

Preface

Very few people argue with the need to address the social determinants of health. The Commission on the Social Determinants of Health (CSDH) affirms that the conditions in which people grow, live work and age have a powerful influence on health. The Commission's holistic view of these determinants calls for sustained action, globally, nationally and locally to overcome the unequal distribution of power, income, goods and services which often lead to unfair access to health care, schools and education and an individual's chance of leading a flourishing life (CDSH 2008).

Asset based approaches offer one means of contributing to these goals by recognizing that traditional epidemiological risk factors approaches to health development such as programmes on smoking cessation, healthy eating and physical activity are insufficient on their own to ensure the health and well-being of populations. In particular, many of the solutions to addressing the social determinants of health rely on the ability of professionals to recognize that individuals, communities and populations have significant potential to be a 'health resource' rather than just a consumer of health care services. The Asset Model described by Morgan and Ziglio (see Chap. 1) provides a framework for establishing fresh insights into how best to collect and collate scientific evidence to demonstrate the benefits of the asset approach for population health and how to harness the sorts of effective practice that strengthen community capacities, promote independence and autonomy. They also have the potential to secure sustainable and cost containment approaches to health and development.

There are two things that should be noted about the asset approach as described in this book. Firstly, it is not in itself a new concept or approach – but aims to add value to other existing concepts and ideas by bringing them together in such away as to promote a more systematic approach to assembling and applying knowledge for health solutions. Secondly, it would be naïve to think that the asset approach could exist in isolation from the more predominant deficit tradition to health promotion. There will always be some situations where individuals, communities or broader populations are exposed to health threats or increased exposure to known health risks and therefore need the immediate attention of health professionals and access to services. However the identification and strengthening of health assets should be a key component of a country's overall development strategy, because

they can act as a buffer or resilience factor to disease risk exposure and importantly can produce health as a positive entity with a focus on quality of life and wellbeing. It is possible to identify health promoting/protecting assets from across all the domains of health determinants including our genetic endowments, social circumstances, environmental conditions, behavioural choices and health services. An inventory of health and development assets would, as a minimum, include family and friendship (supportive) networks, intergenerational solidarity, community cohesion, environmental resources necessary for promoting physical, mental and social health, employment security and opportunities for voluntary service, affinity groups (e.g. mutual aid), religious tolerance and harmony, life long learning, safe and pleasant housing, political democracy and participation opportunities, social justice and enhancing equity (Harrison et al. 2004).

The overarching aim of this book is to stimulate researchers, policy makers and practitioners to think differently about how they approach their goal of improving the health of populations particularly to minimise the risks of exacerbating or widening health inequities. It brings together the work of a number of well known authors who have been working in fields that have direct relevance to the asset model. The 18 chapters included in it provide illustrations as how asset based approaches can be brought to fruition. Of course, it presents only a starting point for further work, particularly in research – but hopefully its immediate impact can be to change the mindsets of those in decision making positions to think of the ‘glass half full, not half empty’ scenario.

We introduce each chapter here, to highlight how they can help us advance the asset approach to ensure it can demonstrate its potential to contribute to the production of health and reduction of health inequities through science and practice.

The Chapters

Chapter 1 provides the overarching framework for the rest of the contributions to the book. It sets out the rationale for asset based approaches and provides a systematic way of thinking about how to build an evidence base which can identify the most important assets for health; help us understand the potential cumulative effect of a range of different assets; and clarify their relative importance over the more well established determinants of health such as absolute and relative poverty. It also provides insights in to the sorts of practices that are conducive to the approach. The chapter highlights a number of existing concepts which can be helpful in developing this evidence base and together help to bring the asset model to life. Salutogenesis is introduced as a concept which can help us to think outside of the deficit, disease orientated approach to health and health services as by its very definition asks what creates health, what helps us to manage and understand the world we live in. By doing so it immediately highlights some of the key assets necessary for the development of health and wellbeing. Lindstrom and Eriksson explore the potential of this concept in more detail in Chaps. 2 and 18. The very well known

concepts of resilience and social capital are also included in the model as ones with potential to identify a set of indicators for monitoring and evaluating the impact of investing in programmes which emphasis the positive rather than negative. Specifically, in this context, the asset model demonstrates how social capital can be applied for health benefit – offsetting some of its criticisms concerning its ‘dark-side’ (Portes 1996). Chapters by Bartley, Kawachi and Baum (6, 9 and 16, respectively) all elaborate the potential for these concepts to contribute to the model.

Another important idea intrinsic to the model is that of asset mapping – this technique seeks to build capacity within local communities by making the most of the existing competencies of individuals, the resources of organisations and institutions and the collective ability of groups take control of their own health (see Chap. 4 by McKnight). The model also identifies the need to develop new indicators and evaluation techniques that can take account of the asset approach and ultimately demonstrate the benefits of investing in it (see Chaps. 5 and 7).

The concept of lifecourse is also important to the model – as the potential for health assets to be offset by all those risks that individuals and communities inevitably face during the life experience, can be understood if we assess those assets that can be accrued at different life stages. Chapters 8 by Morrow and 17 by Baban illustrate the importance of applying the approach to young people’s health and development.

Of course, none of the ideas, concepts or techniques mentioned above can be brought to practical value unless researchers, practitioners and policy makers embrace positive approaches to health and importantly focus on health and wellbeing rather than disease and dying. One of the reasons why politicians at least might favour the latter is on the surface it is easier count death and measure progress against it. The asset model provides an opportunity to make more explicit the concepts of wellbeing and its associated precursors and to demonstrate how they can be measured. The asset model challenges all professionals involved in health development to re-think their strategies for promoting health and to balance their activities between the asset and more familiar needs based approach – more thoughtful investments might then bring the longer term gains required to promote the best health we can and help us manage the limited resources available in our health systems.

Lindstrom and Eriksson (Chap. 2) consider the theoretical and empirical work relating to the salutogenic framework. This framework focuses on positive health, in contrast with the traditional disease-orientated approach.

Salutogenesis centres on two core concepts: Generalised Resistance Resources (GRR) and the Sense of Coherence (SOC). The GRRs are biological, material and psycho social factors that make it easier for people to perceive their lives as consistent and structured. ‘The GRRs lead to life experiences that promote a strong sense of coherence – a way of perceiving life and an ability to successfully manage the infinite number of complex stressors encountered in the discourse of life.’

The authors review a range of other concepts and their relationship with salutogenesis. These include hardiness, theories on welfare and quality of life, learned resourcefulness, resilience and theories relating to social and cultural contexts. The review indicates that salutogenesis draws a range of other related concepts.

The SOC questionnaire has been used to understand and test the role of SOC in explaining health outcomes. SOC has been shown to be strongly related to health, especially mental health. Lindstrom and Eriksson state that SOC, although not the same as health, ‘is an important disposition for people’s development and maintenance of their health’.

These findings suggest that the real potential of a salutogenesis approach relates to the adoption of healthy public policies. Historically public health has operated in a risk framework, while salutogenesis makes other solutions available for improving health. Two themes have evolved within salutogenic research – resilience and sense of coherence – that can now guide action that addresses social and mental wellbeing in a post-modern world.

Kelly (*Chap. 3*) highlights the importance of complexity of understanding how to create the optimum conditions for health by introducing the notion of the lifeworld. This chapter explores the relationships between those assets that help to protect health and those conditions which create vulnerabilities to ill health. It explains how these are located in the lifeworlds of ordinary human experience and the health benefits and disbenefits which accumulate over the life course. Kelly explains that the lifeworld and lifecourse together are the bridge between social structure and individual human biology. Together they constitute the focal point where society and biology intersect and interact. The lifeworld and lifecourse are the mechanisms through which the social determinants of health produce biological outcomes in individuals. Theorising this vital causal link from the social to the biological and from society to individuals, is essential for ensuring the success of the asset approach in practice. Assets and vulnerabilities are the crucial mediating or intervening variables between the wider determinants of health and the human body and it is those intervening variables that produce individual differences in health. Researchers can help us to understand how through the identification of key health assets these differences in health can be minimised.

Asset mapping is introduced in *Chap. 4* as a means of capturing the spirit and energies of communities to assert their ownership on health development. McKnight highlights how policy makers have tended to create hierarchical systems where a small number of people are in charge of the mass production of standardised goods. Clients/consumers in large numbers grow dependent on this cycle of production. Such systems create dependency rather than empowerment. He argues that in creating maps to reflect the way in which these systems work we have tended to neglect the notion of “associated community”; where there is a dependence on consent, choice, care and citizen power. Systems are seen to exploit need in individuals, whilst communities, in contrast nurture existing skills and capacity. Systems identify with “the glass half empty” approach, whilst communities with “the glass half full”. The service culture produces “clients”, whilst the community culture produces “citizens”.

This chapter explores the nature of the relationship between systems, communities and citizens, and looks at the shift, in developed society, from equal relationships between citizens and communities to a relationship where systems are dominant. The authors argue that the move towards an increasingly “consumerist

society” has marginalized the role of the citizen. In order to encourage and build healthy communities we must recognise and appreciate the unique capabilities that communities offer in developing, nurturing and caring for their citizens.

Hills and colleagues (Chap. 5) discuss the limitations of current evaluation frameworks and methods for evaluation of an asset based approach. The challenges that need to be addressed for developing the evidence base on effectiveness are highlighted.

The authors assert that a new paradigm is required for evaluation of a health assets based approach. The orthodox approach, based on the epidemiological discipline, has limited utility for evaluating the effectiveness of community assets, capabilities, risks and protective factors; and for the synthesis of evidence across studies.

There are major challenges for the evaluation of complex initiatives and programmes. There is a need for greater theoretical and methodological precision, particularly with respect to definition of health assets and their operationalisation through appropriate indicators. A more integrated approach to process and outcomes evaluation, formative and summative approaches is required. ‘Improvements in specific health assets need to be seen as intermediate outcomes in a linked chain of progress towards improving overall health and social outcomes.’ Participatory evaluation approaches need to be adopted that provide greater understanding of the processes involved in implementing programmes and their impact on the outcomes of the programme. Evaluators need to have a more direct role in programme development: evaluation becomes ‘reflective practice’.

Realist synthesis is applied to determine the effectiveness of a Canadian Community Interventions Project. This provides an example of an alternative methodology that enables the synthesis of evidence from different initiatives and programmes. Programmes are viewed as the interaction between context, mechanism and outcomes. Systematic review is concerned with understanding ‘families of mechanisms’ across programmes. The ‘mechanisms’ operating in the Community Interventions Project are illustrated, and relate to elements of collaborative planning, community organisation and action, and transformational change. The authors indicate that evaluation of the assets based approach is possible, but will require development of such innovative methodologies.

Bartley et al. (Chap. 6) examine evidence relating to positive adjustment and resilience as an asset which can promote health even in adverse conditions.

Studies show that individuals and families experiencing difficult conditions are more likely to experience negative health consequences. However the processes by which individuals and communities adapt have received less research attention.

Three models of resilience have been identified based on a review of evidence in this field. These three models (compensatory, protective and challenge) are described.

A link has also been made between the study of resilience and research on the life course processes involved in chronic diseases. This has highlighted the need to examine the accumulation of both risks and resources or assets. Health assets are shaped by the social and physical environment. Resilience is a set of conditions that

allow individual adaptation to different forms of adversity. Resilient practices and processes may be viewed as health assets. Such processes need to be identified and promoted by social and economic policies.

The authors discuss issues relating to resilience and freedom. Sen's work indicates that the ability to adapt in the face of adversity can increase an individual's perception of their own freedom to lead a valued life, i.e. resilience increases capability. 'It is important for the individual to have the freedom to pursue health itself, and therefore to understand constraints on that freedom': such as being forced by financial necessity to accept stressful working conditions, and to live in polluted areas.

This means that policy should be concerned with enabling people to make healthy choices while faced with these challenges; different policy responses will be required to address different threats to freedom.

Bartley and colleagues consider a number of cases that show how health resilience can be promoted in communities that are disadvantaged. For example analysis of health inequalities in Europe, has shown that socially disadvantaged populations in Southern European countries, possess a source of resilience in terms of a healthy diet. Although these countries have clear income inequalities, these populations have long life expectancy and less health inequalities. More research is required to understand diet as a source of health resilience but there are potentially important implications for wider policies.

The authors explore how that process of modernisation may lower the economic capability societies with detrimental health consequences. The role of women in the nurture of children and families has added value in traditional economies. However the changes in this role in modern societies (a shift between home and work) are not fully understood and the authors assert that skills in the conduct of family relationships as a major health asset are being neglected – there is loss of 'free emotional labour' and ... 'It is important to increase the capacities of both men and women to choose a way of life they can sustain themselves in terms of both physical and emotional self care'.

Bartley and colleagues argue that there are many aspects of human relationship that function as health assets for individuals and communities. However they are only acknowledged when they are lost. The assets based approach provides the potential for recognising and understanding the processes necessary to development of these capabilities in the modern context.

Wille and Ravens-Sieberer (Chap. 7) consider approaches to the measurement of resilience. Research in resilience does not address pathological responses of individuals to stress but investigates health protecting mechanisms, i.e. the ability of individuals to maintain good health despite considerable stressors.

Resilience research has aimed to identify protective factors or developmental assets that can modify a child's response to adversity. This understanding provides the basis for designing prevention programmes that promote factors that buffer effects of adversity.

Conceptually resilience is characterised by good outcomes despite of serious threats to adaptation or development. Two conditions pertain: the presence of demonstrable

risk and competence in response. There is an interactive process involving a person's constitution as well as functional qualities of its environment.

There are certain conceptual challenges. For example there is some inconsistency in how the term 'protective' is used. Certain authors only use 'protective' to factors that operate in the presence of adversity-buffering the effect of risks, but it is also applied more broadly.

From a salutogenic perspective there is a case for a population based approach for supporting resilience among children and adolescents through direct amelioration as well as buffering of protective factors. Large population based studies that assess a variety of risks and resources can support the design of effective public health interventions. Such studies are rare; however the BELLA study provides an important example of a study that is focusing on mental health problems in children and adolescents and associated risks and resources. The range of measures used to assess risk factors and protective factors are described. The chapter demonstrates the need for researchers to pay attention to better measurement so that their work can be more easily applied to policy action.

Morrow and Mayall (Chap. 8) explore the concept of children's well-being, how it is measured and how it is being researched. The authors indicate that the concept of well-being is not well defined, yet it has become part of public, political and policy discourse particularly in the UK. Given the emphasis of wellbeing in the asset model, this chapter provides important reflections on the issues involved in assessing how best it should be conceptualized and measured.

A number of important questions are raised, including whether other European countries would simply refer to 'children's welfare'; and whether the focus on well-being is 'inherently individualistic', and detracts from a concern for welfare and responsibilities of governments towards children.

The authors conclude with a number of suggestions. Care needs to be taken with conceptualisation of complex concepts such as 'well-being'. There remains a 'danger that a focus on well-being is ultimately an individualistic, subjective approach that risks depoliticising children's lives'. Caution is required when reporting research relating to children, as there is a risk of over-simplification through international comparisons. Both qualitative and quantitative approaches should be used. Children and young people should be involved in the conceptualisation of well-being. There should be greater understanding of UN Convention on the Rights of the Child in moving towards a 'genuinely rights-based approach to monitoring children's everyday lives' that confronts the low social status of children in western societies.

Kawachi (Chap. 9) summaries the nature of the knowledge base concerning social cohesion as a community level asset and determinant of health – covering theories of causation, measurement approaches, empirical evidence and also the potential of social capital as a public health intervention.

Social cohesion is clearly related to an assets based model of health – enhancing the capacity of communities to preserve and maintain. Residents of cohesive communities can access and mobilise to protect their health consist of norms, trust, and the exercise of sanctions. These assets are translated into improved health status

through a number of social processes – socialisation, informal social control, and collective efficacy.

Recent reviews of the empirical evidence link community cohesion to health outcomes. Studies indicate a link between community cohesion and physical health outcomes (including self rated health) and health related behaviours. The evidence on mental health is more sparse and mixed. The majority of studies have been conducted in developed countries. Community cohesion (as a health asset) appears to be more salient in societies characterised by the deficient provision of material infrastructure.

There is debate about the value of investing in social cohesion as a public health improvement strategy. Social cohesion is not a panacea for population and can sometimes have negative consequences. For example strong social networks may demand conformity and restrict individual freedoms. Kawachi identifies a number of principles that should guide investment in building social capital. Broader structural interventions (such as job creation and improved working conditions) aimed at boosting the capacity of individuals and communities to organisation should be considered along side building social capital locally. Attention needs to be given to the type of social capital; building bridging social capital rather than bonding social capital. For example the linking of unemployed youth to employed adults can provide access to role models and mentoring. The distribution of costs and benefits should be assessed to avoid unintended consequences. For example women may disproportionately be expected to provide support. There is also a need for governments to be actively involved in building social capital, voluntary efforts are insufficient.

Popay (Chap. 10) focuses on activities concerned with enabling communities to have greater control over decisions that affect their lives with the aim to improve population health and or reduce health inequalities.

The author provides definitions of community development, community empowerment and community engagement and involvement. A theoretical framework is presented that defines a number of interlinked pathways between activities aimed at increasing community engagement and/or empowerment and health outcomes including both improved population health and reduced health inequalities. In theory different pathways to health outcomes will be operating at different levels of empowerment and/or engagement. Activities involved in giving communities more power and control over decisions that affect their lives are more likely to have positive impacts on service quality, social capital, socio economic circumstances, community empowerment and ultimately on population health and health inequalities.

Popay states that community engagement and development have a long history both in the UK and internationally. Current UK policy across many different areas view engagement and empowerment as the means to finding local solutions and a pre requisite for success and sustainability. However evidence highlights that there are a range of barriers to effective community development which relate to a lack of both community and organisational capacity.

Popay discusses the challenges and limitations relating to the evidence base and provides a comprehensive set of issues that need to be addressed in conducting evaluations. Given the diversity of the evidence base, there is a strong case for constructing a review of evidence that tests theoretical models of the pathways between different approaches to community empowerment and engagement (and specific methods) and different intermediary and longer term outcomes.

Rutten (Chap. 11), Mukhopadhyay (Chap. 12), Franceschini (Chap. 13) and Houeto (Chap. 14) all provide examples of the issues involved in the development, implementation and evaluation of asset approaches to community health in different country contexts. The experiences from Germany, India, Latin America and the Caribbean and West Africa, demonstrate the commonalities and differences of applying the model in different circumstances.

Rutten et al., (Chap. 11) uses the concept of asset mapping to improve opportunities for women living in difficult life situations in Germany to engage in physical activity or ‘movement’ as they define it. It demonstrates how the model can be used to challenge power structures within communities to overcome how professionals in positions of power can work with representatives from the community to achieve their health goals. Importantly they describe a process that could be replicated in different country contexts to help overcome some of the barriers that local communities face in try to have their voices heard by professionals in positions of power. They also highlight how the processes important to the success of community focused initiatives can be captured by mixed method approaches to evaluation and use of indicators that represent the assets necessary for improving the opportunities for health and access to facilities and services.

Chapter 12 focuses on sustainable community based health and development programmes in rural India. It introduces the Khoj project, a community based development programme which exemplifies the power of the asset approach to change the life circumstances of people living in poorer circumstances. Mukhopadhyay and Gupta describe their experience of strengthening the capacities of local communities in remote rural parts of India. The project is set within the broader context of Indian state’s commitment to achieve “health for all”. The overall vision of Khoj is to create an enabling climate for the sociopolitical development of communities living in difficult terrains of the country. The chapter highlights the successes of a non government group through implementation of a range of cross cutting interventions aiming to bring about a holistic change in the lives of the communities by uplifting their socioeconomic and health status. The Khoj projects emphasizes that there is no concept of recipients, as the community is involved in managing the development of the project including efforts access and obtain the resources needed. The chapter outlines the broader context within in which the project takes place with a brief description of the health sector in India and highlights the features of the community centric sustainable strategies of Khoj that brought about improvements in the overall well being of the population.

Chapter 13 by Franceschini and colleagues use the settings approach to highlight what can be achieved in Latin American countries (LAC) where policies and

interventions to tackle poverty and inequalities in health have tended to focus on disease prevention and treatment. The authors argue that to create sustainable strategies it is more beneficial to follow a “settings approach”, based on the belief that determinants of poverty and equity, and their influence on health, can be tackled through activities, which embrace and work with existing community networks and infrastructures. This may include the creation of appropriate public policies and laws and places particular emphasis on the importance of working with regional and local governments.

This chapter looks at the Healthy Municipalities and Communities movement, developed in the 1990s, whose aim was to look at underlying living conditions and build on existing assets. The focus is deliberately shifted from a focus on illness and disease to tackling the determinants of health. The chapter concludes by highlighting the constraints of traditional evaluation methods in their ability to record and assess the significance and impact of “asset building” in projects. Participatory evaluation techniques, it is proposed, may be an effective methodology to engage people in a joint reflection and learning process.

Houeto and Deccache (Chap. 14) provide an example from Benin, West Africa of how parental and community assets can help to control under five child malaria. This chapter reviews the issues around the burden of malaria in the region and details the successful facets of a community-led, assets based, anti-malarial project.

Chapters 15–18 (Makara, Baum, Baban and Eriksson, respectively) consider the asset model through the policy lens and the range of issues that need be addressed by those in positions of power to ensure that appropriate attention is given to the approach.

Chapter 15 (Makara et al.) reflects on the Hungarian experience of adopting assets based approaches and the timeliness of adopting the asset approach as the country faces the challenges of the social and health impact of the economic and financial crisis. A greater focus on assets based approaches could help unlock some of the existing barriers to effective action on health inequities. The chapter highlights that Hungary has a history of asset based approaches in local communities. However, if an asset approach is to be realised, a number of things need to be in place to ensure that the aims and objectives of the New Hungary Development Plan (NHDP) can be reached. This chapter sets out the lessons learnt from the past and highlights the critical conditions for policy to assure they take account of the country’s assets at the national, regional and local level.

In *Chap. 16, Baum* examines the role of social capital in bringing about equity based policies that are central to achieving healthy populations. This involves a review of theories and evidence on the relationship between different forms of social capital (bonding, bridging and linking), equity and health outcomes.

Baum explores in detail how health inequities are created through social and economic structures, opportunities and networks, and psychosocial and behavioural mechanisms, and how social capital can play a role in making the outcomes more equitable. ‘A high social capital society has high social and civic participation with bonded, bridging and linking networks which produce co-operation and trust

among the citizens and a desire to provide a fair go, for all members of the community’.

But there is an issue of direction of causality. Wilkinson’s work indicates that equity of income distribution in a population leads to a society with these high social capital attributes. However Baum points out that it is possible to assume that high social capital society will result in more equitable health outcomes and that social capital is easier to generate in more equitable societies. A virtuous cycle can be established.

The role of governments in creating and supporting social capital, and how social capital can effect political processes, is also examined. Linking social capital implies can be particularly important in bringing about redistributive and progressive policies. A number of historical and contemporary examples are cited that demonstrate how movements of solidarity and democratization can impact on equity that there is a sense of obligation from powerful institutions in society towards the less powerful.

Thus a crucial public policy question is what are the conditions under which a society demonstrates higher degrees of linking social capital and solidarity? How can these attributes be fostered especially in an age in which economic globalisation stresses the value of individual autonomy.

Baum concludes that further research on social capital and its relationship to health equity that is more strongly informed by political economy theory will be important for better understanding of its role as a health asset.

Chapter 17 by Baban and Craciun focuses on the assets required for the health and wellbeing of adolescents living in Romania. They use data from the Romanian Health Behaviour in School Aged Children survey to examine how ‘internal and external assets’ relate to the mental health and health behaviour of this group of young people. In particular they investigate the relationship between school social capital and mental health and consider the implications for health promoting school based policies. The authors argue that the assets based model for health provides a useful framework, demonstrating how school health promotion should focus on building internal and external resources, helping young people to become active agents in the promotion of their own mental well being and health behaviour. Results demonstrate that changes in family structure, parenting patterns and the easy availability of unhealthy lifestyle options means that the contemporary role played by school in the health education of teenagers has assumed greater importance than in the past. Gender differences also emerged from the study, with boys demonstrating more internal and external resources than girls. Data such as this can be useful in developing national school policy, promoting student centred methods that help increase self efficacy and self esteem.

Eriksson and Lindstrom in the final Chap. 18 assess the potential of the salutogenic approach as the basis for tackling public health challenges. The salutogenic approach focuses on assets for health and the processes that can promote health.

Salutogenic theory is conceptually and empirically sound. The application of the sense of coherence scale (SOC) demonstrates the evidence potential as for research and practice.

Potentially the salutogenic approach embraces a number of concepts that are concerned with assets for promoting health. The *sense of coherence* has similarities, as well as differences with a range of other concepts including resilience, hardiness, self efficacy, empowerment and habitus and cultural capital.

There is potential to integrate the sense of coherence as an indicator within the health indicator system. It is important that SOC as a health indicator is assessed on a population level, and the authors propose introducing a new concept RALY – Resource Adjusted Life Year as a measure to include in vital statistics – applied on a general population level. The inclusion of SOC as a health indicator is important for the deeper integration of the salutogenic perspective on healthy public policy – a policy development approach that ‘gives people the possibility to live the life they want to live’. The salutogenic model can also provide a comprehensive cross sectoral framework and coherence for policy making.

The salutogenic framework is also important for public health and health promotion research. The authors introduce a model that draws on a number of theories and brings together ‘research on risk factors for vulnerability and adversities, protective factors for survival and good health outcomes with salutary factors promoting health and Quality of life’.

Together the chapters demonstrate what we already know about positive approaches to population health. In doing so, they raise the issues that need to be addressed if we are to move towards a robust and systematic evidence base that highlights the benefits of investing in the assets of individuals, communities and populations for long term sustainable health and development.

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