Chapter 9
Participation in the New Public Health Landscape

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Abstract The UK government's proposals for devolving power to local authorities and encouraging individuals to take more responsibility in these deliberations are changing the landscape of social and political decision-making and their responsiveness to the public. As a result there are major implications for public health in this process and how the public are consulted and involved and the challenges that they represent. The impact of this process will be explored in two ways. First, an exploration of what it means to be involved in decision-making through a discussion of participation, empowerment and agency. This raises questions about how the individual can be realistically involved and how the health professional's role can be faithful to the principles of facilitating change and enabling individuals to engage. Second, the section on theory into practice will examine how we can translate these ideas into practical guidance and action. It will explore what is the evidence base for community engagement and outline some examples of what action can be taken. Finally, series of questions are posed after each section to enable the reader to explore these issues and a number of key documents are identified which will enable the reader to address these issues in greater depth.

After Reading This Chapter You Will Be Able to

- *Identify the main changes in the new public health landscape.*
- *Identify the meaning of empowerment and agency in terms of public health.*
- *Recognise the role that public health professionals need to adopt to empower communities.*
- *Identify some ways in which public health can be promoted by local communities.*

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K. Regmi (ed.), *Decentralizing Health Services: A Global Perspective*,
DOI 10.1007/978-1-4614-9071-5_9,

Introduction

Over the past few years, there have been major changes in the landscape of government and as a consequence how the promotion of better health is involved. In addition the austerity measures and the severe cuts in public spending have cast a shadow on how public health programmes can be effectively delivered. This chapter will identify these changes and their implications for public health and health professionals.

The idea of empowerment has had a major impact on development work and community action but the theoretical principles underpinning this work have only just began to influence work in public health. Thus, it is important to devote time to discussing the meaning of empowerment for individuals and communities because this will have a major influence on how public health professionals put this theory into practice.

Finally, practical ways of putting theory into practice will be outlined together with suggestions for exploring the growing literature in this area.

At the end of each section, a number of questions have been posed to enable the reader to pursue new lines of inquiry and develop greater insight into the role of empowerment in public health.

The Changing Landscape

When the government launched its 5-year policy programme in 2010 (Cabinet Office 2010a), they did so in the belief that it was time for a fundamental shift of power from Westminster to people. They promoted decentralization and democratic engagement, and they ended the era of top-down government by giving new powers to local councils, communities, neighbourhoods and individuals.

The Coalition considered that governments prevent people from getting involved in their local communities and therefore they should step back and create a new driving force from the grassroots, whilst Labour saw government as providing an enabling role in supporting greater levels of participation.

Whether this vision will be translated into positive change with a real transfer of power and greater public participation to improve local communities and improve health remains a challenge to be fulfilled. The austerity measures and severe cuts in public spending introduced by the Coalition Government will have a major impact on many people and their communities but the kind of impact it will have on levels of participation and involvement remains to be seen. In April 2011, Baroness Warsi (2011), speaking on building a new culture of social responsibility, made the following points: a change is needed in society and we need a "responsibility revolution" which is about a conversion of the heart and mind, and it is a problem that together we can do something about. Responsibility is more about what an individual does and less about what the government can do. This cannot be achieved by government

policy alone. It needs a smarter state and an empowered society. The change in government in 2010 has generated a different approach to community participation; the new Coalition Government's Big Society agenda (Cabinet Office 2010b; Cameron 2010) represents a significant shift in power and cultural change because it attempts to redistribute power from the Whitehall elites to local government and local communities. Ideally, the Coalition Government would like to see local communities take over the running of some public services but also playing a more active role in local planning.

Discussion Questions

How does the new Coalition Government interpret the move to transfer power to local communities?

In what ways can the idea of a Big Society be translated into practical steps that can empower health-related behaviour in local communities?

What are the differences between the previous Labour Government approach to devolving power and those of the new Coalition Government?

Public Health

The White Paper Healthy Lives, Healthy People (2011) sets out the government's new direction and future for public health. Health improvement will be directed locally with local authorities in the driving seat, supported by the latest evidence on behaviour change from a new Public Health England. To ensure public health is responsive to the different needs of each community, the government aims to create local freedom, accountability and ring-fenced health improvement budgets. It sets out how local public health leadership and responsibility will be returned to and strengthened within local government. In the new vision, each local authority and their individual Director of Public Health will act as strategic public health leaders for their local population and will deploy resources making sure that people's health and well-being is at the heart of everything local councils do.

The government's view is that society, government and individuals share collective responsibility for public health and the new public health system will encourage all to play their part in improving and protecting the nation's health and well-being. In order to promote this, a public health Responsibility Deal will be established with industry, the voluntary sector, non-governmental organisations and leading experts from the field. The intention is to make healthy lifestyles easier to achieve.

The past 2 years have seen a major reform within public health. From April 2013, local authorities have taken on board the main responsibility for coordinating local efforts to improve public health, to protect the health and well-being of the public, address health inequalities and ensure that that they can effectively put in place appropriate services to promote population health.

Health and Wellbeing Boards (HWBs) will have a statutory duty to involve local people in the preparation of a Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the Joint Strategic Needs Assessment (JSNA). This strategy will examine the redesigning and reshaping of services and how health and social care can ensure joined-up collaboration with other associated services. The needs of the whole community and particularly those who experience inequalities and those that find it difficult to access services will have to be carefully considered and addressed. Each Joint Health and Wellbeing Strategy will be unique as they address the needs of a local area.

The role of the new Public Health England (PHE) in providing national support and co-ordination has many implications. In the spirit of localism, the government expects that PHE will have a more supportive role for local strategies and implementation. Directors of Public Health will be employed by local authorities and be responsible to them and not to Public Health England. PHE will have a commitment to supporting local action and will avoid prescriptive guidance that would be contrary to the principles of localism. At this stage it is difficult to ascertain how this relationship will work out in practice.

Discussion Questions

What are the powers of Health and Wellbeing Boards to improve public health?

What can local authorities do to engage with the public and promote better health?

What Challenges Does This Represent?

The challenge in this process will be to ascertain who the local decision makers are within the different local structures and who will work with them to develop a shared agenda of what is achievable and how everyone can collaborate and be involved. The participation of local decision makers with organisations who can contribute to health and well-being as well as members of the public in a local area represents a significant challenge. The draft guidance for Joint Health and Wellbeing Boards does not identify how JHWSs will engage with marginalised, vulnerable or excluded groups where deep inequalities are likely.

On the Health and Wellbeing Boards, there is no statutory representation for voluntary and community sectors (VCS). The Department of Health in July 2012 published draft guidance for JHWSs and JSNAs for consultation and highlighted the potential for local VCS to be represented on the HWB. They also indicated that there was scope for additional members of the HWB such as service providers, health and care professionals as well as criminal justice representatives.

The role of Healthwatch (http://www.healthwatch.co.uk) as a champion of the consumer has a statutory place on the HWB. As a result Healthwatch England will provide national leadership for local Healthwatch organisations. The government has also indicated that they will be expected to harness the expertise of the voluntary sector and others at local level.

However, these challenges only highlight the complexity of who participates in the development of a coherent public health strategy and who is responsible for its effective delivery. The background of cuts to public funding and the fundamental changes to public health promotion generates a scenario in which many service providers as well as the public will have considerable concerns about the transition to a new public health role and their ability to influence change at a local level.

Discussion Questions

What implications does a 'shared agenda' have for Health and Wellbeing Boards?

What does 'authentic public engagement' in promoting better health mean in practice?

The Meaning of 'Public' in Public Health

When one considers the meaning of the adjective 'public', we have to assume that at least some aspect of the 'public' must be involved in any discussions of public health. The meaning of 'pubic' in public health was discussed by Vertweij (2007) in his very comprehensive analysis of the concept where he provided very clear insights. Nevertheless, little attempt has been made to develop a better understanding of this term. Following Vertweij's insights, a coherent vision of the term 'public' and its relationship to the health of the public and interventions by the public might be useful in meeting the challenges of the new public health landscape.

When we speak of public health, we are not referring to the state of health of the public but to a practice or set of interventions aimed at the promotion and protection of the public, in other words, the organised and collective efforts of a community to improve health. Thus, the objectives and interventions of public health are 'public'. However, there is another important sense in which the efforts of public heath can be considered to be collective. In order to be successful, public health interventions have to involve the active commitment of members of the public. This means that many interventions need individual citizens to participate (e.g. vaccination programme, no smoking campaigns, not drinking and driving) to ensure their overall success. Also, it could mean that some public health interventions require individuals to take personal care of their own health. In the same way, participation by individuals in a public health programme (e.g. achieving high rates of vaccination) can

lead to collective efforts being more effective. In this way, public health benefits are achieved through collective effort rather than individual endeavour.

Nevertheless, we can argue that members of the public have some sort of obligation to participate in public health interventions on the grounds that citizens should take actions so that others are more safe. Do citizens have an obligation to contribute to the common good? Whether there is a case to be made that we have an obligation to contribute to the common good highlights the complexity of participation of the 'public' in public health promotion.

Discussion Questions

Should people have an obligation to contribute to the common good?

Empowerment

In his article on Durable Empowerment, Drydyk (2008) succinctly outlines his interpretation of empowerment and clarifies what it means. For Drydyk, to be empowered means that a person is able to make decisions and have influence over their life choices, barriers to agency and well-being freedom. He does on to say that their capacity for such decision-making and influence will have been enhanced, if they can maintain these gains with the assets and capabilities they control (individually or collectively) and the opportunity structure in which they act. In these circumstances, it is probable that they can make these gains prevail, in the face of opposition. As a result, people are better able to shape their own lives.

Empowerment as a goal is to have control over the determinants of one's quality of life and health, and empowerment as a process is to create a professional relationship with an individual client or community setting where they take control over determining both the goals of a change process and the means adopted to bring about a desired improvement. Empowerment is a concept that has been much used and discussed for a number of years. However, it is not always explicitly clarified what its central meaning is. The present paper intends to clarify what empowerment means and relate it to the goals of health promotion. One conclusion of this discussion is that empowerment can be seen as a complex goal which includes aspects of the three central concepts welfare, health and quality of life. To the extent that the aims of empowerment are health related, it can be argued that empowerment is a legitimate goal for health promotion. But empowerment is not only a goal; it can also be described as a process or as an approach. This process involves the participants in problem formulation, decision-making and action that means the experts have to relinquish some of their control and power to the people involved.

An important goal of health promotion is to make it easier for people to make healthy choices. This is not an easy task because people may not feel that they have control over their personal circumstances or the environment in which they live.

People can be empowered to take more control over the need to change and learn to make more healthy choices. In this process health professionals can facilitate this process and enable people to move towards empowerment (Koelen and Lindström 2005).

In a key paper, Tengland (2012) compares behaviour change and empowerment in the context of the ethics of health promotion strategies. In terms of empowerment he makes the point that it has two distinct meanings; the first refers to the state of an individual or a community as a goal to be achieved and relating to the control they have in their lives (in this case health-related control) and the determinants of the quality of their lives. In the second meaning, empowerment refers to the process to attain the goals and the means of working towards empowerment, health and quality of life that is directly related to professional practice. In this way, it is a process of letting the individual or the community have as much control over the processes of change that they want (Tengland 2008). The health professional is a facilitator of change and in this role they should feel that they are also an active participant in this process by enabling an individual or community to develop their own capacities, create a vision of what is possible and put in place actions to bring them about through their partnership. In this sense the empowerment process highlights that individuals have the means (internal resources) to make changes and develop in a positive direction.

One of his interesting points is the importance of the role of the professional in promoting empowerment in the context of health promotion whose knowledge should count as an available asset. The professional within a project should have a say in the matters discussed and the decisions made. If they feel their professional responsibilities are undermined, they always have the option to refrain from continuing with the project. They should be 'experts' on how to achieve an empowering process. However, this should not be taken as a professional's right to impose their will. For the professional to have an agenda, other than facilitating increased control over the processes of change in a community or a person's health-related behaviour, would contradict the definition of empowerment as a process. It is morally problematic to attempt to make participants do what they have not consciously and deliberately freely chosen (Tengland 2008). In this situation the health professional in their role as a facilitator has to be aware that people participating in a local project are more aware of 'wider' problems in their community and have knowledge and experiences (e.g. of living conditions, environmental problems, together with perhaps a past history of poor decision-making in their locality) that often a professional lacks. A number of authors have suggested that 'real' participation of those involved in projects, i.e. when people are engaged in what is important to them, is more likely to succeed, and the effects are more likely to be sustainable (Baum 2008; Laverack 2009; Syme and Ritterman 2009).

Tengland makes a number of key points associated with empowerment. He makes the case for an association with autonomy, democratic decisions and the inequalities agenda. Since active participation requires taking or sharing responsibility for what is to be achieved, and for how it is to be achieved, this can lead to the development of various kinds of knowledge, skills and 'well-being' and increase the

ability for autonomy (Laverack 2006). In the same way, groups that participate in a local project can develop their 'collective autonomy', because they are engaged in deliberating, reasoning and negotiating skills and in this process can acquire tools for making democratic decisions (Laverack 2006). He goes on to propose that empowerment strategies aimed at creating more control over health can also reduce inequalities in health. In his view community projects tend to target vulnerable or disadvantaged groups who are associated with inadequate living conditions and poorer health; therefore there is a reasonable chance that empowerment projects will reduce inequalities (Laverack 2006). Empowerment as a goal is to have control over the determinants of one's quality of life, and empowerment as a process is to create a professional relationship and partnership where the individual or community takes control over the change process, determining both the goals of this process and the means to address the problem.

This implies that people can be inspired to recognise the significance of a personal resource and its potential impact on their lives. Health professionals need to recognise that it is not enough to provide people with knowledge about improving their health and provide information about opportunities; their professional skill must go way beyond this. Their knowledge and understanding needs to be applied in such a way that professionals can apply their existing knowledge base of public health so that they can develop strategies to 'know what they can do with what they know and how they are enabled to frame possibilities beyond the conventions of the present' (Bruner 2007; p. 2).

This last point is very important because public health professionals need to help individuals to acquire the power (and have the freedom) to make choices of a certain kind (informed and rational), arrived at in a certain way (noncoercive and non-indoctrinatory), feel empowered to do so and feel that they can have some control of their own lives. For the individual, capabilities are notions of freedom, in a positive sense: what real opportunities do you have regarding the life you may lead (Clark 2005).

The health professionals' role is a complex one as they need (1) to empower individuals to make informed and noncoercive lifestyle choices and to maintain this commitment, as well as (2) to empower whole communities to address the barriers that limit and inhibit their choices and put in place opportunities that can provide them with the vision and power to make changes for their own good and improve health, and (3) to provide real opportunities (and freedom) to fulfil them. In order to achieve these roles, public health professionals will have to establish a more comprehensive and inclusive set of capabilities.

Questions

What are the main interpretations of empowerment in public health?

What is meant by 'agency', 'opportunity freedom' and 'capabilities' in empowerment theory?

Can you identify guiding principles to guide the practice of health professionals to empowering communities?

Theory into Practice

The Department for Communities and Local Government has set out in a recent report (Bringing People Together in Strong, United Communities, 2013) a number of principles that can help people to come together in strong, united communities if they are encouraged and supported to:

- Have shared aspirations, values and experiences
- Have a strong sense of mutual commitments and obligations, promoting personal and social responsibility
- Take part in local and national life and decision-making
- Fulfil their potential to get on in life
- Challenge extremism and hate crime

They believe that if it is led by the people who are most concerned, action to achieve strong communities will be more effective. At first glance, the idea of community engagement in public health appears to be a low priority because there is little evidence to support specific initiatives. The National Institute for Health and Clinical Excellent (NICE) has produced an evidence guide for Community Engagement (NICE 2008) in which they make a number of recommendations to ensure that local authorities and the NHS consult and involve local communities in decisions related to policy, service delivery, managing and governance of health promotion activities and addressing the wider determinants of health. The guidance is aimed at people involved in planning, design, funding and evaluation of national, regional and local policy initiatives; commissioners and providers in public sector organisations, the voluntary sector as well as the private sector; and members of community organisations and community representatives. Within the guidance, there are recommendations and action points for all people involved in making public health accessible to all through community engagement. In addition, there are recommendations for research organisations for further research.

The Scottish Health Council (SHC 2011) has produced a report on improving quality through patient and public participation. They explored the benefits of implementing well-designed, good quality participation and engagement in healthcare services. The paper proposes that that participation can make a positive contribution to improved effectiveness, efficiency and safety within person-centred approaches to healthcare delivery. Nevertheless, they conclude that the full benefits of participation need to be combined with NHS organisations developing a positive culture of participation.

We need to put in place procedures that will enable individuals to take responsibility for their behaviour and actions to improve their health.

Within public health teams, how a practitioner works with individuals tends to involve some behavioural change approach and there is tendency to neglect *how to engage* people, especially hard to reach groups, the lonely and the disinterested. In this context, there is a need to develop training and resources for practitioners in public health to acquire the following skills and demonstrate informed practice.

How do you *reach out* to the:

- Vulnerable
- Disadvantaged
- Hard to communicate with
- Lonely or disinterested people

How do you *connect* with them?
How do you *engage* them with something that will involve them?
How do you *draw out* their confidence and willingness to engage?

In the first place public organisations like government departments, local authorities and hospitals need to establish programmes that promote the health of their own workforce. They could establish champions to promote the idea that a healthy organisation leads to better productivity and a better return on their investment. If they could capture this learning and make it readily available, it would have major implications for all other organisations.

So, for example, there are currently accreditation awards that raise awareness of better health and they stimulate a change in practices, but they reach only a small proportion of the organisations that could be involved. The accreditation process and the provision of evidence to support their application can stimulate a significant change in attitude and practice.

Healthy Early Years Accreditation Award

- Link with health-visiting teams
- Family partnerships

Healthy Schools Accreditation Award
Healthy Workplace Accreditation Award
Housing Associations/Care Homes Accreditation Award

If local authorities could provide financial support to put in place training opportunities for mentors and volunteers to provide support for settings like workplaces, schools and organisations working with older adults, their involvement could be a focus for change. This can be illustrated with a project in early years where parents were provided with training to enable them to work in early years settings or community schemes and in return they were asked to provide between 30 and 40 h of work experience. The parents were able to gain a reference and a portfolio of experiences. The early years settings and community programmes benefited from this involvement and the parents reported positive feelings and confidence with their commitment. Such volunteer schemes can enhance the work of many different organisations.

What can a local authority or public health organisations do to enable the public to take responsibility for their health and to remove the barriers to making healthy choices? The whole process of providing information on better health for the public that is easily accessible and communicates appropriate messages to stimulate change of lifestyles/behaviour or the way that people make choices is an essential start. However, local authorities and public health organisations need to go beyond this process. Putting in place consultation processes that seek feedback on the vision

and direction of health initiatives or programmes needed to ensure that a wide audience is reached and given appropriate time to respond. This needs to be followed by a clear demonstration that they are responding to feedback, listening to alternative points of view and ensuring that there is a balanced response that accommodates the diversity of views. Giving people a 'voice' that is genuinely incorporated into local decision-making enables the public to develop trust in their actions, develops commitment and instigates reciprocal respect.

The following suggestions provide a basis for change:

Short-term changes

- Provide information and advice that people can actually use and understand.
- Give local people a genuine 'voice'.
- Provide support from local authority practitioners and voluntary organisations.
- Establish partnerships and collaboratives.
- Create more better training opportunities for volunteers on evidence-improved practice.

Intermediate changes

- Build the infrastructure for joined-up action.
- Establish joined-up collaboratives.
- Genuine public representation on decision-making committees.
- Establish a resource bank for local communities.

Long-term changes

- Develop shared responsibilities.
- Put in place accountability measures for joined-up practice in public health and effective practices.

At the same time, there is a need to involve individuals and different local organisations in ways that a shared vision for promoting better health can evolve and inform practice. In this way they are building a shared responsibility and joined-up action and creating an infrastructure that enables them to work together.

Finally, the infrastructure of co-operating organisations and individuals needs to generate a process whereby they are able to capture the learning (in robust ways) from their deliberations and practice so that it can inform future decisions and actions. At the same time, there need to be put in place accountability measures that demonstrate where appropriate actions to improve health and address inequalities have been taken.

There appears to be a whole wealth of informed advice and guidance that practitioners in public health can draw upon but there is little evidence-based guidance on effective interventions that medical staff have access to. In this context, there is a need to promote ways in which practitioners can *capture the learning* from their interactions with individuals and as a member of working groups. In addition to these tools, practitioners need to be part of a culture that creates time for its staff to *capture their learning* and see it as an important dimension.

Questions

What are the main recommendations of NICE guidance for community engagement?

Identify in this document—pathways through participation—(1) what creates and sustains active citizenship and (2) the main guidance that can inform the practice of community engagement professionals and public health. It can be accessed on http://pathwaysthroughparticipation.org.uk/wp-content/uploads/2011/09/Pathways-Through-Participation-final-report_Final_20110913.pdf.

Conclusion

This chapter provides some insights into the complex field of engagement in public health and role of professionals in improving the health of local communities. The changes in government and as a result the public health landscape have brought together two powerful change mechanisms that have the potential to empower local communities to bring about change in some of the threats to the health of individuals. However, public health professions need to have a far greater understanding of what is involved in the process of community engagement and what needs to be done to bring about change. There is a great deal to learn and in times of financial hardship optimism will be required to promote more informed engagement with volunteers and the building of partnerships that share a common agenda. In this context there is a need for leadership with a clear vision of what needs to be achieved and the skills to ensure that genuine public engagement in public health becomes a reality.

The recommended readings will provide the reader with a greater understanding of these complex issues.

Recommended Readings

Deneulin, S, & McGregor, J. A. (2010). The capability approach and the politics of a social conception of wellbeing. *European Journal of Social Theory, 13*(4), 501–519.
This is a useful article that addresses the capability approach in terms of social structures and institutions that enable people to pursue individual freedoms in relation to others.

Laverack, G. (2012). *Health activism: Foundations and Strategies*. London: Sage.
A very readable textbook that provides a depth of insights into promoting health.

Institute of Health Equity. (2013, March). *Working for health equity: The role of health professionals*. Available from URL: https://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals
This is essential reading on health inequalities for public health professionals.

Rowson, J., Mezey, M. K., & Dellot. B. (2012). *Beyond the big society: Psychological foundations of active citizenship*. London: RSA. http://www.thersa.org/__data/assets/pdf_file/0004/565411/NEW-NEW-COVER-Beyond-Big-Society-report-V10.pdf

An insightful analysis of the nature of social capital and the hidden wealth of public engagement.

London Civic Forum. (2012). *Take Part in London's Big Society: A review of the latest evidence, policy & provision in response to Londoners' active citizenship learning needs*. (LCF Publication No. 74). London: London Civic Forum.
As the title suggests, a detailed analysis of the learning needs for active citizenship.

Brodie, E., Hughes, T., Jochum, V., Miller, S., Ockenden, N., & Warburton, D. (2012). *Pathways through participation: What creates and sustains active citizenship?* London: NCVQ and Involve.
http://pathwaysthroughparticipation.org.uk/wp-content/uploads/2011/09/Pathways-Through-Participation-final-report_Final_20110913.pdf
This is an important research report because it provides an evidence basis to inform the practice of community engagement in public health.

References

Baum, F. (2008) "Social determinants of health: The key to closing the health equity gap." http://dspace.flinders.edu.au/xmlui/handle/2328/12003.

Bruner, J. (2007). *Cultivating the Possible*. Presentation at the dedication of the Jerome Bruner Building in Oxford on 13th March 2007. http://www.education.ox.ac.uk/wordpress/wp-content/uploads/2011/03/Transcript-Cultivating-the-Possible.pdf

Cabinet Office (2010a) *The Coalition: Our programme for government HM Government*.

Cabinet Office. (2010). *Building the Big Society*. London: Cabinet Office.

Cameron, D. (2010), *Big Society Speech*, 19 July 2010. Accessed at: http://www.number10.gov.uk/news/big-society-speech

Clark, D.A. (2005) The capability approach: Its development, critiques and recent advances. GPRG-WPS-032. Global Poverty Research Group and ESRC.

Department of Health (2011) *Healthy lives, healthy people: Our strategy for public health in England*. HM Government .https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151764/dh_127424.pdf.pdf

Drydyk, J. (2008). Durable Empowerment. *Journal of Global Ethics, 4*(3), 231–245.

Koelen, M. A., & Lindström, B. (2005). Making healthy choices easy choices: The role of empowerment. *European Journal of Clinical Nutrition, 59*, S10–S16.

Laverack, G. (2006). Improving health outcomes through community empowerment: A review of the literature. *J Health Popul Nutr, 24*(1), 113–120.

Laverack, G. (2009). Public health, power and empowerment. 2nd edn. Basingstoke: Palgrave MacMillan.

NICE (2008). Community engagement to improve health. *NICE public health guidance 9*. London: National Institute for Health and Clinical Excellence.

Scottish Health Council (2011). A Scottish Health Council report on improving quality through participation: a literature review of the benefits of participation in the context of NHS Scotland's Health Quality Strategy, *Health Improvement Scotland*. http://www.scottishhealthcouncil.org/publications/research/improving_quality.aspx#.Ul1QKhYbCgE.

Syme, S. L., & Ritterman, M. L. (2009). The importance of community development for health and well-being. *Community Development Investment Review, 5*(3), 1–13.

Tengland, P.-A. (2008). Empowerment: A conceptual discussion. *Health Care Analysis, 16*(2), 77–96.

Tengland, P.-A. (2012). Behavior change or empowerment: On the ethics of health-promotion strategies. *Public Health Ethics, 5*(2), 140–153.

Verweij, M. F. (2007). The meaning of 'public' in 'public health'. In A. J. Dawson & M. F. Verweij (Eds.), *Ethics, prevention, and public health* (pp. 13–29). Oxford: Oxford University Press.

Warsi, B. (2011). *Building a new culture of social responsibility*. London: Cabinet Office. https://www.gov.uk/government/speeches/building-a-new-culture-of-social-responsibility.