The Fifth Wave

by Andrew Lyon

Scottish Council Foundation
independent thinking

NHS SCOTLAND

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Preface

Scotland faces a dilemma. Our health is the poorest in Western Europe. We have the poorest health and the greatest inequalities in health in the UK. We have been trying at many levels to confront these problems through programmes for health improvement for many years. Yet this has led us to recognise the limitations of top-down programmes. Engaging with people is vital, but so-called bottom-up initiatives in Scotland have never reached sufficient scale in impact on the national picture. Therefore, fresh thinking is needed.

In 1998 the Scottish Council Foundation's Healthy Public Policy Network (HPPN) published its first report, *The Possible Scot: making healthy public policy*[1]. It suggested a new approach to health policy in Scotland that would tackle the underlying causes of poor health and inequality. This was followed in 2000 by *Promise and Practice*[2] which analysed the new Scottish Executive's *Programme for Government* to consider the likely effectiveness of these policies in achieving its stated aim of ending health inequality. Since then the cross-cutting, collaborative approach that these documents advocated has been widely accepted. However, there is growing belief that, though necessary, this approach alone will not be sufficient to achieve significant improvements in health and inequalities.

During 2002 and 2003, the HPPN (and particularly the core network group), supported by the Scottish Council Foundation (SCF) and the Public Health Institute of Scotland (PHIS)[3], has been exploring a new way of looking at the challenges that face Scotland in improving health. This document is one of the outputs of this work. Building on *The Possible Scot*, *Promise and Practice* and *Possible Scotland*[4] (the findings of an in-depth study of citizens' aspirations for improving Scotland, conducted by SCF with PHIS and the Health Education Board for Scotland (HEBS) and published in 2002), the intention of this work is to generate conversation among the many people in Scotland who have influence over the way organisations evolve and develop, which will in turn stimulate effective thinking and action to improve health.

To contribute to this discussion and to learn more about the work of the HPPN please log on at the forum page of www.scottishcouncilfoundation.org.

Professor Phil Hanlon
October 2003

Contributors

Many members of the Healthy Public Policy Network (HPPN) provided useful and constructive comment throughout the development of this document. The following members are owed particular thanks for their significant contributions:

Maddy Halliday (The Mental Health Foundation), Margaret Hannah (Fife NHS Board), David Ogilvie (Medical Research Council Social and Public Health Sciences Unit), Adam Redpath (Information and Statistics Division of the Common Services Agency), David Reilly (Glasgow Homeopathic Hospital), Desmond Ryan (University of Edinburgh), Helen Zealley (former Director of Public Health, Lothian NHS Board).

Andrew Lyon wrote the document based on the ideas generated by this group. Andrew Lyon is a member of the International Futures Forum (IFF), established in 2001 to explore new ways of acting more effectively and responsibly in a rapidly changing world of boundless complexity.

Phil Hanlon provided the initial ideas for this document and contributed to the Network throughout its development. Phil Hanlon has been Professor of Public Health at Glasgow University since 1999. From January 2001 to April 2003 he was seconded to establish the Pubic Health Institute of Scotland. He has now returned to academic work but remains a professional advisor to the Scottish Executive and to NHS Health Scotland.

Jill Muirie (PHIS) co-ordinated the Healthy Public Policy Network during 2002-03.

Acknowledgements

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Those who facilitated the learning journeys that provided great insight and stimulation to the group are thanked, especially Neil Macdonald and colleagues at Common Wheel, Stuart Macdonald, director of The Lighthouse (www.thelighthouse.co.uk), and David Reilly and Jane Kelly at Glasgow Homeopathic Hospital. Last but by no means least, our thanks go to Paul Gibson and Chris Whitehead of Forthroad, who facilitated the HPPN meetings during 2002, for their patience and ability to focus our discussions.

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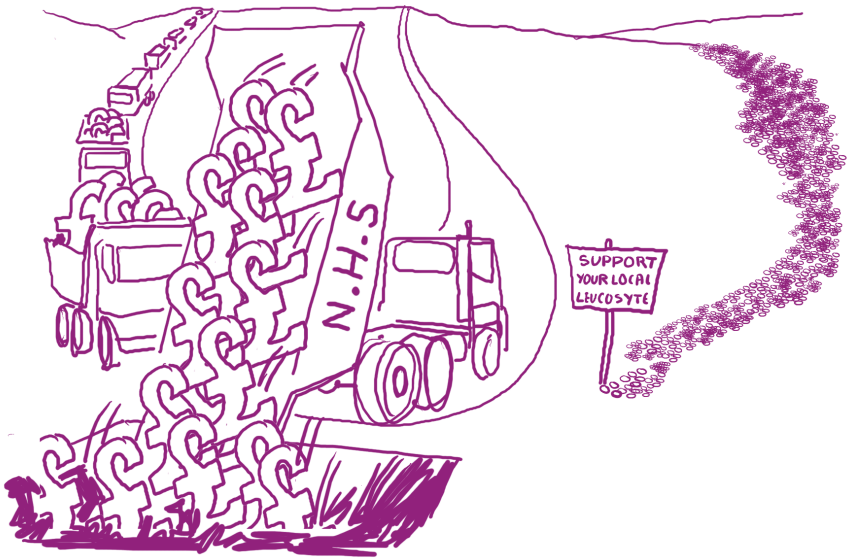
Introduction

> ***"Centrally planned systems don't work"***
>
> ***Kofi Annan***[5]



In government, in the media and in society at large, health remains one of our major preoccupations. In response to this, and to Scotland's relatively poor health status, spending on health services is increasing. Yet despite this, improving health remains one of Scotland's biggest challenges. The purpose of this document is to set out some arguments about how Scotland might achieve a step change in its health status in the hope of generating conversation which will in turn stimulate effective action to improve health.

The report traces the links between some major developments in thinking and associated health interventions since the Enlightenment in the 18th century.

The modern world which we have created heaps blessings upon us. Our knowledge is widespread and increasing, our capacity for communications continues to expand, new technologies abound and so on. Almost anything seems possible.

Yet everywhere our systems are under strain, our biosphere seems overloaded, and the challenge of coping with the increasing pace of change and uncertainty leaves us breathless and anxious. Persistent inequalities abound leaving us divided, confused and ineffective.

Our achievements have made possible a global revolution, and its complexities and scale are difficult to live with. The strains in individuals, societies and systems are all around us.

And what of health and wellbeing? How can we acknowledge and transcend this complexity enabling us to take collective, legitimate decisions which address the wide range of factors which affect and are affected by the wellbeing of the population? Such decisions include the relationship between economy and society, and between the present and the long term, which resonate deeply with our understanding of what it means to be human and to live a happy and fulfilling life.

The main idea proposed here is that an answer to health improvement lies in the celebration of diversity as an intrinsic

value - that one size does not fit all in the search for health. One size fits one. Our current approaches suggest that the energy for health improvement comes from the various systems and organisations we have established, and that rational organisation will deliver what we need. Instead, we suggest that the energy for health improvement comes from liberating and supporting the creativity of many individuals and groups in Scotland.

The action implied by this approach is for our institutions to create a supportive set of enabling conditions which nurture this: wholeness, positive relationships, respect, trust, innovation, love and care.

The report starts with the Tale of the Fisher King, which could have been written as a parable for our health and times - in our search for health we have been looking in the wrong place with inadequate tools. It then outlines Scotland's health record and tells the familiar story: that our health is poorer than in other Western European countries and is improving at a slower rate than elsewhere.

The report then outlines three major shifts in thinking and themes of history since the 18th century Enlightenment and associates four major trends in public health interventions with these, before suggesting that we stand at the point in history where an era shift, of the type which comes along every few hundred years, is occurring. How can we discern the next wave of public health improvement in this theme of history? If we are standing truly on the brink of a new era, what public health action is needed?

In examining this shift from organisational/bureaucratic to individual/creative paradigms, the report looks at some ideas developed in Glasgow by David Reilly. Members of the HPPN undertook some learning journeys to look for the characteristics of this approach elsewhere and highlight those factors that support it where it is found.

The intention of the report is to stimulate. Its tone is exploratory and emergent rather than strident and didactic. Its aspiration is to contribute to our understanding of, and stimulate discussion about, Scotland's health and what we are going to do to improve it.

The Tale of the Fisher King, a parable of our times

> ***A people are as healthy and confident as the stories they tell themselves. Sick storytellers can make their nations sick. And sick nations make for sick storytellers.***
>
> ***Ben Okri*** [6]

The Fisher King appears in many guises in many cultures. In Celtic mythology he is the keeper of the land, a key component of its fertility and ability to regenerate, at the heart of its wellbeing. In medieval legend, he is the keeper of the Holy Grail, the cup from which Jesus drinks at the Last Supper. In this version of the tale, as in all others, he is wounded and debilitated. He has lost the ability he once had to be whole, to experience the joy of his fertile land and the happiness which the Grail is capable of bestowing. Though he searches vigorously he cannot find the cure for what ails him.

His wound refuses to heal. He remains frail and does not improve. Over the years many of his best advisers try to effect treatments and cures for his ailments. Despite the application of their expertise, crafted from the myriad years of their professional experience, he languishes. Operating at the height of their powers, not one of them is able to cure the Fisher King of his ailment. The whole nation is stuck.

Then one day the court jester tries to help. He is unpractised in what passes for the healing sciences in his land. Instead, he treats the king humanely with care and compassion and shows him love and respect, one fellow mortal to another. He does not exhibit the distance normally accorded the Fisher King by his subjects. The Fisher King, for the first time in many years, sees the Holy Grail, which was by his side, close at hand, all the time. He begins to recover.

This story summarises and provides an allegory for the main thread of the argument in this report.

Wellbeing in Scotland will be improved significantly when we can find ways to enable the care, compassion and energy of Scots to be expressed in, rather than excluded from, our civic life. We need new methods that build on and transcend our current organisational forms so that better relationships can form the basis for more effective action in a complex and rapidly changing world.

To unpack this story, we look at Scotland's health record, and how health is enhanced and eroded in everyday life. It will examine the relationship between the history of ideas and the history of public service intervention. It will go on to develop the idea that today's methods of intervention are running out of steam and are no longer sufficient on their own to deliver the levels of health and wellbeing it is possible for Scots to enjoy. We must first agree to look in the right place and overcome the limitation we place upon ourselves by our current thinking.

The ideas presented in this publication do not emerge from a vacuum. They build upon previous publications of the Scottish Council Foundation, the HPPN and its members. These include *The Possible Scot*,[7] *Promise and Practice*,[8] *The Possible Human*[9] and *Possible Scotland*[10]. A key theme in all of this work is that every policy and action in every sector has the potential to contribute to health and wellbeing. Many of the arguments made in those publications are now commonplace and are reflected in our discussion in this report.

Scotland's health record

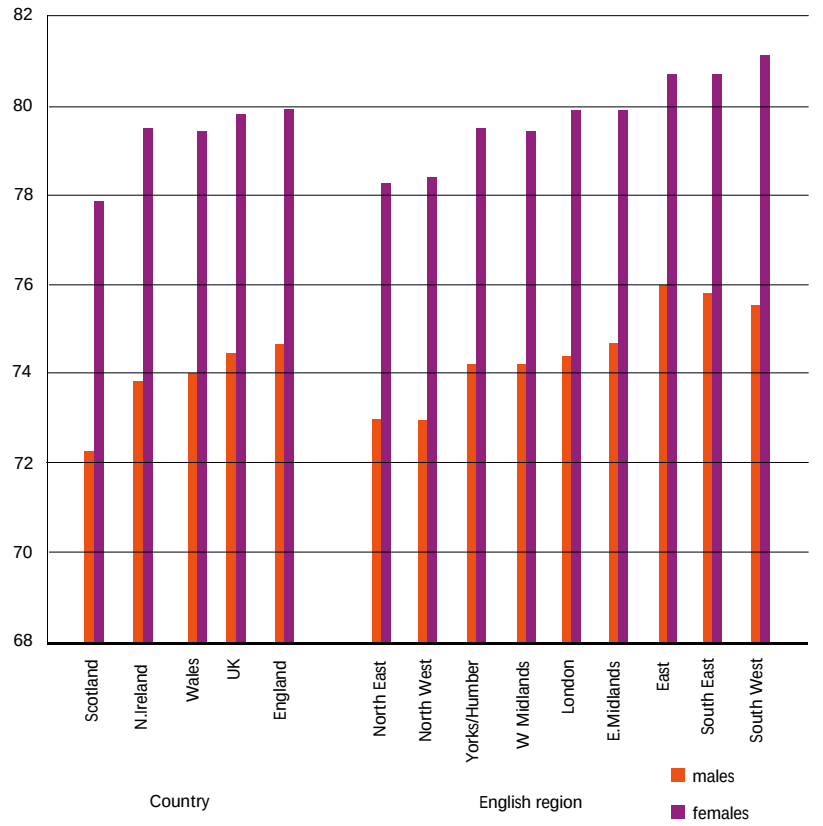
Scotland's health record is slowly improving, but remains relatively poor. Scotland has the highest rate of deaths from all causes, and the lowest life expectancy at birth, of any part of the UK region (figure 1, opposite). Scotland also has a greater proportion of its population living in deprivation (18%) than England and Wales (9%)[11].

The difference in mortality between the richest and the poorest in Scotland is greater than between similar groups in England and Wales - in other words, the link between deprivation and mortality seems to be stronger in Scotland than in England and Wales.

This pattern is persistent, and holds true across all causes of mortality. In fact, Scots are 25% more likely to die before their 65th birthday than their counterparts in England and Wales.

Comparing Scottish local authority areas with English regions, Glasgow City has the worst record in terms of life expectancy in either country, and even the best Scottish areas struggle to keep up with some of the worst English regions.

Figure 1: Life expectancy at birth by country and English government region, 1995-97 (Source: ONS)

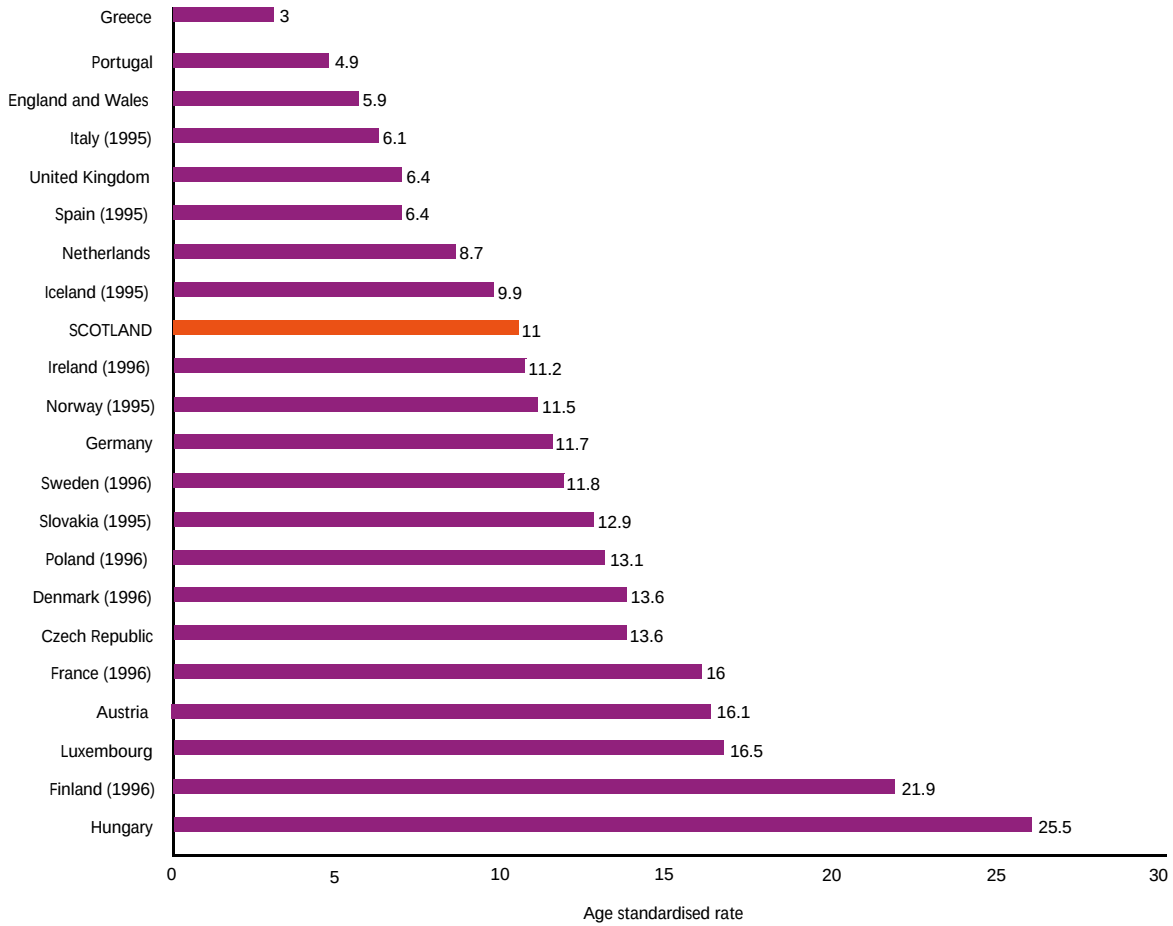


Our nation's mental state can be discerned from the following bleak indicators.

Suicide rates among young men in Scotland have increased by 50% in the past ten years and have increased fourfold over the last 25 years.

The effects of dissatisfaction and alienation are widespread. The signs of emotional poverty - expressed in low self-esteem, emotional illiteracy, intolerance, anxiety and depression - are among the most common reasons for visiting a GP. We do not give our young people enough to hope for (figure 2, opposite).

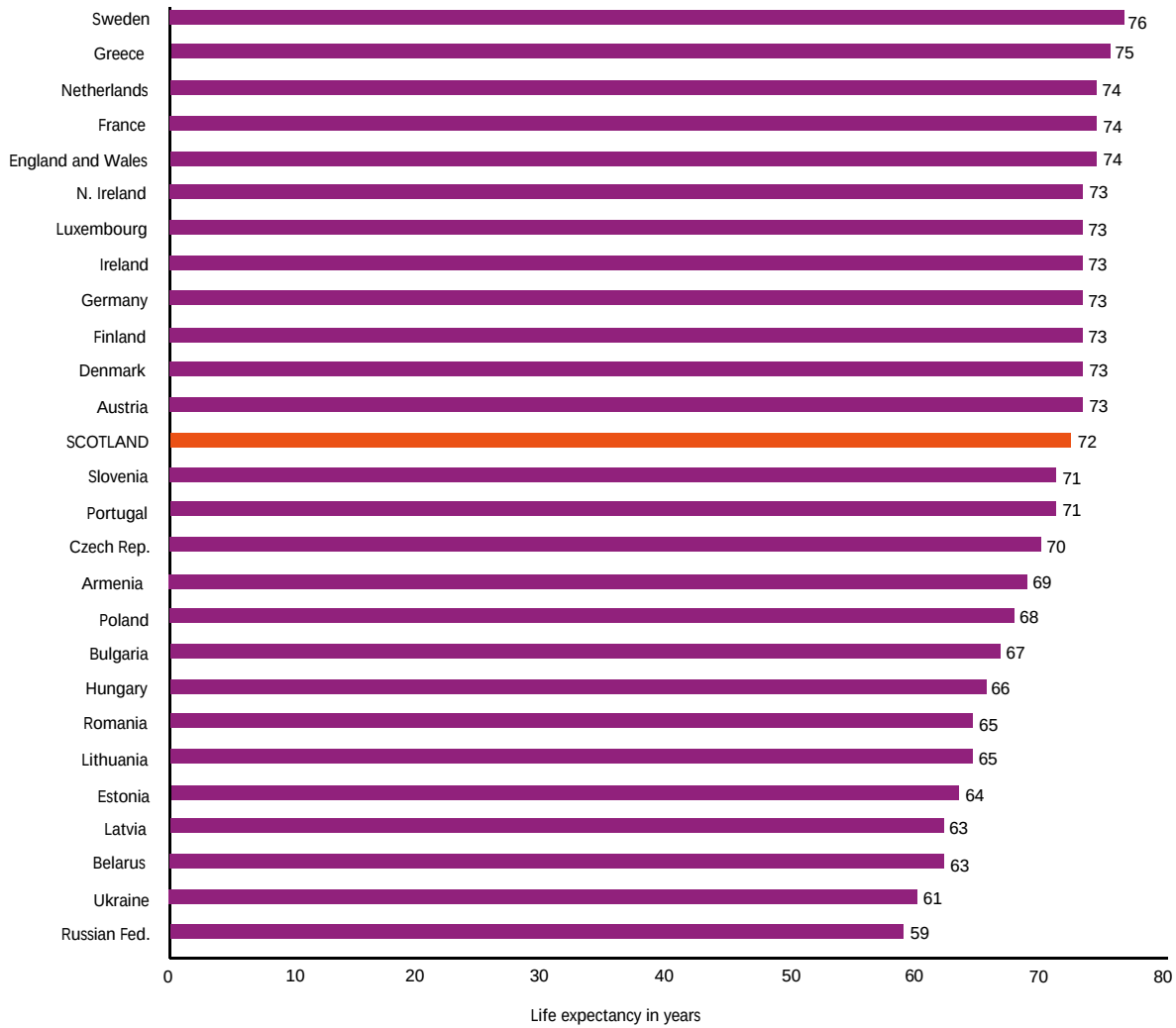
Figure 2: Suicide/self inflicted injury - age standardised death rates per 100,000 population 1997



Scotland's health experience is more like that of an emerging eastern European country than a western one. Barring Portugal, only eastern European countries had higher mortality than Scotland in Europe in 1996. Scotland had almost 50% excess mortality when compared to Sweden, and had slightly higher mortality than Slovenia. An even more sobering picture emerges if we look at cause-specific mortality. Here Scotland's standing gets worse, and is especially poor for heart disease and cancers.

In life expectancy at birth, Scots come in the middle of the table, with all other western European countries ahead and only eastern European ones behind (figure 3, opposite).

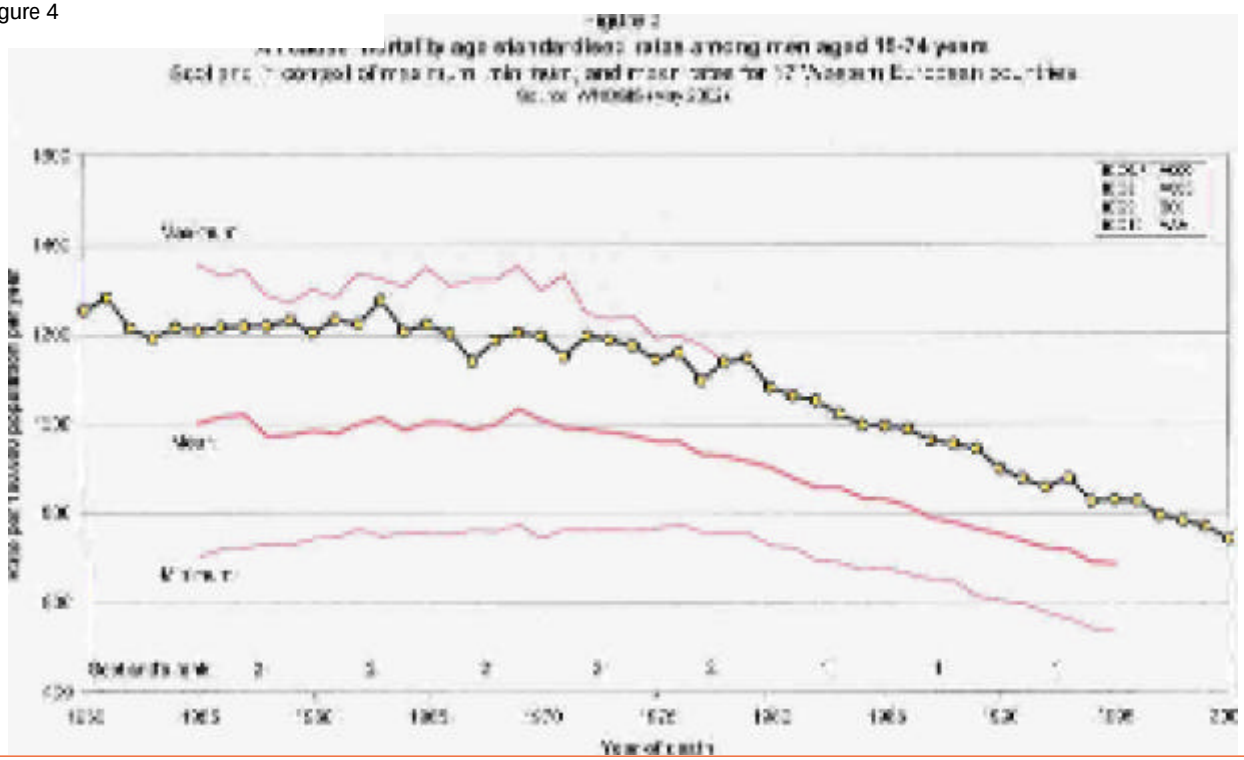
Figure 3: Life expectancy at birth, 1996 - MALES (Source WHO)



Life expectancy is increasing, but Scotland's improvement is slower than elsewhere in Western Europe. Trends in disease are down, but Scotland's rate of improvement is slower than elsewhere in Western Europe. Our relative position is therefore worsening (figure 4, opposite).

This situation is unacceptable. To change it requires a step change in thinking and associated action. We should not be daunted by this. We have addressed similar challenges before - many times.

Figure 4



Current thinking about health

The NHS is an incredible institution, but it was not designed to create health and cannot do so on its own. The NHS spends almost all of its budget treating people after they become sick, and the majority of this expenditure is made in the last year of life. The idea that the NHS could improve health if only we gave it more money now forms a major obstacle to the real work of addressing the origins of Scotland's woeful health record and doing something effective about it.

The purpose of this report is not to criticise the NHS. Instead, we recognise that, in terms of preventing the main causes of early death and excess illness, diminishing returns set into health service activity some time ago - as they have in every other modernised nation. It is no longer true to say that better health services will improve health. In any case, health policy needs to go beyond death and illness and find the paths that will lead to more fulfilling and happy lives. We need to commit ourselves to nurturing a healthy Scottish population, and thus change the nature of Scotland's relationship with its health services. Our aspiration as a nation could include that of being the healthiest nation on earth. We need to commit to this vision and then work together to make it happen.

The 1948 World Health Organisation definition of health says that: " … health is a state of complete physical, mental and social wellbeing and not merely the absence of disease …"

This means three main things:

1 Health is a state of being. It is not an activity or a service. It is not health care, not decent housing or a good local environment, not welfare, or health and safety at work. It is not jogging, eating a balanced diet, or stopping smoking. It is not enjoying ourselves, relaxing, being in a loving relationship, having great friends, laughing or being connected to the world around us. Rather, health is all of these and more. In short, it is the outcome of what makes up our everyday lives.

2 Health is amenable to change. Health can be improved everywhere in Scotland. We create the conditions which give rise to health and we can change them for the better.

3 Improving health requires both holistic thinking and action. Health and wellbeing is not the responsibility of any one organisation, profession, sector or individual working on its own. It requires partnership, joint working and joint budgeting, integrated thinking and action. We need inter-connectedness in our approach to the health challenge, not fragmentation. In addressing the various aspects of life in Scotland through policy and action, we should always seek connections to the whole and not seek to work on health improvement in isolation. By seeking connections in the way we work, we will come to see the whole in each of our fragments.

This delineation of health is now widely known. There is a ready acceptance that integrated thinking and action are more likely to be effective than fragmented thinking and action. It has not always been like this.

Themes of history, themes of policy

> ***"To understand what is happening in Scotland today look at its deep history - the history of 250 years ago"***
>
> ***CK Prahalad***[12]

> ***"Every few hundred years in Western history there occurs a sharp transformation. Within a few short decades, society - its worldview, its basic values, its social and political structures, its arts, its key institutions - rearranges itself ... We are currently living through such a time.***
>
> ***Peter Drucker***[13]

> ***"It was the best of times it was the worst of times"***
>
> ***Charles Dickens***[14]

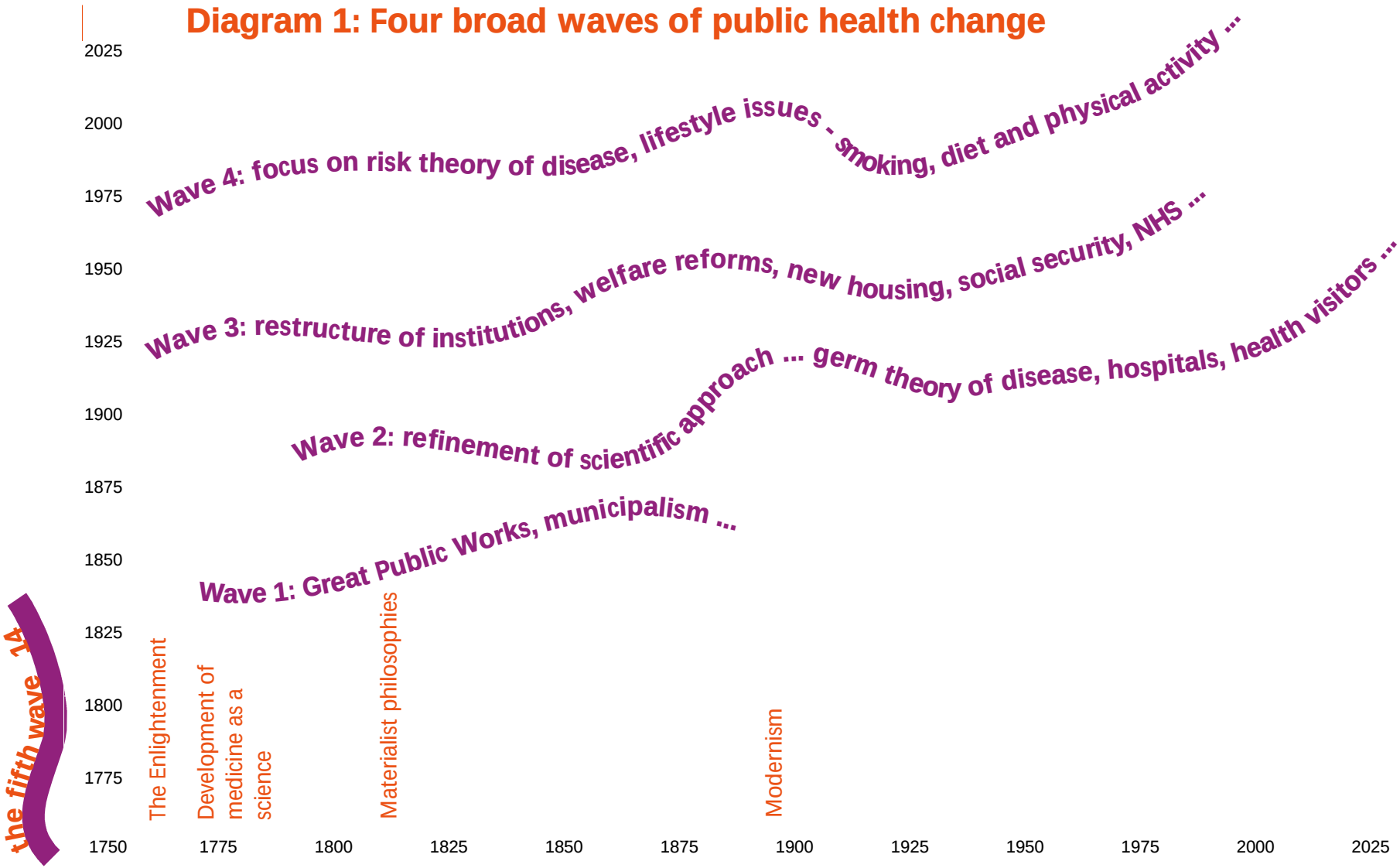
Policy developments and interventions themselves do not take place in a vacuum. They inform and are informed by the emerging ideas of their time. This is as true of thinking about health as of anything else. This section outlines shifts in thinking, from the 18th century Enlightenment through to the present day, that have had a profound impact on the way we understand and act in the world. It outlines the changing socio-economic contexts that have accompanied these shifts. It also highlights associated changes in public health thinking along with the policy interventions that followed from these. An important trend through these changes has been the increasing dominance of large bureaucracies as a key mechanism of organisation in public life. The suggestion is then made that diminishing returns have set into this approach. A key question raised towards the end of the section is: what might we do, based on this understanding, to serve health improvement more effectively in our rapidly changing and uncertain world?

Ideas	Socio-economic change	Policy intervention
The Enlightenment	Industrial Revolution	Appliance of science
19th century material philosophies	Communism, democratic socialism, capitalism	Social engineering, new forms of institution
20th century: previous ideas and how hey play out	Modernism	Large scale organisations Organisation over individual

In what follows, there is no attempt to delineate sequences of events or imply causality. That would require a fuller and more detailed analysis of the relationship between economy, society, culture, policy making and institutions. Bearing this in mind, this idea of change is illustrated in the table above.

Four broad waves of public health change can be associated with these shifts. These do not rise and fall consecutively in neat linear time arrangements. The influence of each previous development can be discerned in those which follow or overlap (diagram 1, next page).

Diagram 1: Four broad waves of public health change



The first wave of public health intervention in modern times is best understood when seen in the context of the disruption associated with the first industrial revolution. Changing social patterns (eg rapid urbanisation, earlier age at marriage, increased alcohol consumption, increasing crime, new disease patterns, concentrations of capital) brought forward interventions which sought to create a new order out of the chaotic patterns which accompanied the shift to an industrial society.

This can be characterised as the appliance of science and the development of rational social order. Great Public Works can be traced to this period, from 1830 - 1900, when miasmic theories of disease were beginning to be seriously questioned, but not comprehensively discredited. Loch Katrine and similar schemes brought clean water and sewerage to the UK's major cities, and municipalism brought its associated improvements in housing, living and working conditions and reductions in diseases before their causes were even discovered.

The second wave of public health intervention, running from roughly 1890 - 1950, is based on the refinement of the appliance of science which had occurred in the intervening period. The main change was a new emphasis on the germ theory of disease. Its emergence was precipitated by discovering the poor health of Boer War recruits. The genesis of modern emergency services is to be found in this period along with universal education, health visitors, co-operative societies and the temperance movement.

The ideas informing all of these changes can reasonably be traced to the interpretation of the rationalist philosophies of the Enlightenment period. Scientific rationalism is to be found in manufacturing, medicine, engineering, transport, municipalism and the development of hospitals. The concept of the expert - a person specialised in a particular and narrowing field - is an integral part of how these ideas unfolded in the new context. This in turn gave rise to paternalist approaches to clinical care based in hospitals. Scientific discovery suggests new approaches based, for example, on the shift from miasmic to germ based theories of disease. Health is characterised by seeing the body as a machine. It takes little or no archaeological knowledge to find evidence of this approach all around us in Scotland today.

A third wave of change can be associated with the materialist philosophies of the mid 19th century, most commonly associated with Hegel, Marx and Engels. The work argued that material changes drive history. Society's institutions and modes of operation are shaped by the structure of relationships between the classes. Health is characterised as the result of the conditions of everyday life.

The use of these ideas can be seen throughout the 20th century in the UK and elsewhere. Examples include the welfare reforms of the 1908 Liberal Government, the Wheatley Housing Act of 1923, the post-war settlement of the Attlee government, the establishment of the National Health Service, the Welfare State, Bevan, Beveridge, and the birth of the concept of social security.

This wave of policy intervention had at its optimistic core the idea that improved housing, education and health care distributed fairly by a just government would cure society's ills. During this period the organisations on which we have come to depend have been lumbered with increasingly complex challenges for which they were not designed or suited. **These changes in understanding can also be seen in the development of a fourth wave of public health policy and interventions around the risk factor theory of disease from the 1950's onwards.**

Towards the end of the 20th century, issues such as what we eat, how much we exercise, how much alcohol we drink and whether we smoke or use illegal drugs all loomed larger in the conversation about what makes health. Latterly this has been extended to the area of mental health where the emphasis is still largely upon what makes us mentally ill and not on what supports mental wellbeing for the population as a whole[15].

More recently, from about 1970 onwards, concerns about health have been characterised by systems thinking. Attempts to integrate services and relate their combined effects to health outcomes have become more prevalent across a range of policy interventions including public health.

A key characteristic shared by these three waves of thinking and the four associated waves of public health intervention is the relative unimportance of the individual and the human spirit. In the society we have created, we behave as if organisations do the work regardless of human capacities, consciousness, energy, passion and effort.

As the mind and the body became viewed as different entities, specialisms grew up around each of them. The change model could be summarised as: get the organisations and the programme right and change will happen. The institutions emerging from the subsequent waves have also been heavily influenced with the expert and paternalistic approaches of the first. Appendix 1 (page 34) shows a table that summarises this well.

It is not the purpose here to argue for a precise number of waves or to locate them with pinpoint historical accuracy. The important point is that one can trace relationships between emerging ideas and the development of new approaches to economy, society, the natural world, health and wellbeing.

A great deal remains to be achieved with these existing approaches. However, much has already been done. Exploring extensions to our understanding and developing new approaches in no way denies this, nor suggests that scientific method is unhelpful or has no role to play. Most commentators and advocates of change maintain a perspective which seeks to retain the best of these current approaches, to augment and complement them. Larry Dossey[16] summarises this view well:

"I have spent much of my life as a physician working in Era 1 [biomechanical] medicine. I am grateful not just for the high profile discoveries of Era 1 medicine such as vaccines and antibiotics, but also for less spectacular measures, such as public health interventions and lifestyle modifications. These latter measures have been largely responsible for the improvement of health and longevity seen around the world in Era 1 … by the time antibiotic treatment became widely available in the 1940's, more than 90% of the mortality due to tuberculosis had already been prevented by other means … Acknowledging the limitations of Era 1 medicine is not disrespectful. Doing so opens us up to other possibilities, other approaches."

A legacy of the biomechanical approach to health is the idea that a cure can be found for every disease, given time and resources. The difficulty is that in our rapidly changing and increasingly complex world, biomechanical cures have come to exhibit diminishing returns and are largely ineffective in addressing chronic, degenerative and age-related illnesses. A sense of unease and dissatisfaction is therefore pervasive

Likewise, a key shortcoming in the idea of organisational solutions to human challenges is well summarised by James C Scott[17]. He argues that in order to govern effectively, state systems must simplify and abstract what are complex realities. States then act on this set of abstractions - statistics and models - to effect policy and action. Quickly thereafter, these actions focus more on the needs of the organisation than of the people they purport to serve. When these actions fall short of expectations we frame new actions and go around the loop again.

An additional creative effort would take us on a different journey which would encourage us to see the world in new ways. This would enable us to rejoin society's loop with a fresh perspective leading to different actions.

This view is elegantly expressed by the International Futures Forum[18] (diagram 2, next page).

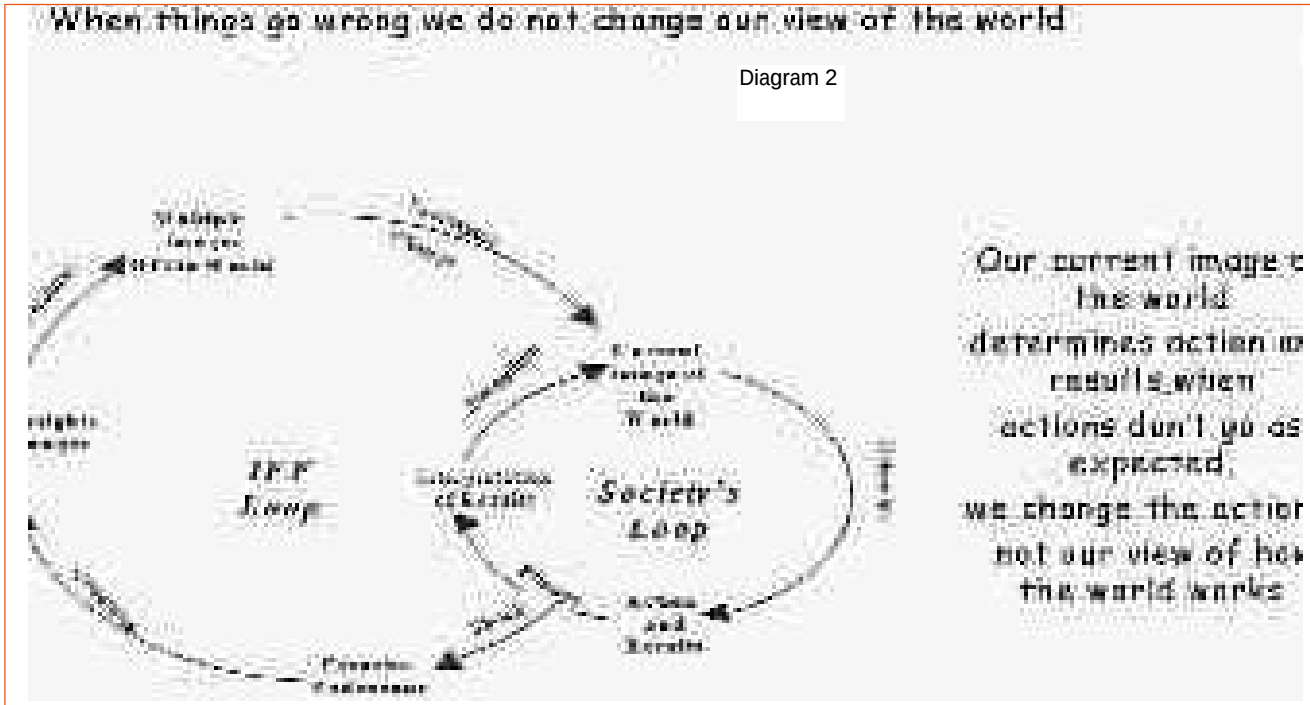


Diagram 2

Our current models, ideas, institutions and interventions seem weak in the face of the messy complexity which comprises life in the early 21st century. It is becoming increasingly difficult to take effective actions with these tools. In addition, the human ingenuity which might help is not fully acknowledged or valued and seems to flourish not because of our organisational arrangements but in spite of them. This can be characterised by the difference between:

'Clock ware': the formal rules which purport to describe the organisation and its functions - formal statements of purpose, rules and guidelines, payment systems, allocation systems and so on,and:

'Shadow ware': the informal actions, connections, actions and thoughts of the individuals who populate systems and make them work more effectively than might be the case if the only actions were dictated by the rules.

These characteristics and the health models implied by them in the field of medicine are well summarised by Cassidy (Box 1, next page).

Box 1: How paradigms affect medicine[19]

1: Opposing characteristics of the reductionistic and holistic paradigms

Reductionistic	Holistic
categorising process	indivualising process
objectification	personification
either / or thinking	both / and thinking
hierarchical approach	co-operative approach
opposition	complementarity
activism	presence
future-time orientation	present-time orientation
focus on state	focus on movement
‘seeing is believing’	‘believing is seeing’

2: Health care differences in the reductionistic and holistic paradigms

Reductionist system	Holistic system
either / or framework	continuum framework
body / mind split	body / mind / spirit intregrated
individual diseases	system imbalances
problems to be solved	challenges to be met
cure	heal
categorised treatment	individualist treatment
practitioner as authority	patient-practitioner team (towards co-production)
patient as victim	patient as active contributor, with shared responsibility

What next?

In the past 50 years or so, service industries have been replacing manufacturing and a new 'knowledge economy' has begun to emerge. In this new world, consumer choice explodes and large rigid bureaucracies find it impossible to control everything in their domain through rules, regulations and coercion. This period of transformation has also witnessed its own brand of profound social change. Crime and social disorder have risen while kinship as a social institution has changed significantly. Fertility rates have fallen, and divorce has soared while out-of-marriage childbearing and lone parenthood have increased. Perhaps most important of all, trust and confidence in all kinds of institutions have declined. Within local communities, mutual ties between people have tended to become weaker and less permanent, and other forms of non-local connection more important.

As the world moves towards a single market in labour and trade, economies tend to experience increasing income inequality. Unless social policy acts to the contrary, a gap widens between highly paid but time poor knowledge workers and unskilled workers in the manufacturing and service sectors, who may have to accept 'third world' wages or risk losing their jobs to international competition. Economies may be under pressure to deregulate to reduce costs and increase 'flexibility' or risk losing investment to other parts of the world economy. Much public happiness may disappear for a lack of care, attention and understanding, as increasingly ineffective bureaucratic arrangements enter a round of tighter and tighter regulation in futile attempts to effectively manage an increasingly complex and rapidly changing world.

In education, the needs of learners tend to come second to the needs of exam systems. In the economy, we have lost sight of the reasons for our economic activity, opportunities to increase the public good are missed by concentration on private wealth, and we may be destroying the biosphere which keeps us alive.

This dilemma has been summarised by the International Futures Forum model which represents two ways of operating in or understanding the world (diagram 3, next page). The model was developed in the aftermath of the September 11 attacks on the Twin Towers.

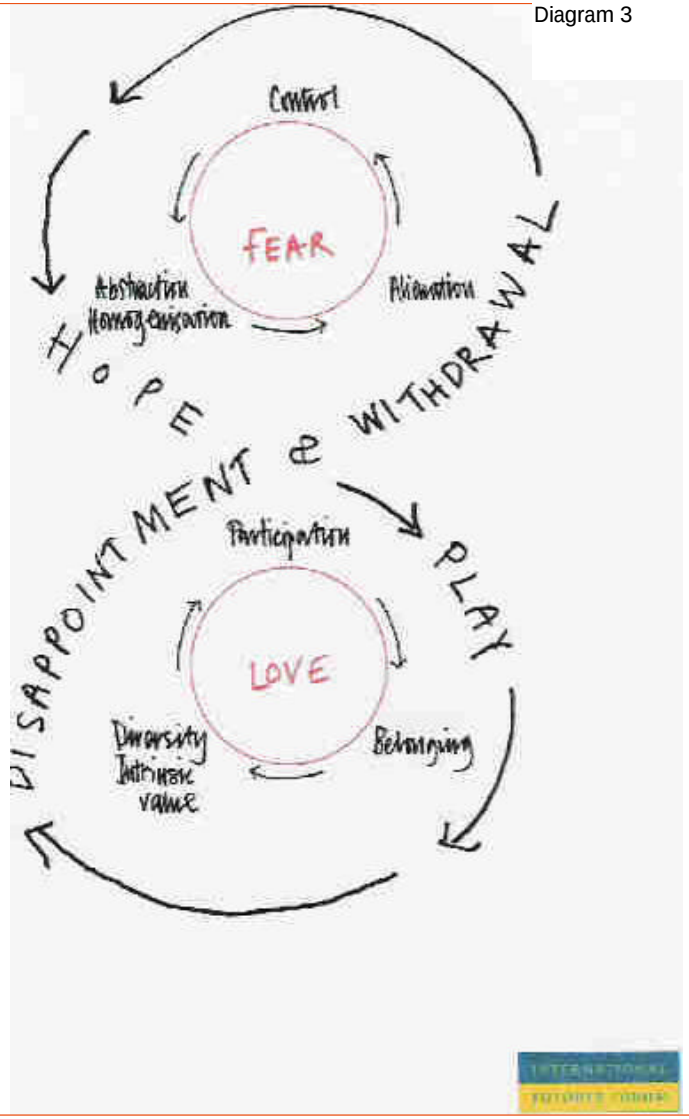


Diagram 3

The top loop is characterised by fear and anxiety and a belief that the world can be understood in terms of abstraction and homogeneity (one size fits all). This leads to a sense of alienation, unease and anxiety in general as people do not recognise themselves in the abstraction of the single truth implied by this approach. This, in turn, leads to an increased need to control and manage, running contrary to idea that complex systems require diverse approaches.

The bottom loop is characterised by love, care, compassion and a belief that the world is there to be lived in and can be understood through active participation, not simply by abstraction. Diversity is accorded intrinsic value in this model. Consequently this approach fosters belonging as diverse groups and organisations recognise that they have a legitimate and valued place in this world view. This in turn leads to further participation. Escape velocity from the top loop is facilitated by a sense of hope and play or experimentation, trying new things and the enabling conditions which encourage this. The gravity of disappointment and withdrawal pulls us back into the top loop, assisted by circumstances which do not encourage risk taking and the frivolity of trying new ways.

Characteristics from both loops are widespread in Scotland today since the loops do not describe different worlds, but rather different aspects of the same world. It is a question of balance. While there have been significant gains in health and wellbeing in the 19th and 20th centuries, we dwell too much in the top loop for further significant improvements to be forthcoming from current policies and actions. Diminishing returns have set into our current approaches, with systems, both here in the UK and abroad, being flogged harder and harder for less and less marginal return. Large organisational forms are not necessarily the most effective way to supply services, let alone achieve valued outcomes, in a more complex world.

This trend is not unique to health services or the public sector. In the world of business and commerce, organisations are realising that forms of organisation for the future will not simply be a continuation of the past and are seeking new ways

to engage and retain creative and passionate staff in new contexts of change and diversity, staff who bring themselves to work and not simply their skills.

> ***"I wonder how we can argue convincingly for this kind of creative thinking and development in professionals in an organisational culture dominated by performance management"***
>
> ***Participant's reflection***[20]

From the individual to organisation and society

The IFF model in diagram 3 holds out hope. It suggests that rather than simply making the journey towards abstraction suggested by the changes described in waves one and two, there is the possibility of making a journey balanced by participation, appropriate for the times we live in, which encourages us to change how we perceive of the relationship between external and internal agency, between mind and body, and among ourselves.

A model adapted from the work of IFF member Roberto Carneiro may help to identify this territory more clearly. The model (diagram 4, opposite) identifies a number of factors which condition our approach to the challenges which we face.

These factors are: different types of economic and social context, delivery systems, ownership and styles of action. For example in diagram 4 the following categories have been suggested:

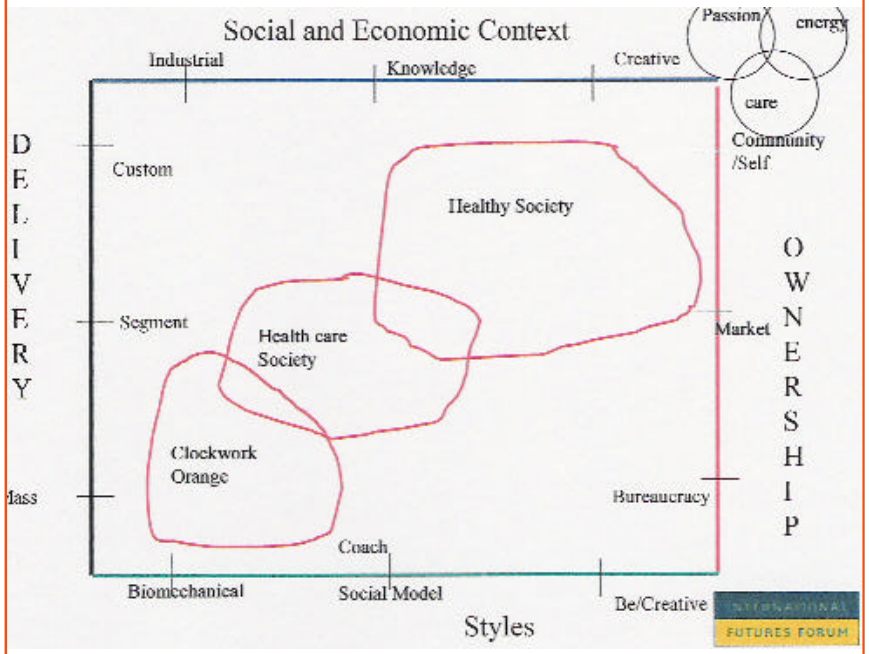
›Social and economic contexts are industrial, knowledge and creative

›Delivery styles are mass, segmented and customised

›Ownership styles are bureaucratic, market and community and/or self owned.

›Styles are biomechanical, social model and participative

Diagram 4



In terms of the discussion above, one can see that for much of the past 200-300 years our approach to health has been mass delivery of care for an industrial society, owned by the bureaucracy. The social model of health relies on some segmentation with benefits coming from the improvement of everyday life, new systems approaches and diversity of approach with stronger market involvement across a range of issues, reflecting the institutional changes from the second wave. A healthy society from the third wave will allow humans to be more central to the process with diversity and intrinsic value being embraced as typical, rather than an exception to this approach.

Two related points to note are: first, that each successive approach is built upon the foundations of the last, not its ruins; and second, that the top of the model is characterised by the importance of engaged primary relationships, whereas the bottom is characterised by secondary or institutional relationships. The top right hand area of the model is where positive human energy, passion, commitment and care largely reside. These are fundamental human motivators and are to be encouraged. This is space with the potential to liberate the human spirit from the worst effects of imposed rationality as the only way to understand the world in which we live. One way to pose the question we now face is: in pursuit of significant public health improvement, how can we move society and its institutions into this space and encourage them to remain there?

Self-confidence and individual identity are social products: they depend on group and community features such as family solidarity, educational progress and social integration. Many people today feel 'in over their heads'. They lack confidence in their ability to 'keep afloat', to control their own lives and destiny. This expresses itself in a variety of behaviours (smoking, drinking, drug use, over-work, eating patterns, damaged relationships).

This creates a challenge for health and health care which needs to take account of the impact of personal factors such as stress, emotional trauma, grief and loneliness on organic disease. Current approaches too often miss out a mind-body perspective. In the health service, consultations can be rushed and treatment overly dependent on prescribed drugs. Patients and staff complain that fragmentation is occurring with too many specialists seeing the one patient and not enough coherence at the heart of care management to keep things together. Interactions with our large modern institutions can often leave us feeling dehumanised and disempowered rather than well cared for.

This suggests that it might be useful to search for ways which enable individuals and groups to become empowered for what they stand for in their actions. This will require us to organise in ways which value, release and support the creativity and care of individuals and groups in systems and not simply expect organisational frameworks to deliver.

This next wave is what we need to discover and develop if we are to respond to the new threats and opportunities in our changing society.

This new fifth wave will create an emerging understanding that it is possible to be more effective by doing things differently. We need to develop a new public health methodology which can comfortably serve a mobile society, in which the nuclear family is in the minority, jobs are rarely for life, most people work flexible hours in the service sector, firms compete in global markets, life expectancy is increasing, education and learning last far longer, consumers are better informed, values are more diverse, and people expect a say in what is going on.

This is the context in which the next wave of change, which we are struggling to articulate in the early years of the 21st century, is developing.

A key part of this approach may be to redirect some of the energy spent on utopian schemes into accepting that humans are not perfect, to accept more of the 'messiness' which this creates and to build our future from there. A key factor in its development is us - not only from the organisations and initiatives which we develop, not only through new science or discovery, but using our

capacity to create forms which allow us to care for and be compassionate towards others in all our imperfection. This is a challenging journey to make as it requires us to work in a context of multiple truths, to learn from taking part and from the mistakes which this implies.

An important question is how we create the enabling conditions which help creativity to be channelled in positive and fulfilling directions. It is quite possible, for example, that in the absence of supportive conditions, anger may turn to delinquency rather than being mobilised to seek positive change. Clues on improvement of public health can be found in the idea of internal locus of control or 'authorship' - the extent to which a person experiences coherence in their life and the extent to which they feel they are able to make a difference and 'community', where individuals can, in reciprocity, be strong for others.

So, for example, there is a developing body of work[21] which suggests strong associations between inequalities in income and wealth and psycho-social pathways to health and illness. Key concepts include:

› Perceived social status or fear of what others think of you has an important and measurable effect of health and health outcomes

› Social affiliation - the extent and strength of friendship and family networks - has a strong impact not only on wellbeing but also on recovery patterns from serious illness

› The physical, social and mental wellbeing of mothers before and during pregnancy and the early childhood period affects child and later wellbeing

This implies moving from a consumerist model, which still largely governs the relationship between public and professionals and is characterised by exchange of goods and services, towards a participative model, which empowers the individual and the community and is characterised by the giving and receiving of support. A key question, therefore, is to ask: what would it take for a much larger proportion of people in Scotland to develop an enhanced sense of 'authorship' or control over their own lives?

A key challenge therefore is: how do we create the enabling conditions in which diversity is intrinsically valued, in a context of more abundant love and care in order to promote both our own healthy growth and that of others?

Presence, the dance and mobilising inner resources - creating powerful, positive interactions

> ***"When love and skill work together expect a masterpiece"***
>
> ***John Ruskin***

As a starting point for this challenge of how to create the enabling conditions for action to support Scots in taking more control over their wellbeing, the HPPN has drawn upon the ideas developed at the Glasgow Homeopathic Hospital by Dr David Reilly.

In his work as a medical consultant in the NHS, Reilly has developed the idea that it is possible to use the occasion of the patient-practitioner encounter to create powerful consultations and so catalyse 'healing reactions'.

These are derived from the positive power of two humans focused on a shared challenge.

A starting point for Reilly is to counter-balance the external interventative model with an exploration of the inherent, if latent, strength of the individual. He explores a germanitive approach including an emphasis on how individual human encounters can be transformative, impacting across the mind-body spectrum. His approach does not deny the skill of the physician or its science, but he sees the encounter as being about more than technique.

Rather this is balanced by the art of care, including self-care, which is brought to the encounter. We need an 'artience' to simultaneously blend art and science and reject the cultural divide of these human capacities and processes. Healing, creativity, growth and change, he argues, may be facets of the same phenomenon. He intensely studies examples of successful transformations, and works backwards ('reverse engineers') to an understanding of the germanitive conditions and creative process. He comments on their relative undervaluing in the current models.

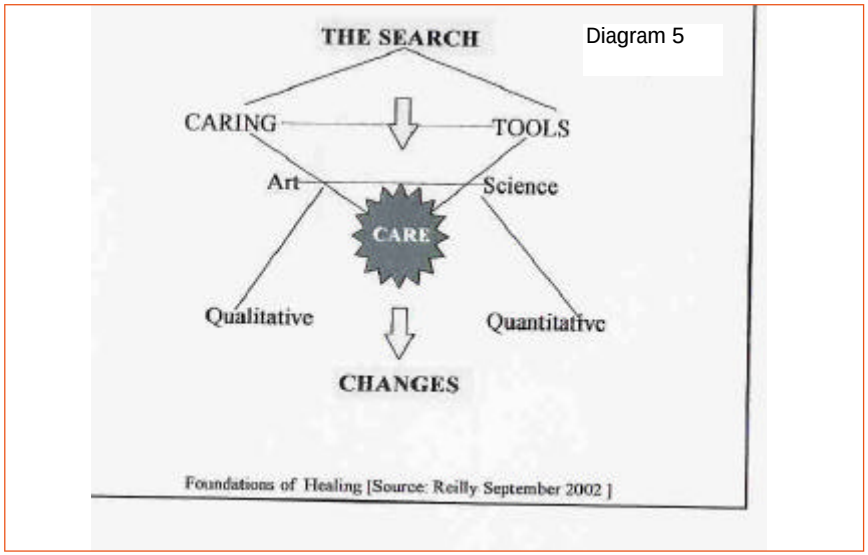


Diagram 5

In this way, therapeutic encounters call upon creativity, learning, multiple inputs from many disciplines, scientific learning, art, and respect for the other in the process. It works for the patient as it validates them as a human being and brings them into the process as an active participant, not simply a bundle of symptoms, problems or objectified characteristics. It works for the physician because it yields better results. Satisfying and effective patient contact decreases the chance of burn out.

It therefore enriches the experience of both partners in the encounter. It fosters an active mind-body link in both doctor and patient. The main ingredients of these positive encounters are human.

Whilst the model, illustrated in diagram 5, appears strongly directional, implicit within it is the learning and development which emerges from each encounter to influence subsequent practice.

The approach is built upon two key concepts. The first is that of intention, and the second the search for the positive life force which is found within us all.

The process has three main characteristics: **presence, the dance and mobilising inner resources:**

Presence: The physician must be there as a whole person, not simply a collection of skill learned during medical training. It is possible to increase presence by preparing yourself before and during each encounter. So, for example, pre activation might include your experience of the consultations of others and what you have learned from them. Self activation - the process of tuning in and listening to what is going on - and sensitivity to the active context which the patient brings to the encounter are crucial factors, since the patient's wellbeing is at stake. Active sensing includes watching out for non verbal communications and active preparation, familiarisation with the patient and an openness to the encounter which is to take place.

The dance: This is a metaphor for the interaction which takes place between the partners in an encounter. Active listening, sensitivity, and an ability to engage, are crucial to the success of the process. Without these attributes, any chance of a meaningful consultation could be over in the first few seconds as it only takes that long for a patient to sense a lack of interest or distraction on the part of the practitioner.

Mobilising inner resources: If presence can be mobilised and the dance goes well, the inner resources of the patient are mobilised and these become available to the healing process. Patient and physician become allies in a joint venture each playing their part as healers, rather than subject and object over a prescription pad.

A recent study[22] of these effects based on 200 patients from the Glasgow Homeopathic Hospital suggests that empathy between patient and practitioner is the single most important factor in enabling patients in the healing process. The other two most important factors were patient's expectations and the doctor's own confidence in the therapeutic relationship.

In a further postal study of 2,311 GPs in Scotland[23] nearly nine out of ten GPs thought a holistic approach essential to the provision of good health care. Only one in 15 GPs thought that the current arrangements for primary care made this possible. These findings suggest deep concern about a stressful situation in which practitioners struggle to deliver what they believe to be necessary for the health of those in their care.

Questions of scale

This process can work well in a one-to-one encounter, especially for those with long term, complex issues in their lives (such as chronic pain). Could the factors which make this a success be scaled up to the level of a group, a community, a service organisation or indeed Scotland as a whole? How do the factors described survive and thrive in human endeavours at various scales of operation? What can we learn from this and what does it suggest about effective ways to organise? For example a housing co-operative may provide for 500 people, a secondary school for 1500, a hospital for a catchment area of several hundred thousand, a local authority across a wide range of services, a corporation across many countries. Are there principles and guidelines, approaches and actions which operate well across different scales of human activity which resonate with Reilly's approach?

In order to address these questions and learn as much as we could about the potential of these ideas in promoting public health in Scotland, members of the HPPN went on a series of learning journeys. These involved visiting people based in Glasgow at The Lighthouse, The Common Wheel and the Glasgow Homeopathic Hospital, and learning through observation and participation in conversations about how they make a difference and what we might learn about our area of interest from this.

Separate documents[24] describe what a learning journey is and delineate the particular journeys we went on, what we learned and how this might relate to significant improvements in public health. In addition to the outputs of these learning journeys, several members of the HPPN submitted case studies exhibiting different aspects of relevance to our search for clues for positive signs of the next wave.

Hopefully, these initial insights from our learning journeys will encourage further discussion, comment and development of our thinking around these issues. After a period of reflection and further discussion we will feel bold enough to take some action. We hope others will join us.

Drawing from these experiences, and the generous input of group members, some suggestions for issues pertinent to the pursuit of the healthy society, from which better public health will flow, are set in Box 2, opposite.

Box 2: Learning journey key insights

Diversity, respect, and responsibility - Problems exist when there are tensions. So, for example, in the homelessness project we saw at The Lighthouse in Glasgow, the initial approaches of a group of architects aiming to address homelessness, were viewed suspiciously by a homeless group and *The Big Issue*. Out of this tension, which was addressed rather than politely avoided, the work was redefined and the homeless participants became the defining clients not passive recipients of architect services. This could be characterised as the dance coming first, leading to greater presence among the architects, which in turn released the inner resources of the client group, who became much more involved originally envisaged. In this new framework, the relationship between architects, homeless people and *The Big Issue* changed dramatically, demonstrating the benefits of users being actively involved in design and planning.

Leadership, intent and conflict - Differences are not always so readily resolved, particularly in areas where long standing antipathies exist. Clear statements of intent and agreement may help here. International experience around peace-keeping and community rebuilding following periods of war may yield valuable insights here. The quality and nature of civic leadership is important in this respect too. In all of the activities which we saw, charismatic people were leading innovation. Some further thought on how to make this a more regular characteristic of organisational form, and how to distribute responsibility would repay dividends and guard against the day when the charismatic leader leaves. Forms of leadership which listen, engage and support creative action in keeping with overall intent and distribute power and responsibility accordingly need to be further encouraged.

Process - The 'how' is as important as the 'what'. There are institutional blocks and incompleteness to 'big solutions'. This is an emergent type of understanding from the learning journeys. Frequently an implicit assumption of the 'big solution' is that organisations can deliver what is required to solve the problem being addressed. This often leads to abstraction and alienation and the failure of the gleaming big solution. From the point of view of the presence, the dance and mobilising inner resources, the power, passion and energy of committed professionals and knowledgeable groups become removed from the process. This potential and engagement is lost to the process. As it becomes the property of fewer and fewer people, its likelihood of lasting

success diminishes. This resonates with the findings in the *Possible Scotland* study, where residents of four diverse communities were more readily able to articulate their aspirations the closer to home these became. They could say readily what they wanted for themselves and their family, but found it more difficult to say clearly what they wanted for the nation. How can diverse groups be supported to participate in the dance in ways which encourage connection, not opposition? What can be learned from community development theory and practice?

Trust - the governance model which dominates currently tends to alienate. A key factor in the success of all the work we saw and discussed on our learning journey was the trust developed among all of the participants. This factor in each case was hard won (through the dance) and required presence to be sustained as a platform for the more creative aspects of the work we saw. In these activities, accountability was not simply to the authority or organisation footing the bill, but between participants themselves.

Possibility is important, not just the actual - This is a key element of the dance. As we saw in the architect/homeless example opening up possibilities, rather than going in with the solution well defined before the start, led to fuller positive outcomes than would otherwise have been possible. What elements would need to be in place to enable our organisations to be more open to the art of the possible? This is especially true if the spirit of entrepreneurship needed for this type of work is to be nourished. This could take us beyond consultation strategies to enablement of locally developed proposals for action.

Time and capacities are vital - The journey highlighted that presence, the dance and inner resources are not linear components of a process. To build trust takes time and a willingness to be around for a while on the same journey with others. Trust develops from experience and development of capacity from the feeling that what you have to offer is valued.

These initial reflections on what we experienced encouraged us to identify some factors which seem to support more effective action and some which are missing from, or weak in, our current institutional arrangements. These are listed in Boxes 3 and 4, opposite and next page.

Box 3: Supporting factors

Connection/integration

People are enthusiastic and confident when working in caring organisations that acknowledge and respect their individual skills and abilities. The scale of the organisation may be important in this respect. These qualities need to be held by a number of individuals, and their organisations must also behave in a way that is coherent with this and/or make a context that supports them. In other words enthusiastic individuals are necessary but not sufficient - they must be working in an appropriate environment. People's consciousness and values need to be valued more. Emotional intelligence and interactive skills could be developed. Developing these skills also benefits professionals and ultimately their quality of work, as we found in the homelessness project where the outcome was much richer than initially expected.

Diversity, multiple truths

Forms of engagement, description and action which recognise 'multiple truths' simply make more room for a wider range of engagement as people recognise themselves and their views in the process and feel comfortable about participating.

Individuals, care, context, ethos, agreement

Processes coherent with this, eg workshops with homeless people, were energised by a redefinition of purpose owned by all participants. Investments in primary relationships, emotional intelligence and effective relationships make the difficult possible.

A minimum of resources

This includes staff, a building (usually) and some form of capacity to act, think, learn, and train in the ways of making a difference seems a necessary part of the work which we viewed. What are the more precise resources for this new approach and how can we encourage a programme of activity which is accountable in terms which are engaging for sceptics? For example, what would an action research programme similar to that developed by David Reilly to investigate his approach be in other spheres of activity: the social, economic, environmental, cultural, their connections and the implications for practitioners and policy makers?

Box 4: Missing factors

Structures don't trust and release energy and creativity

This is especially the case when they are too driven by targets and profits. In our discussion after the learning journey, we acknowledged that much of what we saw is made possible by love, care and compassion. This took place in a context where human interaction is characterised by a willingness to learn by participating with others in an uncertain context, and creating new and shared understandings. Our typical organisational arrangements tend to discourage this. They are more based upon the 'culture of numbers': targets, profits and abstraction. What is the balance between these approaches which will give better outcomes? What arrangements would support, enable and encourage creativity? What disciplines do we need to put in place to ensure creativity is the norm rather than the exception?

'Matrix working' and flexibility

There is too much hierarchy in most organisations. What is needed is more space for honesty, reflection, respect and learning.

Role of collective/individual

Organisations and individuals benefit from people who are strong for themselves and strong for others. Acknowledgement and celebration of this is missing in many aspects of our society.

Attention to individuals at macro level

To be more effective, large scale planning and development exercises need to develop processes which respect and support the input from the micro level - from the individual and local group

Hopefully, these initial insights from our learning journeys will encourage further discussion, comment and development of our thinking around these issues. After a period of reflection and further discussion we will feel bold enough to take some action in an agreed fashion. We hope others will join us.

Concluding remarks

This has been quite a journey. It started in the 18th century with the Enlightenment and took in the major shifts in thinking since then, ending with modernism of the late 20th century via scientific materialism.

We linked these shifts to the backdrop of industrialisation and highlighted several waves of public health interventions which are associated with these shifts in thinking: medicine as science, Great Public Works, the redesign of our social institutions and systems thinking.

Apart from anything else, such a journey ought to raise awareness of how the systems of influence in which we are currently operating are often more enduring than we think or allow for.

It also highlights that our current operating conditions are complex and changing, and it is folly to believe that we can understand this fully from a single perspective, let alone manage or control it.

We then looked at the ideas being developed by David Reilly at the Glasgow Homeopathic Hospital around therapeutic encounter, especially the ideas of presence, the dance and mobilising inner resources, framed by intention and the search for the positive energy of patients..

Acknowledging the power of these ideas in one-to-one encounters, we set off on a number of learning journeys designed to ask whether similar processes could be seen in successful practice involving larger number in diverse fields of activity.

This led us to make a number of observations on the enabling conditions which can be found in cases where presence is discernible and missing when it is not.

We examined the limitations of what we have created in relation to health improvement and suggested that to achieve significant progress, a step change in thinking and action is necessary.

The good news is that it is possible for Scotland to change its health status, but incremental change is not enough and an ever-expanding health care budget is not the answer. We need to look in the fabric of our everyday lives, where everyone has both a contribution to make and a benefit to enjoy in the creation of a possible Scotland where wellbeing is the outcome of our relationships and actions towards each other - person to person, organisation to organisation, sector to sector, Scotland to the rest of the world.

The main proposition of this report is that mobilising the energy within ourselves and others will provide a basis for positive change in Scotland. We have called this energy 'love, care, or compassion'.

Together with positive intention, it is possible that the energy of Scots in every walk of life could be mobilised to create a society based on more positive relationships in all areas to get things done.

This is set against the system of modernist institutions which currently prevail. These have yielded a great deal over the years in terms of improvement and care. Yet the world in which they currently operate has changed a great deal from the world in which they were conceived. Consequently, they are becoming less effective and attempts to make them more so lead to growing frustration, rising budgets and diminishing returns.

The size and scale of our institutions tends to douse the commitment and energy of those who join them in order to do good. Without these, our systems of understanding come to nought. Scientific endeavour would wither without the passion for discovery, social reform would waste away without a passion for justice, fair trade would disappear without the energy of the new economist, health care

would be much diminished without the love of doctors and nurses for their patients, and learning would be purely mechanical without the care of teachers for pupils.

Responses to the case we make in this report may include scepticism ('seen all this before'), resignation ('hopelessly optimistic'), or doubt ('this is simply secular religion'). It is true that we should learn from what has been tried in the past and guard against utopian idealism. Yet, everybody can remember who the good teachers were at school, those who inspired us and made us feel worthwhile. When asked to describe this effect, we do not discuss the curriculum, nor do we rely too heavily on trying to rationalise how it affected us. The effect is more usually described in terms of the energy, passion and enthusiasm for subject combined with a feeling that this person genuinely cared about you and your development. How do we recognise and value this effect and how can we enable it to be more widespread?

Herein lies a major challenge. The price of abstraction to gain effectiveness has been the slow erosion of human energy from our main systems. Many people choose their professions in the hope of doing some good in the world, but become alienated from their organisation and its objectives, which they perceive as stifling this desire. Those who look to organisations for support and services too often come away dissatisfied with their experience - alienated, demeaned and marking time, when they could have been inspired.

Consequently, much of our precious energy is used up in resisting, outmanoeuvring or simply dealing with systems that no longer offer the opportunity to serve, or the service they were set up to provide.

Many of us will have felt the dead hand of bureaucracy, the reduction of self, aspirations and hope to a number, or pigeon hole. Despite their best efforts, organisations seem unable to respond adequately.

How can we overcome these tendencies towards alienation and mobilise our own energy and that of others to enable professionals to do the job they wanted to do?

In searching for greater effectiveness of action to create a possible Scotland, it is not enough to assume that more of the same kinds of action will yield the changes we desire. Organisations and forms of action which were appropriate in the past may no longer be completely so. The organisations which we currently have, and the actions they support us to take, may well have a role in making a step change in Scotland's health. This will depend upon their willingness to change.

What are the key challenges to be overcome in order to create the healthy 21st century Scotland we aspire to? Perhaps we could start with the following:

›What are the assumptions underlying how we approach improvement currently? Are these adequate?

›How do we develop systems, organisations, service mechanisms which are sufficiently sized to deal with the scale of the challenges we face, yet remain personal, and encourage the enthusiastic input of staff and public?

›What sorts of governance arrangements should we investigate and develop to make positive change possible?

›What enabling conditions are needed to encourage widespread responsibility for wellbeing?

›How do we develop systems which combine science and art, creativity and effectiveness, flexibility and continuity to enable innovation and engagement in the pursuit of improvement as a matter of course rather than exception?

›Where are the examples in Scotland and elsewhere that indicate to us the possibility of sustaining our improving aspirations?

›Finally, how far can we go in developing leadership which seeks not to micro manage effort, but to enable the inherent positive energy of Scots to flow more freely?

Appendix 1: Biomedical vs holistic models

Bio-medical model	Holistic model
Assumption: health is the absence of disease	Assumption: health is a systematic disposition which includes the absence of disease
Assumption: disease is defined by its symptoms and underlying pathology	Assumption: disease reflects imbalances in the entire system, symptom is only a reflection
Therefore, termination of symptoms is tantamount to restoring health	Therefore, termination of symptoms is only part of the larger goal of restoring health
Assumption: medicine ought to be practised as efficiently as possible	Assumption: efficiency requires both comprehensive and long-term perspectives
Efficiency requires authority, detachment and passive interaction of patient with physician, as well as identification of local symptoms and causes	Comprehensive long-term health goals require consultation, involvement and active interaction of patient with physician,- a system-wide, multi-level approach
In a localisationist approach, diagnosis is tied to physical causes; the molecular level is stressed; psychological causes are minimised. *Treatment* is viewed as elimination of symptoms and, where possible, their linear causes. *Prevention* is undertaken on a type by type approach, not parallel to treatment procedures	Systems approach views diagnosis as reflecting multiple interactions, including psychological and environmental factors. *Treatment* requires changing many variables (nutrition, stress etc.), often with complex interactions. *Prevention* requires a comprehensive approach that parallels treatment
Repeat only as necessary, that is when sickness occurs	Health promotion is a daily part of life on many levels
Process is underwritten by the metaphysics of scientific materialism	Process is underwritten by the perennialist metaphysics of interpenetrating levels of energy-consciousness.

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More information from their website www.internationalfuturesforum.com

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