In Search of Transformational Change

7.1 The Future Public Health: An Integrative Framework

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AFTERnow: In Search of Transformational Change

The Future Public Health: An Integrative Framework

INTRODUCTION

The future is radically open and experience shows that trying to predict the future in any detail is relatively futile. That does not mean, however, that we simply leave everything to fate. There are ways to move forward with intention which will help shape the future. Previous sections of this website have drawn together some of the many strands of evidence which support the contention that modern society is undergoing a 'change of age'. We have illustrated for example, that obesity, unlike public health problems for which there is a technical solution, has developed at the population level because we are biologically 'hard wired' in a way that does not suit the modern world of convenient and affordable high calorie food and drinks. The same might be said of our loss of well-being and our psychological 'wiring'. Humans all evolved in closely-knit kinship groups which probably possessed a strong collective sense of identity and we now find ourselves ill-equipped for the hedonic treadmill of modernity.

In short, many of our most intractable health problems are the product of modernity, so the tools of modernity are ill suited to finding solutions. Looking beyond public health, the modern world is confronted with an ingenuity gap – the gap between a spectrum of problems we encounter and our capacity to devise effective solutions (Homer-Dixon 2000).

One pertinent example is the regeneration of disadvantaged inner city areas that have undergone de-industrialisation and decline. Such neighbourhoods typically suffer from high unemployment, low levels of amenities or services, high levels of crime, low levels of trust, poor educational outcomes, and much else, including poorer health outcomes. Various governments have attempted regeneration in these areas for several decades, rebuilding houses then rebuilding them again. Yet the problems apparently remain intractable.

Part of the difficulty is that, true to our modern mindset, we approach regeneration as if it were only a material problem. This is not to deny that lack of material resources plays a large role in the problems encountered by these areas. The point is that the material dimension of life inevitably interacts with emotional, aesthetic, moral and even spiritual dimensions. For regeneration to be effective, these dimensions also have to be considered, but rarely are. People working in large bureaucratic organisations find it difficult to engage with this wide range of issues because those organisations are not structured to support such an integrated approach.

The result is they continue to spend millions of pounds on housing and the physical environment and are unable to understand why there are only small scale improvements in the health and well-being of populations so targeted. In these settings, it is becoming clearer that what we know how to do is not what needs to be done.

Nevertheless, there is little evidence that our failure to solve the deeper problems created by modernity is causing us to radically change tack. For example, the obesity epidemic is not automatically self-limiting. If left unchecked, it may bring other unforeseeable changes and difficulties. If it is to be reversed without harm, we will probably have to change our whole food economy, the balance of what we eat and how active we are. This is only likely to happen if we change the way we organise our lives and our society.

There is precious little evidence that we are even attempting such change. We are, for example, adapting to and normalising a much larger body shape. For some, this may be a positive and anti-discriminatory development. For the public health community, it remains problematic because of the implications of unhealthy weight gain for health outcomes and quality of life over the longer term. Equally, for all the rhetoric about abolishing child poverty and addressing social justice, almost all indicators of inequality in the UK are moving in the wrong direction.

We could, on the basis of the four previous waves of public health set out in the first section of this website, be tempted to assume that a fifth wave will develop in the same way. An alternative view is that the nature of the challenges facing public health at the beginning of the 21st century are such that a fifth wave of public health will not appear from its accumulated traditions but rather will emerge from radically different ways of thinking, being and doing. There is evidence that the whole wave of modernity is peaking and is moving into decline. So, to create a fifth wave - the future public health – a dynamic is needed that transcends modernity, whilst retaining its still valuable aspects.

Public health may require a new and more appropriate paradigm with which to navigate the turbulent present and (as yet) unknowable future. Much of this paper describes some of the possible ingredients of a new paradigm, in the form of key features and a conceptual framework which could be used to underpin the future public health.

PROPOSITIONS FOR THE FUTURE PUBLIC HEALTH

If transformational change that addresses the challenges of sustainability, equity and health is to be achieved then, for all the arguments rehearsed throughout this book, a new and integrative approach will be needed. The future public health will plausibly need to be radically different from today's orthodoxy, whilst retaining all that is worthwhile in current practice. What will be the plausible features of the future public health if it is to realise this ambition? For now, five key features are suggested:

1. To succeed, the future public health should seek to be **integrative**. That is, public health will play its part in re-integrating dimensions of life that have been effectively separated by modernity itself – the interior and the exterior; the objective and the subjective; the individual and the collective; the good, the true and the beautiful, or science, ethics and aesthetics.

2. The future public health should aspire to be **ecological**. It may take time for a consensus understanding of 'ecological public health' to be agreed and a worthwhile public health practice to emerge but at this stage in its development two dimensions seem to be important. First, a systems perspective is needed to gain insights from the many natural and man-made complex adaptive systems that influence human health and wellbeing. Second, to the already well-established focus on ecosystems in nature, there is a need to expand our awareness of cultural, social and human ecologies.

3. The future public health needs to be **ethical** at two levels. Individual human rights are fundamental but these should be integrated with collective imperatives; in particular, the need for equity and sustainability.

4. To overcome the ingenuity gap, the future public health will require **creativity**. The human imagination, the ability to envision something better, will be a key resource. However, the capacity for creativity seems to be a product of human consciousness and, if public health remains trapped in the consciousness that helped to create our current problems, creativity will be blocked. This suggests that our personal practice and our institutional structures should be consciously designed to unblock the forces that impede creativity.

5. The future public health also needs to be **beautiful** in the sense that it 'raises our spirits' and 'fires our imagination'. Activities and relationships that are beautiful in this sense will have the power to attract others, and will help to maintain the enthusiasm and continuing commitment of those involved.

These positive features are, we hope, likely to constitute the future of our discipline. However, the next section looks to the past in an attempt to describe what might be called the root cause of some of modernity's problem. Any response to our current predicament must be judged in terms of its ability to grapple with the root causes of that predicament, and not just its symptoms. So it may be helpful to think about the nature of modernity and its origins.

ROOT CAUSES OF MODERNITY'S PROBLEMS

Consider the time in history when Galileo joined a small group of those who argued that the earth moved round the sun and not the other way round. In the world of medieval Christianity it was not possible to examine the objective scientific truth of planetary movements without simultaneously challenging ideas of morality (Man and his world as the centrepiece of God's creation, with moral responsibilities [whereas women were responsible for the fall from divine grace]) and beauty (the harmony of the geo-centric universe). Galileo was met by opposition primarily because those who objected had never differentiated what is 'true' (science) from what is 'good' (ethics and morality) and what is 'beautiful' (aesthetics and art).

Part of what made the modern world possible was the ability to examine evidence in order to establish 'truth', without this process threatening morality and aesthetics (the good and the beautiful). In the centuries that followed Galileo, science and its associated technologies brought us multiple benefits. The modern differentiation of the spheres of art, ethics and science set each free to pursue its own path and values. However, this differentiation also allowed an imperialistic form of science to develop and dominate the other spheres by claiming that it alone had access to 'reality', through the objectivity and value-neutrality of the scientific method (an ideology best described as scientism).

RE-INTEGRATING THE TRUE, THE GOOD AND THE BEAUTIFUL

The three categories introduced above - the true, the good and the beautiful (or science, ethics and aesthetics) (see Figure 1) - are ancient and derive from Platonic thinking (O'Hear 2000). They also resonate with Wilber's (2001) integral model of the four key dimensions of human experience (see Figure 2). Such thinking remains relatively unknown within public health, yet provides insights that we need and can put to use.

FIGURE 1: THE TRUE, THE GOOD AND THE BEAUTIFUL

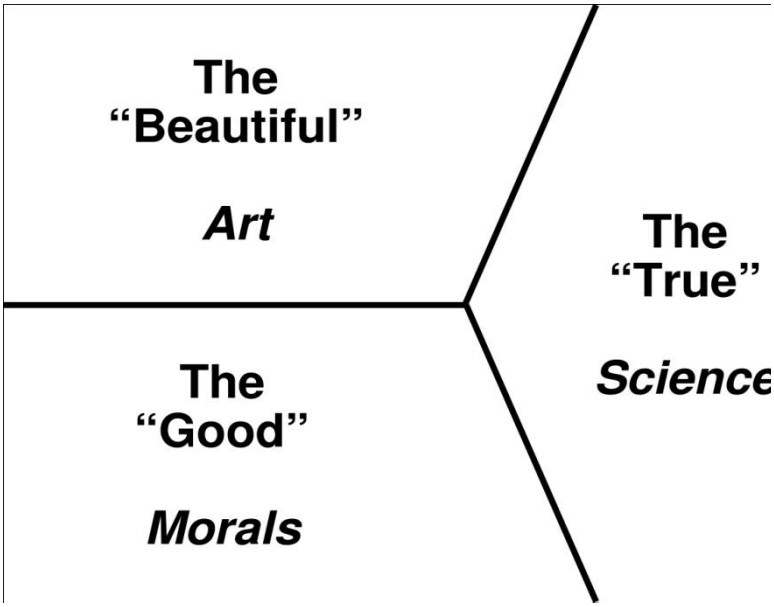


FIGURE 2: WILBER'S INTEGRAL MODEL

	Subjective-Interior	Objective-Exterior
Individual level	*I* The inner world	*It* The body, the physical world
Collective level	*We* Culture	*Its* Society

The idea of the 'true' (i.e. science) corresponds to the right hand column of Wilber's four quadrant model, which deals with the objective, exterior dimensions of life, at both individual and collective levels ('it' and 'its'). Ideas of the 'good' (ethics, morality) and the 'beautiful' (aesthetics, art, creativity) correspond with the left hand column, which deals with the subjective, interior dimensions, at both individual and collective levels ('I' and 'we'). The key point here is that, in everyday life, we tend not to differentiate these dimensions of experience: rather we integrate them naturally, as a matter of course. As an example, imagine that you are an experienced public health worker with a young family, who has been given the opportunity to work for a charity in sub-Saharan Africa.

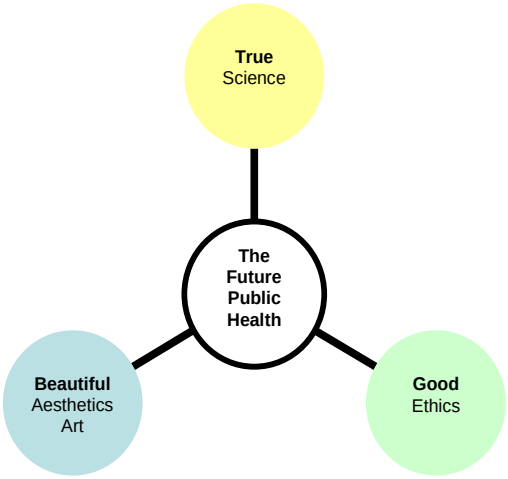
Before accepting you and your family would try to ensure all aspects of the job, arrangements for accommodation, schooling for your children, their safety and health, a possible role for your partner and much else, are properly investigated. In short, you would objectively assess what is '*true*' about the proposed venture.

At the same time, you would be likely to ask yourself questions like 'is this the right priority for us at this time?'; 'are there other more important experiences the children need, or would it be good for them to experience another culture and language?', and so on. Again, it is part of human nature to be alert to these issues: what is the *'good'* and right thing to do?

You and your family would also be sensitive to the aesthetic and creative dimensions of such plans. You would probably ask yourselves whether this would be a *'beautiful'* experience, in the sense of giving all of you a chance to live more creatively and expand your awareness.

However, considerations of the 'good' and 'beautiful' rarely occur to us in our daily working lives within the dominant systems of modernist institutions. These have yielded a great deal over the years in terms of health and social improvements but the narrowness of their cultural values can douse the commitment and energy of those who join them in order to work for 'the good'. This is why the future public health needs to integrate the true, the good and the beautiful (see Figure 3).

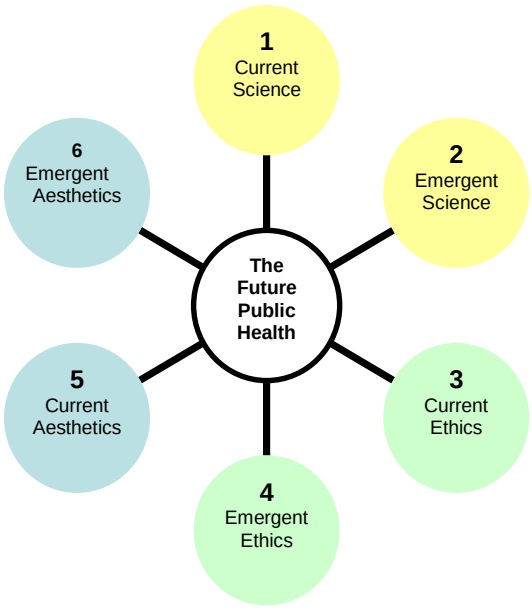
FIGURE 3: THE FUTURE PUBLIC HEALTH



The question is, how this to be accomplished? Public health will need more than current forms of science, ethics and aesthetics. We will also need 'emergent' forms of these (explained below). It is important to emphasise that this approach to public health would still adhere to the rules of evidence based practice and good science, with no compromise over scientific integrity. It does imply that, in addition to the value we place on the currency of conventional science, other currencies will also be valued.

As was argued above, these will include systems and ecological insights, qualitative methods and the wisdom that can come from narratives, dialogue, personal experience and pattern recognition. The six dimensional framework (see Figure 4) set out below incorporates the components of the future public health that will need to be integrated. A description of these components follows.

FIGURE 4: SIX FULLY INTEGRATED COMPONENTS



1. CURRENT PUBLIC HEALTH SCIENCE

An examination of the curricula for public health training in the UK suggests that the five basic sciences of Public Health are epidemiology, biostatistics, environmental science, management science and behavioural/social sciences. Other fields of knowledge include demography, social policy and health economics. Communicable disease control and environmental health together constitute a significant body of knowledge within public health, while skills like health needs assessment, health impact assessments and health equity audits have become increasingly important. Finally, public health needs the skills to critically appraise and evaluate practice and to formulate new research.

This is a daunting and demanding list. Public health practitioners may feel overwhelmed by their current workload, so our practice stands in need of a greater sense of balance – of the ability to stand back and take a wider view of the landscape wherein we operate, to understand the whole and not just work on the parts. The problem here is current public health sciences are overly reliant on reductionist approaches in seeking to grapple with the escalating health problems of modernity or emerging ecological threats to health.

Reductionism has helped us to understand a great deal about the natural world. It does so by separating out strands of information from reality, which is highly complex, and reducing them to the interactions of their parts. There are numerous ways in which reductionism has proved to be an effective tool for creating understanding which, in turn, has led to interventions that improve our lives. Yet it has limitations: a complex system is always more than the sum of its parts and cannot be explained by reducing it to individual constituents; and the real world has an intra-personal dimension which is missing from the strictly objective world view. Different types of thinking are therefore needed to help explain reality and to help us understand the nature of the health challenges that we face.

2. EMERGENT SCIENCES FOR THE FUTURE PUBLIC HEALTH

Reductionist viewpoints and holistic viewpoints can be thought of as two ends of a spectrum, where each has validity in seeking to describe and explain that complex and multi-dimensional entity that we (usually) refer to simply as 'reality'. The second component of our future public health framework will use insights and perspectives drawn from the more holistic end of this spectrum. What is 'emergent' is the idea that a much wider range of paradigms, methods and mindsets will inform our science as we confront the problems of a change in age.

Consider the example of environmental health, which has long been a pillar of public health and is already beginning to move in a more holistic direction. Its key task has been to determine, assess and measure environmental threats to health which can then be removed; where this proves impossible, populations can be protected by containment or protection. This approach is typically rigorous and reductionist, and none the worse for it.

More recently, awareness of the threat of global ecological hazards to human health has seen the emergence of 'ecological' forms of public health. A number of different approaches to this topic can be discerned within our discipline (Hanlon and Carlisle 2010). Some, for example, have applied a very traditional scientific model to particular issues that will arise from a given rise in global temperature (Haines *et al* 2006, Costello *et al* 2009).

Consider, for example, the challenge of 'contraction and convergence' (Meyer 2000). This is a concept that has been developed in response to global warming and other environmental threats. The idea is simple. The world needs a contraction in output of carbon dioxide but for all to buy into such an agreement it must be transparently just: hence the need for convergence. Less developed nations must be allowed to develop, which may mean increased carbon utilization, whilst industrialized and post industrial nations must make substantial reductions. However, an ethical framework which ensures global justice and equity while safeguarding the rights of individuals has yet to emerge. This will be a key challenge if the world is not to face runaway climate change and collapse.

Our track record on global justice is variable. For example, there have been campaigns and international agreements to cancel debt and reduce the flow of money from the world's poor to the world's rich. Yet in 2006 nearly $500 billion more was transferred from poor to rich countries, than flowed the other way (Simms, Moran and Chowler 2006). This is an ethical and moral issue and should be addressed for those reasons. However, because of the dominance of scientism and economism, moral and ethical arguments often hold little sway. Current public health ethics have almost nothing to say about how such examples of social injustice are to be addressed.

The challenge of reducing inequalities needs to be linked to the ethical challenges of over consumption and sustainability. The rich have been successful in resisting appeals for greater equity but the point about problems like climate change is that we will all be affected and we all need to participate if a solution is to be found. Unless a new form of ethics emerges that sees the connected nature of all people (indeed, of all life), we will find it hard to achieve transformational change in inequalities.

A move in the direction described above implies a change in values and mindset. Our understanding of who we are as people and those to whom we relate with care and inclusion has changed in the past and will change again (Rifkin 2009). The challenges are great, but so is our individual and collective capacity to respond: we have perhaps never been so close to the development of an empathic civilisation as we now are. However, changing human consciousness takes us into the territory of the final two components of the future public health framework.

5. CURRENT AESTHETICS

This part of the framework is probably the most unfamiliar to public health. We talk about combining the science and art of public health but seldom define the latter. Since *Homo sapiens* emerged we have been engaged in creating: making tools; painting the walls of caves; crafting personal decorations; and much more, possibly as part of the human impulse to create meaning. Without creativity our work can become commonplace and without meaning. Yet in modern culture even this aspect of our humanity has been commandeered for instrumental purposes and commodified within the consumer marketplace. So, art becomes of value if it is part of regeneration or therapy but not for its own sake or for its capacity to inspire or be meaningful.

6. FUTURE AESTHETICS

The scale of the challenges facing human health and well-being is clear. The need for transformational change to meet these challenges is equally clear. As human beings we will need to create new art, stories, myths, symbols and much else to help us make the inner and outer transformations that will be needed. We use the term 'emergent' because, while we are sure change is coming, the manner in which we will respond in our individual and collective imaginations will need to emerge from a continuing and dynamic process of discovery and creativity. So, activities in this dimension of the framework will centre on being fully human: being creative; being playful; developing consciousness; fostering empathy, and much else.

Creativity is important because it is part of our nature and, as positive psychology has shown, we are often at our happiest and most fulfilled when lost in the flow and challenge of creativity (Csikszentmihalyi 1990). It is also from our creative selves that solutions to our most profound problems often arise. Creativity is also important because it balances some of the more intellectual and instrumental modes of being that tend to dominate our working lives.

AN INTEGRATIVE FRAMEWORK FOR HEALTH

Our emphasis has been on integration because we perceive separation and fragmentation to be fundamental to the mindset that has created our most challenging problems. So we end this chapter with a tentative summary of what elements needs to be integrated as we work towards the future public health. The Integrative Framework for Health represented by Figure 5 suggests that the future public health will be part of an emerging integrated way of life.

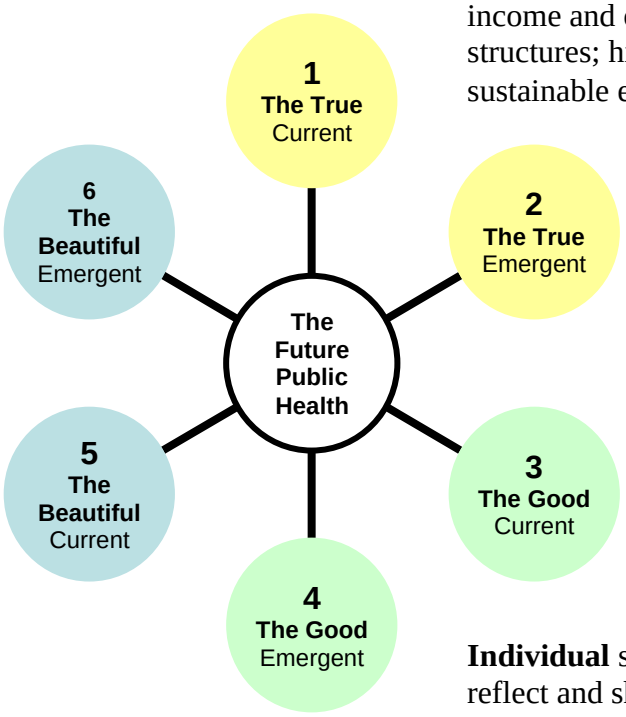
FIGURE 5: AN INTEGRAL MODEL OF HEALTH

Individual health evident in physiology, immunity, morphology, fertility, strength, endurance, flexibility, speed, balance, agility, mental resilience, sexuality etc.

Systems and social health evident in buildings and infrastructure that promote health; institutions that nurture people; just laws and regulations; economy that puts people before money; equality in wealth, income and opportunity; nurturing family structures; high quality air and water; sustainable ecosystem.

Individual self-awareness, sense of being loved, and belonging. Purpose, hope, motivation. Vision and intention. Creativity. Work at raising consciousness.

A culture that fosters personal and collective growth. Creativity recognised as central to life. Healthy community identity. Mutual awareness and acceptance. Sustainability as a cultural



Individual self-responsibility, ability to reflect and show discernment. Moral values, Connectedness to and empathy for all.

Collectively we have good interpersonal relationships, high trust and cooperation, mutual awareness and acceptance, social justice, strong ethical principles. Ethics arises from empathic concern. Intergenerational justice and empathy

Progress needs to be made in all six segments simultaneously and not just in one. However, the framework is not intended to suggest that health equals success in all areas: that would be utopian. Equally, the framework is not suggesting that those with major problems (including disease and/or disability) cannot be healthy. Rather, the Integrative Framework is a summary of activities that will need to come together to create the concept of health and well-being required for the successful navigation of a change of age.

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