7\)

4.2. **Lack of capacity in systems**: Emphasis is typically placed in programmes on the capacity of lay communities to engage within society. However, successful engagement and partnerships requires action to release and also build the capacity of whole systems (people who live and work in an area for example and the institutions responsible for commissioning and delivering public and private sector services). This includes for instance action to develop appropriate skills and competencies of organisational staff; tackling a dominant professional service culture; the overall organisational ethos and culture; and the dynamics of the local and national political systems.\(^8\) For a model attempting to address these issues at the neighbourhood system level, see NIHR Collaboration for Leadership in Applied Health Research and Care for the North West Coast (under point 7).

4.3. **Power dynamics between communities and agencies**: The imbalances of power has been frequently neglected in engagement activities or programmes. Community scepticism and

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conflict may result from a lack of clarity or disagreement about the degree of influence that members of the public hold or should have with regard to decision making.9,10

4.4. Influence of social context: Where initiatives aim to engage within a geographical setting, pre-existing social conditions/cohesion may affect the abilities of people living and working in an area to engage with each other. This is influenced by the extent communities have a shared sense of place, a shared history, or previous experience of engagement. Such factors can influence whether communities are willing to interact or feel able to come together around shared interests within their community. While such factors have traditionally been construed as barriers to participation, the process of engagement may, over time, result in new and strengthened social connections and cohesion as residents come together and engage with each other, and with other organisations.11

Response to Q12.

5. There is some evidence of health and social impacts for individuals and communities arising from civic involvement in initiatives aiming to involve communities in neighbourhood decision making. Particularly, there is evidence that engagement of citizens is an important element of successful action for cohesion in local communities Evidence summaries are provided from public health studies of two English place based programmes (New Deal for Communities, Big Local) and a model of neighbourhood resilience being tested in the north west of England.

5.1. The New Deal for Communities (NDC) initiative was a government-funded programme introduced in 39 of the poorest neighbourhoods in England in 1998. The aim was to improve the social conditions and health of people living in these areas. Local residents had to be involved in planning and delivering NDC projects but they were engaged in different ways in different areas. Our research identified different approaches to civic participation ranging from those that gave residents considerable influence over NDC decision-making and build community capacity for engagement to those in which professionals were more likely to engage with residents more instrumentally to gain support for their organisation’s agenda. The results show a mixed picture but the general pattern in these results suggests that, in those NDC areas in which residents had the greatest influence over NDC decisions and opportunities to participate, local people were more likely to report that the NDC had improved the area, and that relationships in the community, levels of trust and mental health had improved over time than residents in areas in which they had less influence.12

5.2. Over the longer term, however, pressures faced by the NDC programme to deliver ‘early wins’ and the initiative’s top-down performance system appeared to create a disempowering environment at odds with a more gradual community development process needed for true empowerment and engagement to evolve. NDC local

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programmes that appeared to retain their commitment to an ethos of civic engagement and community influence over time were able to draw on organisational ‘resources’ that protected or enabled this ethos to be sustained (e.g. strong leadership committed to empowerment values) in the face of governmental pressures to spend funding and show results.\(^\text{13}\)

6. **The Communities in Control (CiC) study\(^\text{14}\)** is assessing the health impact of the Big Local programme. Big Local is being rolled out in 150 areas in England with funding from the Big Lottery.\(^\text{15}\) The study’s first two phases (2014/17) were funded by the NIHR School for Public Health Research (SPHR) and undertaken by a collaboration of five members of NIHR SPHR1 (the LiLaC collaboration between the universities of Liverpool and Lancaster, the universities of Sheffield and Exeter; The London School for Hygiene and Tropical Medicine; and Fuse; The Centre for Translational Research in Public Health). The findings reported here present an early assessment of the health and social impacts of programme that will continue to unfold over the longer term.

6.1. **Impacts at the collective level arising from civic engagement:** The study has identified numerous examples of the positive impact that the exercise of collective action by residents is having on the physical environment and on social relationships in Big Local areas. The findings also show how communities experiencing place-based stigma (which other research has shown to have negative impacts of life chances and quality of life) can take positive action to improve the reputation of their neighbourhood and the people who live there. Across these examples there is a common thread of how the process of taking actions around neighbourhood issues is resulting in the accrual or strengthening of community resources (e.g. social networks, physical and financial resources, power) within these local systems as residents take action themselves, collaborate with others or seek to gain a greater voice in, or influence decisions taken by others. On the other hand, the research also found examples of how ‘feedback loops’ can negatively impact: with collective action generating conflict and dampening confidence when residents’ perceived their efforts (e.g. local projects or events) to have not been successful.

6.2. **Individual level impacts of civic engagement:** Longitudinal survey data from 15 Big Local areas has provided some evidence of improvements in subjective assessments of control and mental health among those residents most actively engaged in Big Local. While these findings are based upon a relatively small sample, this supports a hypothesis that empowerment of residents at the collective level may have positive effects on mental health and wellbeing for those who participate. However, impacts are complex. For example, residents most closely involved in Big Local activities also reported challenges and stress from participating in these collective decision making processes. In some cases, these experiences were reported to have had significant negative impacts on subjective feelings of wellbeing.\(^\text{16}\) In contrast, other residents reported that involvement, particularly social opportunities beyond core decision-making structures, had positively transformed their subjective wellbeing. This points to the need for initiatives to create


\(^\text{14}\) NIHR SPHR ‘Communities in Control study’, Available at: http://sphr.nihr.ac.uk/health-inequalities/about-the-communities-in-control-study/ [accessed 6 sept 2017]

\(^\text{15}\) http://www.localtrust.org.uk/

\(^\text{16}\) NIHR SPHR (July 2017) Health Inequalities Research Programme: Communities in Control Study Phase 1 & Phase 2. Final report. Available from: j.popay@lancaster.ac.uk
multiple opportunities to increase the breadth and depth of participation and for evaluations to track the differential effects of these over time.

7. *NIHR Collaboration for Leadership in Applied Health Research and Care for the North West Coast: Promoting resilience at a systems level:* Throughout the UK severe funding cuts are straining the capacity of local governments, Decreased public funding for services increases pressure on individuals and communities to cope with socioeconomic adversity without external support. Promoting individual or community resilience alone is not enough to reduce health inequalities locally. Enhanced resilience at a systems levels, underpinning engagement between paid workers, the institutions they are employed by and communities, has the potential to improve the social drivers of improvements in collective and individual health. The NIHR CLAHRC NWC has a programme of work focusing on developing system resilience in nine neighbourhoods in the North West of England. Features of this work include promoting more equal collaboration between residents, Local Authorities, community organisations and private sector organisations where appropriate to understand, and influence, action that can promote system resilience, as well as resident led local enquires to help plan for action and help evaluate the impact of changes put in place.

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