

In Search of Transformational Change

## 2.2 Applying the integrative framework to the major public health challenges & the future NHS

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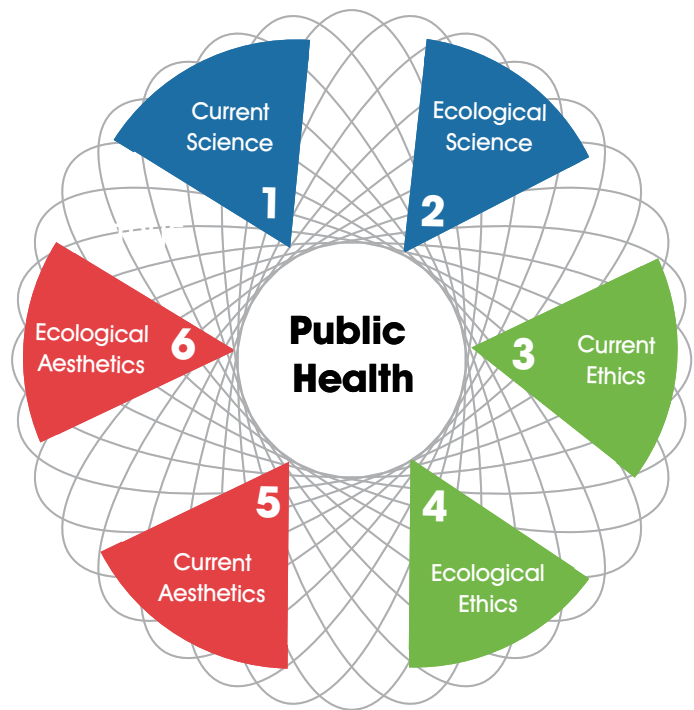
# Introduction

**In other sections of this website, a series of escalating public health challenges were explored including widening inequalities, obesity (Foresight Report 2007) and addiction-related harm (Alexander 2008), and loss of well-being (Lane 2000, James 2008). These, together with the health threats of ecological collapse, are referred to in the sections overleaf as the major public health challenges.**

For each of these major challenges the argument has been made that conventional public health approaches fail because they fail to recognise that the problems are manifestations of modernity itself.

In response, paper 2.1 in this section proposed an Integrative Framework for Health. In this paper we use a slightly modified version of the framework to consider what integrative and ecological responses to the major

public health challenges might look like. We then apply this integrative and ecological model to health care, in a future NHS.



**Figure 2: Applying an integrative and ecological framework to the major public health challenges**

**Current science**

Work conducted by the various sciences that underpin public health practice will continue to have relevance. More will be discovered about each of the major public health

challenges and this will add to the evidence base for action. However, unless these insights are integrated with other dimensions of the framework, the ingenuity gap will persist: insights

from conventional sciences face diminishing returns in terms of what they are able to add to existing knowledge, using purely scientific methods of enquiry.



## Emergent science

Systems-based analysis has already established the links between obesity and the increasing use of oil for transport and food production (Foresight Report 2007, Roberts 2005). It is probably that the only force powerful enough to reverse the obesity epidemic will be the emergence of a society that moves beyond current energy intensive approaches to agriculture and food production and makes the car a less central part of life. Addressing the challenge of peak oil and the need to decarbonise the global economy (or use carbon in a different way) provide the only realistic way in which this might be achieved. In turn, these changes require a move away from economic growth as the central aim of most societies.

Such a change in emphasis would take the wind out of the sails of consumerism, thus allowing people

to slow their pace on the 'hedonic treadmill', pursuing short-term gratification at the expense of long-term well-being. That treadmill also needs to become less valued, which would encourage people to jump off and pursue more worthwhile alternatives. There would be less money in circulation and carbon would have to be shared equitably to ensure that limits were observed.

The result could be a reduction in inequalities in income which may have beneficial impacts on inequalities in health (although greed in some sectors of society may well be profoundly resistant and possibly ineradicable). The pace of life could become slower but people could well feel less isolated and pressured. Finally, the economic system may shift its focus, so that it becomes more economical to grow food locally and to manufacture

goods closer to the point of consumption (thus reducing energy costs for transport). Such changes could provide meaningful work for many who, in recent decades, have been excluded.

Recognising the links between, energy, food, transport, economic growth, obesity, well-being and inequalities allows us to imagine a radically different set of interactions which could become the emergent qualities of the change of age. A vast array of far less desirable futures is of course possible, but this fact does not reduce our responsibility to use these insights to work for a healthier, more equitable and sustainable future. The interdependencies between problem could lead either to spirals of rapid decline, or to positive transformation.

# Current ethics

The liberal market economy dictates that almost all goods and increasing proportions of services are seen as commodities; in this context, it is assumed that the ethics of the market place dictates what is produced, promoted, sold and consumed.

Some have attempted to bring a social justice perspective to bear on this argument and have argued for

fair trade policies and practice. Others have suggested that regulation and taxation should be used as instruments of policy to promote greater equity and less waste. However, these still tend to be minority voices: the ethics of the market place are still dominant.

It seems that our concept of justice remains focused primarily on individual freedoms, and the promise that

continued economic growth provides the 'rising tide' that 'lifts all boats'. Yet there are now grave doubts that the current economic model is sustainable; evidence suggests not.

Those guided by ethical concerns for others will want to minimise the enormous potential for harm that will accompany any collapse of our current way of living.

# Emergent ethics

This dimension of the framework could lead to the conclusion that healthy, equitable and sustainable ways of living should be both an individual and communal goal.

This means that our use of energy and consumables has to decrease overall whilst becoming more equitably distributed. It seems plausible that only a transparently just, global agreement

on such matters will be acceptable world-wide. This suggests that a collective debate is needed as to what constitutes a good life in a good society.

That life and that society could be rich in many aspects (time, relationships, and creative work) even if it has less in the way of disposable material goods. We need to remember that the future does not already exist and is not 'out

there': it will be created through human activity and its making will change both the destination and we ourselves.

The value base we bring to bear on the coming transition is also vitally important: either we are genuinely all in this together, or we are not.

# Current aesthetics

The manner in which the world might change so that it is more successful in raising our spirits and firing our imagination can be illustrated by focusing on one key 'commodity' in modern life: food. The point is that food is never simply a commodity.

The production and consumption of food is intrinsically rich in meaning in all human societies: it is used for ritual purposes, for celebration, for social interaction, to promote family solidarity,

to demonstrate care for others, and much more. The preparation of food and its presentation has long been an expression of human creativity, although this has been suppressed to a large extent by the industrialised processes around food production found in modern society.

The 'Slow Movement' recognises this aesthetic and meaningful dimension of food and seeks to promote a more mindful engagement with its

preparation and consumption. It seems clear that an appreciation of the aesthetic dimension of food is integral to its healthy and sustainable use.

If this is the case for food, it is plausibly the case for other forms of consumption and all aspects of work. A slower, more creative and mindful approach could transform our sense of well-being and enhance our sense of connection to others.

## Emerging aesthetics

This dimension of the framework reminds us that our engagement with others actually helps us to become more aware of ourselves, in relation to each other and the planet. Many people in modern society are already aware of this, and public health needs to join their number.

We should also be aware that this new aesthetic must emerge in the presence of the old one, so its path is not assured. Modernity is implicated in the creation of the major public health challenges in that they are a fundamental manifestation of our inner life (our mindset and worldview) and our outer life (the structure of our society and culture).

Therefore the tools of modernity (government programmes, public health interventions, social marketing or whatever) are unlikely to make a fundamental difference.

In short, the major public health challenges provide us with both threat and opportunity. The opportunity is that the waning of materialism, individualism, consumerism, scientism and economism could help a different form of society to emerge, one in which the major public health challenges list above have been reversed. The vision to work towards is a world with a stable population, sustainable forms of production and consumption, lower levels of

depression and anxiety, less obesity, higher levels of well-being, more human association and humane organisations, less addiction and greater equity.

Those who think this inconceivable might reflect on just how 'imaginable' a (relatively) clean and modern city of the 21st century, with all its facilities, would have been to a 19th century agricultural worker, forced off the land to work in the early factories of the industrial revolution. The integrative framework provides a starting point for public health to play its part in grasping the opportunities inherent in the transitions we face.

# Applying the integrative & ecological framework to the future NHS

The implications, for the NHS, of the framework introduced in paper 2.1 and illustrated in Figure 1 above are addressed below, as an example of how it might influence practice.

By working through this example, different solutions to the current approaches to the economic downturn and financial pressures on the UK health service become possible. Currently we use either

financially-led salami-slicing of budgets or rationalistically inspired ideas about efficiency in order to get more out for the same or less input. We offer here a different perspective: one based on more ecological and integrated forms of thinking and practice which could provide a stimulus for fresh dialogue on contemporary challenges.

What would the NHS look like if it adopted more ecological and

integrated forms of thinking and practice across the currently fragmented domains of the true (science), the good (ethics) and the beautiful (aesthetics)? The six dimensions of the framework shown in Figure 2 are explored in turn.

We then consider how close the NHS is to adopting such a model, and whether any other organisations 'do it better'.

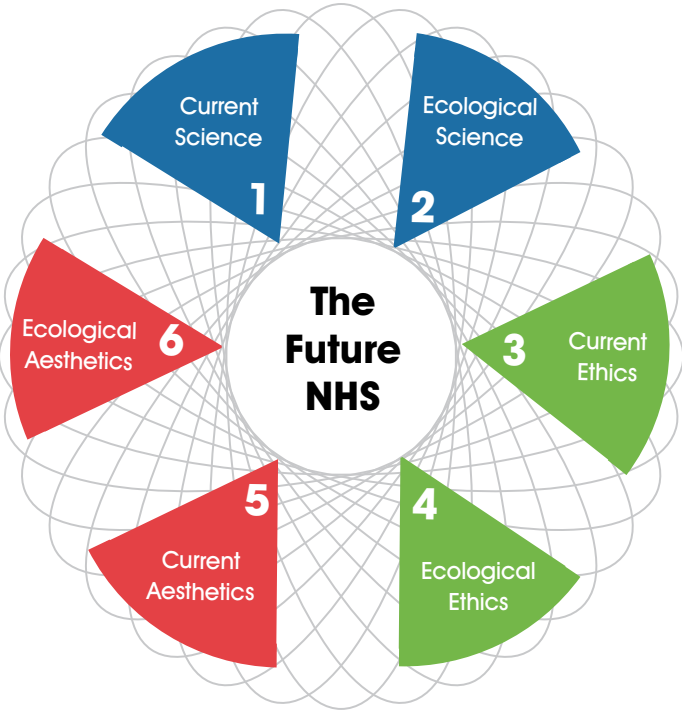
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Figure 2

Applying the integrative & ecological framework to the future NHS



Current science

The future NHS would remain dedicated to conventional or current science and the tenets of evidence based medicine. Integration of all six parts of the framework does not mean that any one of them is compromised, but overly reductionist forms of thinking would not dominate other

dimensions. Reductionism has helped us to understand the natural world by separating out particular strands of information from that larger, more complex world, and reducing them to the function and/or interaction of their parts. There are numerous ways in which reductionism has proved to

be an effective tool for health care provision, not least that it 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 (Jones 2000).

# Emergent & ecological science

Other forms of scientific thinking (systems theories, complexity theories, insights from the social sciences) are also of value in helping us explain reality.

Complexity theory and chaos theory study systems whose complexity defies accurate predictions of their future, but which nevertheless exhibit underlying patterns (Gleick 1987). Understanding underlying patterns can help us cope

in an increasingly complex world. Insights from systems, chaos and complexity theories, when combined with insights from the social sciences, would enable us to understand the NHS as a complex, adaptive system that operates in a shifting cultural environment.

In consequence, greater attention would be directed to the 'order generating rules' that create structure

and dictate functions. System science insights would also be combined with socio-cultural insights to allow the system to become self aware, learn and develop (Capra 1997).

Systems thinking is now becoming commonplace in some parts of the NHS; the problem is that the system is still perceived as an objective reality, and not the subjective construction of all its participants.

## Current ethics

Two of the foundational principles of conventional ethics need to be addressed. First, the injunction to: 'do no harm'. Iatrogenic disease is far too common in the UK health service and the more treatments that are administered the greater the harm that may result.

The new NHS will need a deeper dialogue between patients and professionals about the desirability of ensuring that, in particular contexts, less rather than more is done – fewer procedures and less treatment in some cases. The current system conspires to increase rather than decrease activity, and there are many contexts where this may be inappropriate.

For example, it is not uncommon for older people to be on more than ten different drugs to treat an assortment of diseases and prevent others.

The risks of harmful interaction rise exponentially and, with more than five drugs, have a high chance of harm occurring.

This is a useful example of the modern mindset, which treats individual diseases as if they are independent of each other. In this context, drugs are given to prevent adverse outcomes - as if this were safer than not adding yet another drug to the list of those to be taken. This is an issue rarely discussed with much conviction in the medical press although individual GPs, and their patients and patients' relatives, are concerned and confused.

'Less' is not just beneficial from the perspectives of ecology and the economy but also, and crucially, in terms of health itself: less poly-pharmacy for older patients, less

multiphasic screening, and so on.

The disease factory model of the hospital would benefit by a shift towards a 21st Century version of the 'house of healing' (using insights from palliative care and elsewhere). Decreasing some forms of care, where clinically appropriate, will also release resources for where they are most needed and to address unmet need.

It should be emphasised that this is not an argument for service rationing or reduction on the grounds of economic or any other instrumental aim. One way of expressing this in ethical terms is to understand healthcare is currently practised from a defensive ethic; an alternative might be a creative ethic.

Second, the ethical principle of autonomy needs a new and relational emphasis, one that focuses releasing our inner resources and acknowledges

## Current ethics (cont)

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reciprocity. Modernity has emphasised the patient as a consumer with individual rights (Anderek 2007). True autonomy should rather lead to greater capacity for care of the self and others.

Many in our modern specialised society have become deskilled and disempowered. Simple economics and the pressures of demographic change will make it not just desirable but inevitable that we develop new models

based more on our capacity to provide self and mutual care. We should therefore make a virtue out of necessity, and promote a new manifestation of autonomy wherein people can seek help when needs dictate but lack neither the skills nor the confidence for self-care, when appropriate.

The result of these two changes in emphasis will be a reduction in some types of health care, the emergence

of greater capacity for self care, mutual care and integrative care from the NHS and, potentially, the diminution of unwarranted forms of professional interference.

Resources released by this change in emphasis could be used to address unmet needs where self care is not possible.

## Emergent & ecological ethics

A simple aim of policy should be to reduce the ecological footprint of the NHS. This could conceivably be achieved in several ways.

- **First**, pursue activities directed at energy efficiency, food procurement, and equipment design. Many parts of the NHS are already beginning to explore these options.
- **Second**, abandon resource intensive policies that have marginal health gains (the disposable instrument culture is one example).
- **Third**, do some things differently. A very large proportion of acute care is directed towards patients who are in the last six to twelve months of their lives. Yet we have a default position which drives an approach to investigation and treatment that is resource intensive and often fails to serve the needs of the dying person.
- **Fourth**, do less, where appropriate. We may have to accept that in a resource-constrained world, we could be satisfied with less: fewer consultations, less treatment, less of some forms of health care. This does not mean that outcomes would automatically worsen; they could well improve.
- **Fifth**, simplify the NHS. The future is likely to be characterised by what is currently called 'downshifting' – voluntarily making life simpler with less choice and fewer demands. The NHS could embrace this philosophy and release the creativity of staff and patients so that a model for practice emerges which is not only simpler but leads to better outcomes and patient and practitioner satisfaction.
- **Sixth**, make every NHS facility accessible on foot, by bicycle, and by public transport.
- **Seventh**, produce drugs and equipment with as little reliance on petrochemicals as possible; all consumables used by the NHS should be produced locally where possible.
- **Eighth and last**, the NHS should acknowledge and act on broader ecological principles of 'contraction and convergence' (Meyer 2000) in the service of global social justice.

In addition, rather than speaking of the NHS as an abstract reality, it might be better framed as staff, patients, teams, services, facilities and so on, all working with the personal intention to leave the world in a better shape than we found it. This is a restorative ethic, relational and intrinsically more resilient than our current just-in-time delivery style.



## Current aesthetics

The emerging NHS environment will be a healing environment. The meaning and purpose of an NHS building should be reflected in its physical manifestation (CABE 2009).

Is it too much to imagine healing and care in the context of green spaces and beautiful but ergonomic design? The NHS will be efficient in a new kind of way – a way that lifts the spirits and

is 'beautiful' in the sense of being aesthetically satisfying.

The core purpose of this is to enhance healing change and emergent integrative processes, which could be achieved by promoting the idea that all professionals are inherently creative. That is, we are all 'artists of our lives' in the sense that we can live creatively and are imbued with

individual creativity that we wish to bring to the work environment. We create in order to make life, work, and even the experience of suffering, meaningful.

The barriers to realising this vision are perhaps financial rather than imaginative, in an organisational culture where 'value for money' – although obviously important – tends to dominate other considerations.

## Emergent & ecological aesthetics

The process of working for the NHS or experiencing care in the context of the NHS should foster a growth in consciousness, empathy and compassion, thus enhancing an enabling and integrative approach. Staff should be sustained in this, both

by their daily practice and the culture of the whole working community. Continuing Professional Development (CPD) should promote human, humane and ecological insights as well as keeping us abreast of relevant factual/scientific developments. Training should

cover the integrated application of all six domains of the framework shown in Figure 1. All professional work would consciously integrate 'the good, the true and the beautiful'.

# Are we close to this framework?

The NHS does, increasingly, try to follow evidence based practice so it has strengths in the dimension of current science, shown in Figure 2.

However, part of our critique is that the pursuit of this dimension to the near exclusion of the other five is unhelpful, even dangerous. In the contemporary NHS we find few signs of dimension 2 (emergent and ecological science): little systems science or consideration of order generating rules, and scant insights from disciplines like anthropology, cognitive biology and the environmental sciences.

The NHS does have a commitment to ethical practice and governance procedures (dimension 3 of the model). Nonetheless, it can be accused of failing to promote deeper patient autonomy and creating too much iatrogenic disease (such as hospital acquired infections and some of the

effects of poly-pharmacy, especially in older patients). These can be seen as symptomatic of the way the system is currently organised, perhaps even a price paid for its power.

As far as dimension 4 (ecological ethics) is concerned, the NHS still has a throw-away culture where narrow ideas of the financial bottom line drive most decisions, which in turn tends to drive out the human dimension from which the system derives much of its positive effect. Ecological ethics receive insufficient consideration and the conceptual work of considering how ecological and other emerging ethical concerns might impact on the NHS has yet to be completed.

Finally, the NHS arguably performs least well at present in dimensions 5 and 6 – the aesthetic dimensions of the model. Conventional aesthetics hardly feature at all and we do not believe that many

NHS workers feel able to fully bring their own self into their work, far less express their creativity. The idea that working for the NHS (or, for that matter, encountering it as a patient) might mobilise inner forms of consciousness (deep personal reflection, and so on) is far from the ethos of the current NHS project.

Individual practitioners probably know something of the power of mobilising inner responses in their patients, but their working environment is unlikely to encourage this.

There are, perhaps, some honourable exceptions to this with regard to the aesthetics of the built environment and the emergence of different, more integral philosophies of care exemplified in the development of the ‘Maggie’s Centres’ for cancer care in the UK (Heathcote and Jencks 2010) and the King’s Fund project on enhancing the healing environment (Kings Fund 2010).



## Does anyone else do it better?

Increasingly large numbers of patients are turning to Complementary and Alternative therapies (CAMs), which have a greater commitment to the art of care and the creation of healing environments. In short, they are strong on dimension 5 of the model – current aesthetics.

However, they are weak on dimension 1 (conventional science and its evidence base) and have probably not fully engaged in what we have

called the emerging ecological dimensions (2, 4 and 6) in this model.

The hospice movement is strong on dimensions 1 (evidence based practice) and 3 (traditional ethics). Hospices tend to be more able than other parts of the NHS to promote autonomy and the ethic of doing no harm. They also pay great attention to beauty and the therapeutic environment – dimension 5 of the model. So, the NHS may have something to learn from the hospice

movement, although it is deeply ironic that patients may have to wait until their final illness before experiencing an integrated form of care.

However, the hospice movement, like CAMS, has yet to really address dimensions 2, 4 and 6 in our model. It has not yet begun to grapple with the 'change of age' we all face, and what it may mean for their work in future.

## How may we help ourselves improve?

The central dilemma is that the logic of the arguments rehearsed above may be sound but the prospects for such radical change seem, at present, implausible.

If an integral approach was advocated via political and/or managerial means, the probable response from both patients and practitioners would be one of profound distrust. Massive change can only be catalyzed by informed professional leadership but would also, and crucially, require endorsement and leadership from the general population. We have merely begun to sketch out what the future NHS might look like, in response to the challenges of sustainability and our current ingenuity gap.

We believe that people everywhere have an intuitive understanding of 'the true, the good and the beautiful', and an inherent ability to integrate these in their day to day personal lives. Yet those of us

who work in the UK health system may find ourselves in a context that largely inhibits the expression of that intuitive understanding and inherent ability.

The future NHS would look very different if underpinned by integrative principles and perspectives: it would have internalised the challenges of the modern dis-eases as well as conventional disease; it would have adopted an ecological perspective and a genuine commitment to social justice, at local and global levels.

It would be a living system, created by the interactive responsibilities of staff and patients and their families. And it would work with staff and patients to raise their aspirations (where possible) and inspire individual and collective transformative change. There is much else that needs to be said and done if a new transformational approach to healthcare

in the UK and other affluent, post-industrial nationals is to become a reality.

The current system with its constant growth in expenditure and activity will have to change, both because it is doing (unintended) harm and is unsustainable across many dimensions (Hannah 2010). It will take a change in the culture of healthcare to change the system of healthcare.

Mobilising the inner resources inherent in each of us could transcend the shortcomings of the existing system, which will in turn mobilise the healing resources of individuals, communities and systems so powered. Transformational (cultural and individual) change will help to release this resource but healthcare practitioners will undoubtedly need supportive and participatory processes to help them make this transition.

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