

# Community psychology in health context: How to promote citizens' participation

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## Zusammenfassung

### **Gemeindepsychologie im Kontext der italienischen Gesundheitsversorgung: Zur Förderung von bürgerschaftlichem Engagement**

In Italien sind Empowerment und Partizipation zentrale Themen gemeindepsychologischer Forschung und Praxis. Ein Bereich in dem die Beteiligung von Bürgern an Entscheidungsfindungsprozessen bereits vielfach Berücksichtigung findet, ist die Gesundheitsförderung. Die Autorinnen, Brunna Zani und Elvira Cicognani, sehen erst durch die Partizipation der verschiedenen Akteure in den Planungs- und Implementierungsprozess eine nachhaltige Wirkung von Gesundheitsprogrammen.

In Italien gab es 1978 eine bedeutende Gesundheits- und Psychiatriereform, in der die zentrale Rolle von Partizipation und Bürgerbeteiligung festgeschrieben wurde. Diesen Reformen folgte eine grundlegende Transformation in der Bildungs- und Sozialpolitik sowie Gesundheitsversorgung. Sie bildeten einen fruchtbaren Boden für die Entwicklung von Schlüsselkonzepten der Gemeindepsychologie, wie partizipative Aktionsforschung und Gemeindeorientierung. Dieser günstige sozio-politische Kontext förderte Kooperationen zwischen GemeindepsychologInnen und KollegInnen in Erziehungs-, Sozial und Gesundheitsberufen. Damit gelang die gesellschaftliche Verankerung gemeindepsychologischer Konzepte sowohl in verschiedenen Praxisfeldern als auch auf politischer Ebene.

Im vorliegenden Artikel stellen Brunna Zani und Elvira Cicognani zwei Beispiele von Bürgerbeteiligung auf lokaler Ebene im Kontext der Gesundheitsförderung in Italien vor. Hierbei folgen sie der Konzeption von Campbell & Jovchelovich (2000), die drei mögliche Einflusswege von Community Partizipation beschrieben haben.

Ziel beider Forschungsprojekte in der Region Emilia Romagna war es, die Bürger bei Entscheidungen über Fragen der Gesundheit einzubeziehen. Das bedeutet eine Stärkung ihrer Interessen und Ermutigung, von politischen Entscheidungsträgern eine Positionierung einzufordern, welche Bürger als dringend benötigte Beteiligte beim Thema Gesundheitsförderung anerkennt. Beide Projekte unterscheiden sich methodologisch durch den Grad der Beteiligungsmöglichkeit. Das Erste ist ein partizipatives Aktionsforschungsprojekt, bei dem der Empowermentprozess einer Gemeinde nachgezeichnet wird. Im zweiten Projekt werden individuelle Kriterien bezüglich der Einschätzung und Wertung der gesundheitlichen Grundversorgung mittels eines strukturierten Interviews erfragt. Die aktive Beteiligung der Bewohner endet hier.

Die Autorinnen weisen auf die Unschärfe der Konzeption von "Partizipation" hin, welche vielfältige Bedeutungszuschreibungen jenseits einer gemeindepsychologischen Orientierung zulässt. Partizipation meine eben nicht nur einen informierten Bürger, sondern darüber hinaus Institutionen und staatliche Gesundheitsprogramme, die den Partizipationsgedanken in ihre konkrete Arbeit integrieren und damit eine gesamtgesellschaftliche Entwicklung ermöglichen. Brunna Zani und Elvira Cicognani kommen zu dem Schluss, dass partizipative Forschung - trotz großer Herausforderung bei der Umsetzung - im Sinne eines Empowermentansatz die Methode der Wahl ist.

Schlüsselwörter: Partizipation, Empowerment, Gesundheitswesen, Gemeindepsychologie in Italien

## Summary

One key area of research and intervention for Italian community psychology is the role of community participation and citizens' empowerment in enhancing individual and collective health and wellbeing. In this paper, we present and discuss two examples of programmes promoted by the Region Emilia Romagna (Northern Italy), in which community psychology's theoretical principles and methodological approaches of participatory action research have been adopted with the aim to involve citizens in decisions about health issues. The first one refers to the health promotion approach of "Local Plans for Health", in which citizens' active participation is solicited in order to identify the population's health needs to be addressed by policy makers. The second one was aimed at assessing the criteria that, according to citizens' perspectives, should inform policy makers' decisions about the allocation of economic resources to satisfy basic health needs included in the Essential Levels of Assistance.

Key words: citizens' participation, empowerment, health contexts, community psychology

## 1. A key issue in Community Psychology: Promoting empowered citizens

The concept of "community participation" has a central place in community psychology. Wandersman and Florin (2000) defined social participation as *"a process in which individuals take part in decision making in the institutions, programmes, and environments that affect them"*. The community psychology perspective emphasizes that social participation takes place within a community context. Forms of participation are determined by issues arising within a (local) community, and include its culture, norms, values and institutions. The community and the social groups in it are the context/settings within which it is possible to experience the different forms of social participation. As clarified by Campbell and Jovchelovitch (2000), *"it is through participation that the key constituents of community are enacted"* (p. 264). Participation is considered a necessary precondition for community development and change, and is consistent with some basic values of this discipline, such as empowerment and social justice.

A domain in which community participation is considered fundamental is health and health promotion (Campbell & Murray, 2004). Community development approaches to health promotion move from the assumption that only health programmes may have an impact only through the participation and the representation of grassroots communities in their planning and implementation (Campbell & Jovchelovitch, 2000). This assumption also featured in the WHO declaration of Alma Ata (1978). Since then, a growing consensus on the need to involve local peoples in the process of improving health and health care provision has also emerged among policy makers and international agencies. In some countries (e.g., the UK), citizens' involvement in health research is now part of an established movement toward creating a "patient-lead" health service (Oliver et al., 2008). In this context there has been a call for innovative approaches to appropriately assess the complex causes of community health needs and to identify appropriate solutions through the participation of local citizens (Minkler, 2000).

In Italy, the central role of citizens' involvement and participation in prevention and health promotion initiatives was first acknowledged in the Health Care Reform Act and the Psychiatric Reform Law; these laws were passed in 1978 as a result of intense political struggles over the seventies with the engagement of different social groups, such as students, women, mental health patients, and health professionals to achieve recognition of their rights (Zani & Palmonari, 1996). Over the years, such laws profoundly transformed educational, social and health services and represented a fertile ground for the exploration and concrete application of some of the key theoretical concepts and methodologies of community psychology, such as participatory action research and community development (Francescato, Arcidiacono, Mannarini, & Albanesi,

2007). This favourable socio-political context also facilitated the establishment of collaborations and networks between community psychologists and social, educational and health service professionals (further emphasised by more recent laws, e.g. Law 328/2000, as a necessary component of all intervention programmes in the social and health domain), and the "socialization" of community psychology concepts, approaches and methodologies among different areas of practice and intervention, including local administrations (e.g. municipalities, provinces, regions) and policy makers (Zani & Cicognani, in press).

Campbell and Jovchelovitch (2000) distinguished at least three paths through which community participation can impact citizens' health. One of these is the involvement of local community groups and associations in decisions about health service design and delivery. This is important for addressing issues such as inequity in access to health care, the role of cultural differences in health practices, or the influence of prejudice and communication difficulties on the type and quality of health service provision received by some groups. A second form of participation by citizens is the direct involvement of local community groups in the design and implementation of initiatives to promote healthy behaviours. Finally, living in a community characterized by strong local networks, trust, mutual support and a high level of involvement in community programmes of mutual interest is important for citizen health and wellbeing. The role these components of social capital play for health outcomes has now been confirmed by several studies.

Reviews of the use of participative approaches in the health domain have also emphasised that effective participation is not easy to achieve, and several problems have been pointed out, which stimulated theoretical reflections on its meaning and usefulness (e.g., Guareschi & Jovchelovitch, 2004; Stephens, 2007), and a greater attention to the appropriate methods to achieve it and assess its impact. One critical point that has been raised is that the vagueness of the concept of "participation" opens the way to different meanings and interpretations depending on the perspectives and role of the different stakeholders. Among these, a basic distinction has been proposed between the "empowerment" perspective, considering participation as a set of empowering practices used to re-balance power structures and developing community competences, and a "utilitarian" or instrumental approach, conceiving community participation as a means to legitimate projects and use local resources to offset costs. Among the latter, Guareschi and Jovchelovitch (2004) include the risks of what they call the *"technocratic emphasis on the institutionalisation of participatory thinking ... in national ministries of health in detriment of empowerment of citizens and civil society's participation"* (p. 313).

According to the community psychology approach, enhancing participation entails a process of growth of the local community (Serrano Gonzales, 1991; Zani & Palmonari, 1996; Mannarini, 2004). In particular, the "empowerment" approach to participation adopted within this discipline moves from the recognition of the existence of different types of local knowledge and expertise within the community, and the possibility of establishing a dialogue between them in order to stimulate critical awareness (Freire, 1973). In this way, participation is thought to increase community members' self esteem and awareness of their strength as a group. This is especially true for citizens who can be active members of a process they usually perceive as an exclusive domain of professionals. Moreover, participation allows citizens to be more aware of the resources available in their community, and more capable to control some choices concerning their health. For example, through participation individuals become capable to analyse their living context, and to identify potentially pathogenic aspects of their environment.

Several attempts have been made to understand and investigate forms of citizens' participation in health issues and evaluate their effectiveness and impact.

In a systematic review of the existing literature on citizens' involvement in health research, Oliver and colleagues (2008) developed a conceptual framework which describes the *approach* to involvement in terms of three dimensions: Whether lay people were involved as individuals or as members of organised groups; whether the public involvement occurred at the invitation of the research programme or in response to action by the lay public; and the degree to which the public was involved (consultation, collaboration and lay

control). With regard to *methods* of involvement, there are different formal and informal possibilities (e.g., committee membership, written consultation, focus groups, public meetings, citizens' juries, opinion surveys, etc.). Developing suitable approaches and methods of soliciting citizens' input into community health assessment and health promotion programmes has become a focus of public health efforts over the last decade. Not all approaches and methods share the same potentials for building citizens' and community empowerment, according to the community psychology perspective: Despite good intentions, the methods used and the ways they are implemented are critical.

In this paper we will illustrate and discuss two examples of methodologies for citizens' involvement in health promotion programs in the Italian context, following the first path identified by Campbell & Jovchelovich (2000).

## **2. A methodology for involving citizens in health planning: The experience from Plans for Health in the Region Emilia-Romagna**

Among policy makers there is a growing awareness that the extensive demographic, social, cultural and economic changes occurring at the macro social level require the adoption of a different perspective in public health approaches and interventions. Critical issues are the increase in economic expenditure for health, the impossibility of satisfying the growing and increasingly complex health needs of the population, the crisis of the state and de-legitimization of public action, the consequences of globalisation processes on the economy including the emergence of new needs, ambivalence between the needs of belonging and individualistic tendencies, and the new forms of social and geographical exclusion. In this context, public policies are orienting towards the promotion of health and wellbeing at the intermediate level: The local community, such as the municipality or neighbourhood (the community defined in terms of geographical-administrative boundaries or socio-cultural and relational dimensions and citizens' sense of belonging). Social, urban and economic policies are aimed at promoting social capital and community development, in order to enhance social participation of the civil society in the definition of plans and policies, so as to initiate and sustain a dialectical interchange between the political and social dimension.

In this context the Regional Council deliberation of the Region of Emilia Romagna (March 2000) emphasised that local administrations have the instruments for promoting health policies, that inter-professional actions are needed for solving health problems, that community "informed" participation is always necessary; that numerous factors interact in influencing health (Biocca, 2006). Moving from these assumptions, Local Plans for Health (LPH) were introduced, and can now be considered a "brand" of the Emilia-Romagna Region in the domain of health promotion. A LPH is defined as "a multi-year plan of action developed by a group of actors, coordinated by the local government, engaging human and material resources with the purpose of enhancing population health through the enhancement of health assistance".

The core aspects and cultural challenges of the regional strategy and LPH are the role of the local community as a social actor; the promotion of consensus building processes grounded in trust that arises from working with people and taking into account their ideas and interests; the elaboration of collective decisions. The plans are designed in concert - and through a negotiation process - between local administrators, social organisations and citizens who are involved in the different phases of the planning process. These phases are: 1. Assessment of the needs and health problems; 2. Selection of priorities; 3. Elaboration of projects; 4. Implementation of actions, and 5. Monitoring and evaluation of results.

Participatory planning can have several important functions:

- a. Combating the ineffectiveness of the paradigm of technical rationality, according to which for each problem there is always a standard solution that can be offered only by the "experts";
- b. Contrasting the self-referentiality of the systems of services delivery, their tendency to "create" needs from the already available solutions;
- c. Promoting innovations: The new solutions can be developed within contexts where different forms of knowledge (lay and professional) can interact;
- d. Promoting negotiation when conflicts arise between different interests or definitions of the problems;
- e. Dealing with complex problems that require integrated consideration of their different constitutive dimensions;
- f. Exposing existing as well as hidden resources;
- g. Enhancing actors' self-confidence; developing participants' sense of belonging to the project.

In this context health is considered as a common good, and everybody should have a part in its construction and maintenance.

Participation in the LPH requires not only a more informed and competent citizen, but also institutions and social organisations capable of valuing such participation, by transforming it into concrete actions (Berti & Antonelli, 2006). In this sense, participation allows professionals to reach important objectives, such as a better knowledge of health problem indicators and citizens' opinions. Another important objective is community development. This is facilitated by the creation of opportunities for citizens and institutions to meet and exchange opinions; the widespread responsibility of the different actors involved in the definition of health priorities; the development of networks and collaborations between institutions and civil society; the increase of citizens' power and competences; and by the strengthening of trust between institutions and citizens (Zani & Cicognani, in press).

Following the initial positive experiences with LPH in different local administrations (Biocca, 2006), this approach to health promotion is becoming increasingly established and the initiatives planned within the Regional Plan 2006-2008 have been implemented, using the social and health district as a local context of reference, which has been recognised as the optimal geographical dimension for the analysis of health needs and definition of priorities.

As a concrete example of how citizens may be involved in this process, we will describe the methodology of participatory planning of LPH 2005-2007 of the Bologna District.

## The context

The Territorial Health Conference of Bologna in June 2005 approved the document "Project for the construction of Plans for Health 2005-2007"; this document followed the guidelines of the Region Emilia Romagna establishing LPH as a point of reference for the health promotion planning. The aims were:

- a. Identifying health priorities to be addressed by actions at different planning levels, guaranteeing integration between different interventions;
- b. Experimenting with specific "good practices" by testing models of participatory planning;
- c. Introducing the method of Health Impact Evaluation to analyse actions of local administrations, local health services and civil society;
- d. Streamlining the process of allocation of resources.

The document also indicated that the process of health needs assessment and prioritisation should occur at the district level, by soliciting forms of involvement and participation from the organised community, so as to guarantee a wide representation of different stakeholders.

## The "District Steering Committee"

In October 2005 the "District Steering Committee" was constituted, including about 60 members, with different backgrounds (institutional, technical, political, interdisciplinary professionals and representatives of the civil society). The composition and number of members of the committee allowed to balance the need of representativeness with the possibility of concrete active participation, by guaranteeing wider forms of consultation over specific issues.

The committee had a mainly consultative role; its tasks were to analyse the health needs of the population living in the district, using existing instruments of participation at municipal level and technical support provided by the Office of LPH, and to report to the District Committee the objectives and priorities of intervention for the LPH.

In order to support members of the District Steering Committee in their tasks, a specific *ad hoc* training was devised. This training consisted of providing knowledge and basic competencies: about health and its determinants; on instruments for the construction and implementation of a LPH; and on instruments for the evaluation and identification of health priorities. Another important component of the training was the adoption of a shared common language among the different members.

## The training programme

The training programme included six half days and employed a mixed methodology.

a) The first three meetings adopted an information giving approach, including seminars by administrators and technical experts of the Municipality and Province of Bologna. The contents were aimed at providing participants with an exhaustive overview of the following topics: values and principles of LPH, their organisational model, planning instruments, the meaning of participation (first meeting). The second meeting was centred on helping participants to analyse and interpret epidemiological data on mortality, work accidents, life styles, health of migrants, and comparing such data with information provided by citizens' perceptions, obtained by surveys and interviews. The third meeting was focused on providing information on health impact evaluation through examples of its application and possible future scenarios (see the website of the network of healthy cities [www.retecittasane.it](http://www.retecittasane.it)).

b) The last two meetings used a more dialogic approach, including separate work in small groups and final reports and discussion with the whole group of participants. This method was considered necessary in order to actively practice the theoretical notions acquired, through sharing and discussing observations, comments and experiences, before developing collective proposals. For this purpose, all members of the Committee received a summary of the most significant data of the community health profile of the city of Bologna, which was used as a starting point for the subsequent analyses.

More specifically, during the fifth meeting, after a short presentation of the health profile in order to emphasise the most significant issues, three work groups of 9-10 participants each were formed (of different background and expertise), and coordinated by a facilitator. The groups' tasks were to:

- a. Analyse the community health profile of the city of Bologna (participants discussed the epidemiological data and the survey data of the health profile, and were asked to identify issues that were missing or inadequately addressed);
- b. Identify indicators of the factors that have an impact on population health, and evaluating them according to a list of predefined criteria (severity, frequency, importance for society, resolvability with regards to costs and available instruments),

- c. Identify health determinants for the different indicators of health. This activity was conducted individually by each participant and then discussed within the group, allowing each group to fill a summary table including all group choices.

The meeting ended with a plenary discussion that included the town administrator responsible for the health services. The coordinators of the different groups reported the results of their work to the whole committee.

The following meeting started with a plenary presentation of the summaries of the work of the three groups; this allowed for the identification of the seven health determinants that were chosen by members as the most important (health system, social services, poverty, social exclusion, social/cultural environment, living conditions and eating habits) and their corresponding indicators. This was followed by group work, during which each group was asked to focus on two determinants in order to identify the more important indicators in this list, and to specify the target population for whom interventions should be developed, the instruments to be used, and the possible actions. This task was performed individually in order to give participants the opportunity to write their opinions from their personal experience and viewpoint, and subsequently results were discussed in the group. The meeting ended with a plenary discussion in which the town administrator again participated.

The subsequent steps have been the following: a) Elaboration of the final document including objectives and priorities identified by the LPH. This document summarised the results of the work conducted during the training programme and was prepared by the LPH office in collaboration with the Conference of all the Presidents of the Bologna Neighbourhoods; b) Presentation of the plan to the territorial Health Conference.

## Final comments

The methodology adopted in the elaboration of LPH was informed by an empowerment approach to participation. It is possible to identify some crucial phases of this process.

- a) The "call" to participation was addressed both to traditional stakeholders and to other representatives of associations, institutions, and the organized civil society representing the human and social capital of the local community. The participants played the role of mediators and constructors of bonding relationships between institutional subjects and the community: Their role was fundamental for health planning actions.
- b) The call elicited a positive response, as shown by the number of participants to the training and the quality of their work. They were highly involved in their activity and the methodology adopted (the mixed informative/dialogical approach) proved to be successful in facilitating the acquisition and sharing of information and perspectives.
- c) The experience demonstrated that there was a desire to be involved and to participate, and the feeling that there are opportunities to express one's opinions.

One of the programme's strengths was putting the community health profile at the core of the process and familiarising it amongst "non experts", by selecting some significant data on demographic, socio-economic and environmental factors, as well as information on social and health services and on life styles. The profile was constructed using not only statistical-epidemiological data, but also subjective perceptions from citizens. This allowed for a more complete picture of the situation, through the integration of different types of knowledge, "lay knowledge", locally produced, and "scientific" knowledge. Reflections on these data put the role of citizens in a central position, not only through their validation of needs analyses conducted by professionals, but also through their learning and growth of competence, and the acquisition of a greater awareness of a community's capacity for change and empowerment. The presence of different stakeholders

enhanced forms of collaboration through networking fundamental for implementing a LPH.

The construction of bonding relationships creates a sense of belonging to the community, which contributes to citizens' capacity to solve conflicts, and enhances social cohesion. The adoption of a bottom-up approach helps to recognise that participation is not only stimulated or guided by local administrations, but can develop from the bottom.

The work done has been valuable and needs to be supported and made visible, but it is vital that proposals are followed by concrete actions. It is important that the expectations created by the process are met by the implementation of concrete positive interventions in the short or in the medium term in accordance with the priorities identified. Moreover, local administrations should expand the role and tasks of the District Steering Committee, including the monitoring of the process. Further, it is fundamental to develop a culture of evaluation of interventions and to create synergy and integration among all the actors involved in the process.

### **3. Citizens' opinions on Health resources allocation**

Another example of a methodology for involving citizens in health promotion planning is provided by the project of the Health Agency of the Region Emilia Romagna "Instruments for the assessment of health priorities: Citizens' perspectives" (2005).

#### **The background**

One problem faced by all health systems in Western industrialized countries is how to guarantee services and treatments that are more and more costly and complex in a situation of scarce economic resources. Since the early 1990's, several attempts have been made to modify the institutional and administrative systems in order to increase the quality and effectiveness of treatments and prevent the waste of resources. Specific committees have been appointed in several countries in order to make decisions about the allocation of economic resources and to define a common set of agreed criteria to make such decisions. The issue of how to achieve a fair and efficient allocation of resources is crucial: Different possible standards can be used including economic criteria (e.g., cost-effectiveness calculations), moral criteria (e.g. equity, universality; social utility) and medical criteria (e.g., severity of the disease, clinical effectiveness, QALY) (Cookson & Dolan, 2000). The adoption of economic criteria has proven to be unsatisfactory, increasing the risk of inequalities in health provision between different categories of citizens. Therefore, the issue of equality, ethics and fair allocation of resources has been the topic of considerable discussion (Bowling, 1993; Taroni, 2000).

More recently, public policy researchers and psychologists have taken an interest in consulting citizens (Domenighetti & Maggi, 2001); it is increasingly recognised that, although experts can advise on the technical "facts" in priority settings, only members of the local community can express community health values (Bowling, 1993).

#### **How to involve citizens in allocation decisions about the Essential Levels of Assistance (LEA)**

Essential Levels of Assistance (LEA) have been introduced in Italy by the Decree of the President of Council of Ministers 29 November 2001, "Definition of Essential Assistance Levels". They comprise a list of treatments the Italian National Health Service (NHS) should guarantee to all citizens. Its introduction



represents the Italian Government's response to the international movement towards increasing rationalisation of health services, as an instrument to make explicit the treatments and services guaranteed to the population and to develop economic policies that favour the introduction of the private market into the health arena.

Moving from the above considerations on the need to include citizens' perspective among the criteria that should inform allocation decisions, The Health Agency of the Region Emilia Romagna started a research programme with the aim of assessing Italian citizens' opinions about setting the priorities for the LEA. This involved engaging in the process of constructing and validating an instrument that would allow the collection of lay opinions, taking into account the criteria they use when reasoning about the allocation of treatments included in the LEA list. The final aim of the project was thus to construct a standardised instrument (questionnaire) for the assessment of citizens' subjective criteria for prioritisation of health services and resources, that could easily be used in large scale research on representative samples, thus providing health care authorities with information to better inform decisions about resource allocation. The involvement of lay people was required especially in the first, qualitative phase of the research programme, which will be briefly described below (for more information, see Cicognani, Mancini, & Nicoli, 2007).

A convenience sample of 100 individuals (adults), recruited in the territory of the region Emilia Romagna, were individually presented a list of 52 forms of treatments covering all the principal categories of treatments included in the LEA list, partially excluding certain health services which may however be guaranteed by the regions with their own funding (e.g., dental care), and totally excluding a number of treatments (e.g., alternative medicine, aesthetic surgery). Participants were first asked to rank the 52 forms of treatment in terms of their importance, by placing them in one of ten categories, from the least to the most important. After completion of this task, each respondent was interviewed in order to determine the criteria they used to make each decision.

Results indicated that participants used a wide set of criteria only partly corresponding to the criteria used by experts. In particular, analyses indicated the presence of two main underlying dimensions that can summarise specific criteria. The first one concerns the **functions** that, in participants' opinion, the health service should guarantee; it is defined by the criteria *prevention* and *diagnosis and care* (on the negative polarity), and the criteria *primary care*, *severity*, *vulnerability*, *economic*, and *ethic* criteria on the positive polarity. The second dimension concerns the **extension** of the health service provision and includes, on the positive polarity, the *universalistic* criterion and on the negative polarity, the *selectivity* criterion (the idea that the provision of treatment should be based on the subjective and specific needs of different categories of citizens). Moreover, it was possible to group the specific criteria into four main macro categories. The first one corresponds to the *right to care and health* (most important criteria included in this category are primary care and severity of the disease), that is the idea that the NHS should guarantee health treatments and interventions to all citizens. The second one corresponds to *specific needs*, that is, the idea that treatments and interventions should be provided first of all to specific groups of citizens; it contains the following specific criteria: vulnerability, personal responsibility, personal experience, opportunity of choice, ethic, quality of life and not health-related needs. The third macro category includes *economic criteria* (efficiency, effectiveness, economic); this dimension is independent of the others. The fourth includes *community criteria* implying the idea that the NHS should improve prevention and diagnosis at a community level to promote health and prevent illness; it loads the following specific criteria: prevention, diagnosis and therapy, empowerment, utilitarianism.

A further interesting result is that layperson criteria are associated with the importance placed on the different treatments included in the LEA list. In particular, when participants consider the treatments as "not so important" (e.g., this occurred for treatments not included or partially included in the LEA, such as non-conventional medicine and aesthetic surgery, but also, interestingly, health care for "stigmatised" groups - mental patients, drug users -, extension of health care abroad and preventive medicine), they explain their choice using *economic* criteria. The criteriin of *right to care and health* is used mostly for justifying those treatments or services that, in participants' opinion, cannot be renounced (first aid medicine, such as emergency

medicine, emergency intervention services, general practitioners, paediatricians, high-technology surgery for life-threatening conditions).

The criteria *specific and individual needs* is used for justifying both treatments that participants consider not important (e.g. cultural health practices, such as circumcision and cosmetic surgery, not included in the LEA) and treatments deemed of moderate importance (preventive medicine, environmental health, workplace safety, food hygiene, etc.). Lastly, *community criteria* are used to justify treatments that participants consider highly important (quality of life improvement, health care for elderly, chronic and terminal patients, diagnostic and specialist services), which should be universally available.

Overall, participants' opinions seem in agreement with universalistic principles, according to which existing treatments should be provided to all individuals. However, they also use a set of criteria for specifying what should be considered less important; among these, the economic criterion appears independent of the other dimensions, suggesting that it may be used to justify the introduction of selective criteria based on personal characteristics of the recipient of health care (including their ethnic origin), or one's dislike of individuals who are seen as responsible of their condition (e.g., drug users). This study provided useful information for the construction of a structured instrument, but also left several issues open for future investigation, for example, the role of personal prejudices and of moral reasoning in affecting laypeople's opinions and implicit criteria. Unfortunately, the method used to collect individuals' opinions (structured individual interview) did not allow for the possibility of further exploring the process of social construction of citizens' opinions and the role played by both individual characteristics and inter-group dynamics. Other methods (e.g. focus groups) might be more appropriate for this purpose, by providing opportunities for collective sharing, reflection and dialogue. Therefore, even if the use of the final instrument may help health authorities to better tailor their resource allocation decisions to citizens' perceived needs and criteria, the "empowering" potential of this method for participants appears to be very limited.

## 4. Discussion

In Italy the participation and collaboration between different community actors, including members of the civil society (citizens' organisations, associations, laypeople), public administrations and professionals of social, educational and health services are considered a central component of health promotion interventions. The experience currently being accumulated allows us to make critical reflections about both positive results and difficulties and problems that will require further work.

The two experiences illustrated in this article exemplify two methods of involvement of local community groups and associations in decisions about health service design and delivery (Campbell & Jovchelovitch, 2000) that are consistent (especially the first one) with the empowerment approach to community participation. In terms of the classification provided by Oliver and colleagues (2008), in both examples the call for public involvement was at the invitation of the initiator of the programme (Local Administration and Regional Health Agency), but important differences between them exist. In the first case participants were involved as groups and in the second as individuals. Moreover, the extent of their involvement differed: From a mere consultation in the LEA project, providing opinions by structured individual interviews, to a more fundamental collaboration in the Plans for Health project.

The LPH project has been characterised since the beginning by providing participants an opportunity to express their opinions, their subjective perceptions of the severity and relevance of community health problems and needs, even though these were in contrast with the "objective" data provided by epidemiological surveys. The process of collective training, involving representatives of social organisations, volunteering associations and professionals, enhanced the development of their knowledge and competencies, and the sharing of language and methodologies useful in intervention planning. From this point of view, it can be

considered as a good practice in terms of its potential for community development.

The second project was guided by health authorities' awareness of the need to include community members' perspectives about health resources allocation besides economic, ethical or technical criteria. Its focus was more limited because the interest was in citizens' perceptions of health services included in the LEA list, and assessment of the presence of health needs not currently addressed through the development of a more structured instrument to be used by local and regional health services. Participants were merely "consulted" about their opinions but they did not participate in a more active way, thus limiting their possibilities to share and discuss their points of view with others and the empowerment potential of the programme.

From a community psychology perspective to health promotion, it is important to emphasise the usefulness of working together for community development. Communities can be considered as a cultural laboratory, a place capable of generating a new culture, new ways of thinking, acting, planning and organising and of developing and nurturing a sense of community. Approaches involving citizens and using participatory action research methods are more consistent with the empowerment approach. Work from this perspective may be difficult and challenging, but it is the direction toward which we need to move.

Some possible directions for the future of community health promotion are the following:

- a. Constructing "good local institutions": Institutions should be considered as "public goods", constructed by citizens with the aim of enhancing bonding relationships and reciprocal recognition, facilitating democratic decision making and the protection of the rights of the weak; enhancing the potential of all citizens;
- b. Activating services for the individual, so as to create opportunities of encounter between "social demands" for the protection of individual and collective health, and "social responses", provided through the organisation of formal and informal public and collective resources;
- c. Enhancing partnerships amongst different forms of community associations: The community is made visible by the increase in associative forms which allow individuals to experience the "sense of us" and help to face new challenges and problems as collective entities. This aim requires the enhancement of interdependencies; sharing the interest toward pursuing a shared model of development, including the recognition of the central role of different social actors (individuals, public institutions, voluntary services, associations, organisations).

Is important to add that, if participation and sense of community can be considered a sort of "protective factor" against loneliness, anomy, alienation, both for adults and young people (Cicognani, Albanesi, & Zani, 2008), it is necessary to avoid the risk of ideologizing it as a form of homogenisation and homologation of the differences. Participation does not mean generalised consensus, but it must also include conflict: It is therefore necessary to develop basic life skills, such as conflict management, problem solving, effective communication, listening. From this perspective, it is important to focus more attention on what happens inside participatory contexts including those reported here, the psychosocial factors characterising deliberative and decisional processes and how they affect health outcomes and community development. In conclusion, participation is not compulsory, but it is a moral need associated with citizenship and sense of social responsibility, and as such, it is a qualifying aspect of a competent community.

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