Transcription of Professor David Hunter's lecture:
Tuesday 13 February 2007

Dr Linda de Caestecker:
Good afternoon to everybody and thanks to you all for coming. I've been asked to welcome you here and to introduce David Hunter to you. My name is Linda de Caestecker and I'm the Director of Public Health in Greater Glasgow and Clyde and also a member of the Management Team for the Glasgow Centre for Population Health. So we are delighted to have Professor David Hunter to address our seminar here this afternoon. David will be well known to many of you through his work on health care reform and public health policy. He is, as the flyer tells you, the Professor of Health Policy and Management at the University of Durham and also the Director of the Centre for Public Policy and Health at that same university. He is also the Chair of the UK Public Health Association. So he comes to us with a very good range of qualifications and credibility to speak about this subject on 'The crisis of confidence in public health policy and practice: the search for a new paradigm'.

I've been particularly interested in coming along to this session because I do think we are in a kind of crisis in public health in terms of the way we are thinking about it. Here we are in NHS Greater Glasgow and Clyde and we're an organisation that calls itself a public health organisation. We have a number of transformational themes in our organisation and one of them is that every member of our top senior management team and at every level of the organisation we should provide support and leadership to promoting public health, to improving health and to addressing health inequalities. We've also got a whole range of targets and performance indicators that are about health improvement as well as about acute services and waiting times. We've got community health partnerships whose role is meant to be addressing health and social inequalities. Yet at this very same time all our resources still go to the acute side, the demand for acute care is continuing to rise and certainly if we see problems in waiting times for the acute side it gets a lot more attention than if we don't meet our targets for health improvement. We have also got an improving economy here in Glasgow and yet we are still seeing health inequalities and, in some cases, the health inequalities are worsening and for some of our issues such as alcohol and obesity they seem out of control and we are still not making the impact we want to make. So at a time like this where the context for public health has never been better – very favourable local and national public health policy – and yet are we really making the difference in public health and health improvement? It's really important that we have this seminar today so, David, we look forward to you inspiring us and giving us new ways of thinking and new approaches to this issue. So over to you David.

[Applause]

Professor David Hunter:
Thank you for that introduction, Linda. 'Inspire' wasn't the word that came to mind when I was thinking about this talk, but if I can inspire you and not depress you then that's an even better outcome. In many ways I see this talk as a wake up call more than anything else. Linda has set the scene very well in terms of where we are and what some of the critical pressure points are in shifting the paradigm and moving in a new direction in public health.

Anyway, thank you very much for inviting me to speak in this illustrious series. You've had some very eminent people, clearly you have run out of names now, but I'm delighted to be here. *[Laughter]* I never like speaking in front of so many people I know – it's nice to be anonymous – but anyway, thank you for coming. Some of you may already have heard some of what I'm going to say, but hopefully we can have some good discussion because like all academics I don't have the answers although I hope to pose some questions and set out some dilemmas that we are in and maybe offer some pointers in terms of how we might want to move forward. I'm very conscious that exactly a year ago to the day – 14 February 2006 – Ilona Kickbusch addressed this series of lectures and talked about global health and the public health crisis at a global level. In many ways what she said in her lecture and what I'm going to say tonight have many parallels except that I don't intend being quite so global. Rather, I want to bring the issues closer to home in terms of where we are in the UK. I say the UK although I know the UK is not the UK now so much in health policy. But I hope what I'm going to say travels reasonably well across the UK. Ilona's remarks about public health, the crisis in public health, and the crisis of governance are absolutely right and these are the themes I want to pick up on and develop, building on what Ilona said, but applying the analysis much more to where we are in the UK while not forgetting that we are part of a global agenda.

Let me begin with a word on my main thesis which is that public health is in crisis, is losing its way and has been for some time – much in the way Frenk concluded some 15 years ago. Julio Frenk will be known to many of you. He's Minister for Health in Mexico, but when he wrote these words some 15 years ago he was Professor of Public Health before joining WHO.

Public health has historically been one of the vital forces leading to…collective action for health and well-being. The widespread impression exists today that this leading role has been weakening and that public health is experiencing a severe identity crisis as well as a crisis of organisation and accomplishment.

I consider this to be a correct and succinct statement of the dilemma facing us in public health today. It may have faced us in '92, but it's certainly facing us today in terms of the identity crisis being experienced in public health and the crisis of organisation and accomplishment. Those are the key words for me in this statement. In the heady optimistic days of the Ottawa Charter and Alma-Ata Declaration, and other visionary documents in the '70s and '80s, we thought we were heading for that step change required to achieve healthy public policy. Yet, here we are reinventing a lot of that as I'll come on to say later. We still haven't made that step change in terms of commitment, implementation and delivery.

The structure of my talk is in three parts. First, why are we in crisis? I fully accept that crisis is an often abused and overused word but it's a legitimate one to use in making the case for change and as part of my wake-up call. Second, what is wrong with our present policy, governance and leadership arrangements in respect of public health? I think there is a lot of dysfunctionality and symbolic posturing in these areas

at the present time. And, finally, what might the new governance in public health begin to look like?

We are confronting a huge policy paradox. Public health is rarely high on the policy agenda, but it is enjoying that position at the present time for reasons that are well-known and well-documented, including: rising levels of obesity which are the consequence of an obesogenic environment; alcohol misuse; rising mental health problems and so on. Furthermore, we haven't succeeded in a major way in narrowing the health gap between rich and poor – that's still very much with us and widening in many respects in terms of the gradient and the widening income gap fuelled by significant salary rises at the top. Whatever aspect of public health one chooses to look at, the general picture is not a very positive one. There are exceptions with some very good things happening in little projects here and there, but in terms of the big picture progress is disappointing. And this is the crux of the paradox. Though public health is high on the agenda, it remains incredibly weak and fragile in terms of its capacity and capability. We haven't succeeded in aligning the two to ensure that the means are up to the challenge posed by the ends in terms of improving the public's health. We talk the talk, but we don't walk the talk is how I would want to put it. Despite renewed interest in public or population health it tends to wax and wane, principally as a consequence of dominant political alignments and ideologies.

Why does this state of affairs persist? You will have your own reasons but for me, increasingly, I perceive a confused and inconsistent government response to be a major factor. Increasingly, we have a government with a policy that is a victim of the tension (not new in public health) between the nanny state on the one hand versus the enabling state on the other. How far should the state be commanding and controlling? And how far should it be enabling, facilitating and setting some loose framework giving people advice and information? This is not a new debate in public health – it comes round repeatedly – but it is certainly a key issue at the present time. In addition, we have increasingly inconsistent policies that push and pull in different directions. For example, on the one hand we talk about encouraging partnerships – there's endless talk about collaborative working, partnerships and so on. Yet, at the same time, the push is very much to have more diversity, more pluralism in the way services are organised, more marketisation of services, and more choice, all of which potentially fragments what is already a highly complex context and makes that collaborative approach and that partnership working infinitely more difficult. I accept much of this assessment applies more to England than Scotland but such thinking may not be entirely absent here.

Almost every social institution and policy realm has health implications – a point to which I shall return. If the field of public health is to have sustained policy influence, it requires a persistent constituency, a strong organisational base both inside and outside government, and academic respectability. I am not convinced that any of these features figure strongly enough to secure a future for public health and avoid the crisis it's in. Public health, despite the rhetoric and as Wanless was quick to point out in both his reports for government in 2002 and 2004 respectively, is not central to health policy. Public health is not institutionalised in the way health care is. We have had some understanding of the social determinants of health for several hundred years. From time to time, the issue breaks through to public attention but it has not had much staying power or remained a continuing concern or gained a real foothold on policy. This is despite the fact that social and environmental factors affect the health of all of us. The problem is not simply an issue affecting the poor.

We also have a policy which is about going upstream, keeping people healthy and preventing problems from arising. At the same time, in the health care sector we have a set of policies (again this may be more true of England) sucking people into hospitals. Hospitals will survive in future by the amount of work they do, the number of patients they see, and the volume of ill health they treat. It's not in the interest of a hospital to have healthy people in their community – the sicker the better because that way you will have beds filled and you will have possibly more beds as a consequence.

So you have this glaring anomaly or disjunction, if you like, between what some policy is saying on the one hand and what the reality is on the other, with the incentive structure to achieve the policy not very well aligned with it. Nor is there an alignment of policies and governance which is part of the crisis as well. The crisis we are in may prove functional in the long run and help us break out of the cycle of despair, but at the present time, as Linda implied, we are not making much headway in the context of this confused environment and these jigsaw policies that do not cohere and do not, whatever the rhetoric may say, actually make it easy to move forward in a different direction and one which favours public health.

Let me expand on this point. I know you have your own version of the prime minister here, but Tony Blair, in a keynote speech in July last year on healthy living, captured this dissonance quite well because if you look at that speech (which is on the No.10 Downing Street website) to my mind it's rather confused. On the one hand, he is saying, yes, we want firm action by government, and he uses smoking and the smoking ban in England (which, by the way, wouldn't have happened in England had Scotland not led the way within the UK). He says he's been on a personal journey of change – he did not initially want the smoking ban, now he does, and agrees that firm government action is both desirable and legitimate. Other examples are school meals and banning junk food advertising on children's TV. So, he's been on a personal journey of change. However, on the other hand, in the same speech he talks about how no one trusts government any more so we can't have the state acting as nanny even if this was desirable. And in alcohol and gambling, for reasons that are not entirely consistent with the approach adopted elsewhere, a laissez faire approach holds sway. But, we are advised, we need to settle for an enabling role for government which essentially means standing back and allowing people to make the individual lifestyle decisions themselves. He doesn't see individuals as being part of a collective or community or polity. Rather, he sees them very much as individuals making their own free choices.

So I sense in that speech a real, and largely unresolved, tension between what the government's role in public health should be and where the individual has a legitimate role. It is an uneasy mix of liberalism and paternalism which does not seem to me to be a stable or sound recipe for good policy. The speech displays a lack of theoretical underpinning that gives a clear conception of what the respective roles of government, the individual and communities might be. All in all, then, a very confused speech, which I think reflects the reality in terms of the policy agenda to which I'll return later.

This tension between the individual and the community is nothing new but instead of taking that journey and actually making progress on the healthy public policy agenda, there is a cyclical process at work, as it has been for decades. And that for me is part of the crisis: we accept the analysis, in terms of socio-economic determinants being a key factor in shaping health, but what we haven't been able to do is adopt organisational, policy and governance arrangements that make that a sustainable reality.

Let me recall a few comments the Chief Medical Officer for England, Liam Donaldson, made in his 2005 annual report published last summer on the state of public health because I think there are some interesting points here that have a much wider resonance far beyond England. He is critical of the constant raiding of public health budgets to reduce hospital deficits and/or meet acute care targets. There is nothing new here but the fact that the CMO is saying it seems to me to be important and possibly unprecedented. Here is the government's most senior health official openly criticising government policy and without pulling any punches. He goes on to complain of the lack of investment in the public health workforce. We have a workforce but it lacks the capacity to meet the enormity of the agenda in terms of what's required. Now we might want a debate about what that workforce is or could be – it's not just what happens in the health service, and it's not just about those who would call themselves public health specialists or practitioners, or about what they do. But there is an issue about the wider public health work force and who actually calls themselves a public health practitioner. Finally, the CMO talks about the dysfunctional and negative effects of constant NHS reorganisation from which Scotland has largely managed to escape since devolution. But the nub of the CMO's critique is nicely captured in the following sentences:

This situation has not been created by any person or group of people. It is the result of many disparate factors, but at its heart is a set of attitudes that emphasises short-term thinking, holds too dear the idea of the hospital bed and regards the prevention of premature death, disease and disability as an option not a duty.

This excerpt nicely captures the essence of the crisis and disjunction between what the policy rhetoric says on the one hand and the prevailing reality on the other. The CMO is saying here that this isn't about individuals or even groups of people – it's a systemic problem amounting to a failure to shift the mindset in terms of thinking about health in a quite different way. We still think of health as hospital and bed-based. We don't really take prevention seriously. It's seen as an option, not a duty or a right or whatever term you prefer. Decades of talking about this agenda hasn't resulted in any real shift in the way that our present organisations or policy systems seem to relate to that agenda. Arguably, and for whatever reason, they simply don't take it seriously.

Let me cite one more piece of evidence in support of my thesis that we are in a state of crisis. This is a recent unpublished study from the Audit Commission which looked at health inequalities in Greater Manchester and what was being done about them. Manchester has, like Glasgow, tremendous problems of early mortality. There is a difference of seven or eight years between males living in Manchester and those living in Dorset. The gap is not as bad as Glasgow's, but is still significant. The Audit Commission report makes interesting reading in terms of listing the key barriers and impediments to tackling inequalities. There is no health vision and a lack of champions; there is no overall leadership; constant NHS reconfiguration prevents progress; management time is focused on planning for spending small amounts of money; 'projectitis' is rampant; good things are happening but at a very low level of aspiration and delivery; there is a lack of engagement with the voluntary sector; and there is minimal use made of information (lots of information is around, but not much of it is finding its way into decision-making); and the Director of Public Health has too wide a range of responsibilities known as 'job stretch'.

Now none of these things are new in themselves – we've been discussing them and looking at ways to resolve them over many years – but what's interesting is the fact that despite the policy and the government's intention to tackle some of these things, we're still talking about them and haven't made as much progress as we should have done. It is a conclusion that was confirmed by Derek Wanless in his second report to the UK government in relation to public health. You will be familiar with that so I won't dwell on it, but a point Wanless makes is the lack of alignment of incentives in the system to focus on reducing the burden of disease. Again the rhetoric is there, the language is there, but not the reality. In his words:

Numerous policy statements and initiatives in the field of public health have not resulted in a rebalancing of policy away from health care (a 'national sickness service'). This will not happen until there is a realignment of incentives in the system to focus on reducing the burden of disease and tackling the key lifestyle and environmental risks.

So why this continuing inability to make progress or bring about the 'step change' desired by Wanless? Wanless and others have documented the obstacles and barriers quite thoroughly. They include capacity problems, the impact of successive NHS reorganisations, the terror by targets culture, lack of alignment of performance management mechanisms between partners, fitness for purpose, weak leadership, absence of effective governance. Maybe this is more of an English problem than one evident in Scotland. But certainly in England you have a terror by targets culture which is very unforgiving in terms of the victim-blaming that it breeds on the part of practitioners and managers.

So what we end up with is what interestingly the former deputy CMO for England, Aidan Halligan, put his finger on in a fairly frank interview following his departure from office.

Any suggestion of real reform has been a deceit. Working patterns, practice and custom are at the heart of many capacity issues [in the NHS] and have never been challenged. It is extraordinary the gap between highly motivated frontline staff and the systemic dysfunctionality in which they operate.

He is talking about the NHS reforms but there is a wider resonance here in terms of the public health agenda. What he is saying is that, despite all this fiddling around with the systems and the structures, we haven't really changed anything. In particular, we haven't really changed the mindsets of doctors and nurses and others in the system think and we haven't motivated frontline staff. 'Systemic dysfunctionality' is still very much in evidence and that, I think, is equally applicable to the public health system as we have constructed it.

So, what's wrong with policy, governance and leadership? A number of factors are at work.

- Politicians have become managers – politics have become managerialised
- Managers have become politicians – management has become politicised
- Terror by targets
- Balloon squeezings
- More of the same is the answer: more management, more performance assessment
- Does government want leaders or followers?
- We are not dealing with a machine but a complex adaptive system.

This is not an exhaustive list but it seems to me that perhaps the most significant development is that we've turned our politicians into managers, and politics (and I mean party politics, parliamentary politics) have become increasingly managerialised. We have technocrats as politicians who think they know what it means to run and manage complex systems, and they speak the language of management without really understanding what it means. But at the same time we've tended to infantilise managers – either that or they've become politicians. Management has become politicised because managers daren't do anything unless it has the blessing of, or is sanctioned by those politicians who themselves are trying to manage the system. I don't think that relationship, which has shifted in the direction I've suggested over the last twenty or twenty-five years, is at all healthy or functional, particularly in running complex systems of which public health is a clear example.

I don't believe you can run a complex system through a top-down target-driven approach and by means of mechanistic performance management. If you look at the literature on complexity theory, the last thing you do is set targets, particularly targets that are imposed from on high and have no connection with the people who are responsible for delivering on them. All you get is a succession of what has been called 'balloon squeezings': you just move the problem around. In tackling waiting lists, for example, you just shift the problem to some other point elsewhere in the system and create a balloon effect there. We aren't looking at how our actions impact on the whole system as opposed to bits of it. We just squeeze the balloon in a different place every time and what we do when confronted by failure is react in the classic, but wrong, manner, namely, by reverting to 'more of the same'. The cry goes up: 'Let's have more management! Let's have more performance assessment! Let's have more targets!' But this is precisely the problem: instead of adopting a root and branch analysis of the problem we reach out for the familiar weapons in the armoury. Despite these having failed in the past, we refuse to acknowledge that. We just think that if we do it better or we have more or different targets then the system will somehow work better. But all we are doing is bolting these arrangements onto structures that are themselves part of the problem, not the solution. We haven't yet reached that point where we have to accept that we need a new approach, a new conception of how we should organise and think about these issues. Even where the talk is of complexity, and a lot of the documents that one looks at, a lot of the glossies that come out of government concede the complexity of the issues, somehow there continues to be a mismatch between the language and the rhetoric and the actions that are then consequently taken. We don't seem to be able to make that bridge between the acknowledgement that this is a complex issue and the fact we need quite different tools and approaches to address those problems. Remaining wedded to the old ways of doing things while making little progress or headway is precisely why politicians thrash around wildly and become increasingly frustrated. The public health problems we are facing have outpaced the capacity of our institutions to respond and change. Our arrangements have become calcified, ossified and incapable of the type of change required. We struggle with institutions that are no longer fit for purpose. They have been overtaken by the pace of events.

When Tony Blair says: 'Oh I'm really frustrated, I'm exasperated that public services are not changing fast enough' he's right, they're not changing fast enough nor are they able to keep up with the pace of problems that are affecting those systems. Our problems, put simply, are running ahead of our institutions to keep up with them. That's why people are burnt out. That's why managers, practitioners rush around wildly trying to cope with an endless flow of demands on them because they are pressured by an environment that's not fit for purpose in terms of what it is that they are supposed to be doing in a context where all the constraints and obstacles are lined up against them. So when politicians like Tony Blair say 'I want to get this

system working better' he's right about that, but the tools he's using, I would suggest, are the wrong tools and they are actually going to make the problem far worse, not better so more targets, more performance management will not address the problem. We will come back in five years, if that long, and say it's failed and commence another round of dislocating 'redisorganisation'. This is what has happened in the NHS since the mid-1970s with three major reorganisations in England alone since 1997. It's outrageous when you consider the cost and lack of progress evident, and the absence of change on the frontline. So, if we're serious about change (and perhaps we're not!) then we have to change the paradigm of how we restructure these systems because what we've got now just ain't working and is definitely broke. The system has all but seized up.

Leadership will be crucial in charting a new direction but do governments really want leaders. They say they do and talk endlessly about leadership but do they know what leaders are, real leaders and what they do? I don't think so. We might want to discuss that in terms of what the leadership challenge amounts to. I do think we need leaders, but I don't think the government does. What government wants are good administrators, good followers, people who will do their bidding. The point I made about politicians being the managers – they are the leaders (or they think they are), and they don't want people who will challenge them. They want people who will deliver for them on their agenda and terms and that's not what leadership is about at all. It's not about delivery, it's about changing things, it's about doing things differently. And finally, we are not dealing with a machine, but governments and politicians, because they don't understand management in a complex system, think they are dealing with a machine. They think if they twiddle with the levers and knobs at the centre things will happen. The fact they don't happen is proving a great cause of puzzlement on their part, but they are not inclined to think afresh about how to change the system, they're thinking 'oh well let's bring markets into the public sector to solve issues of efficiency, productivity and innovation. Let's have more privatisation; let's bring business in'. They don't think through what a different approach to public policy making might be in this sort of context and, therefore, I think the notion of the complex adaptive system, while appearing now and then in government documents, has not really shifted the mindset in a way that it needs to if we are going to get a grip on the governance and leadership issues. I now want to move onto these issues.

I should say briefly what a complex adaptive system is. Here is a definition from Paul Plsek and Trisha Greenhalgh writing in the *British Medical Journal* in 2001:

A collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents.

This definition is a good summary of what a complex adaptive system is. It is about everything that government tries to control but can't and therefore we need to acknowledge that and work with it 'going with the grain'. That's where this kind of approach can appear threatening to the scientific rational linear approach that governments favour because they know no other. Because the problems are complex we should be using language to reflect this, but instead governments resort to scientific management concepts that are wholly inappropriate and outmoded for this way of thinking. Hence the point about targets, and about thinking in silos, or in departments which I'll come back to in a moment. But we urgently need to begin to shift towards this type of thinking in public policy and in governance. We are starting to talk a bit about it round the edges, but it's not mainstream.

The public health system is therefore also a complex adaptive system. But under present policy it's a complex *maladapted* system. We don't manage the system in any way like a complex system. Instead, we resort to managing chunks of it that can be driven through vertical silos.

The notion of a public health system produced by the US Institute of Medicine in a report that came out in 2003 is an attempt to begin to see all these elements as belonging to interrelated communities. They include the health care system, employment and business, the media, academia, and governmental public health infrastructure all of which impact on the conditions for population health. It's trying to get away from that vertical silo driven mentality, trying to see the public health system in holistic terms. The definition of that system is this:

a complex network of individuals and organisations that have the potential to play critical roles in creating the conditions for health. They can act for health individually, but when they work together toward a health goal they act as a system - a public health system.

This is not a startlingly new concept, but is still powerful in its simplicity, and looks at the public health system more broadly than simply through the health care system.

So what might the new governance begin to look like? Well it seems to me that we need to be shifting from looking at healthy institutions to looking at healthy populations – something we don't do. We're still locked up in our health care delivery systems, in our partnership systems, in our primary care systems. We don't look at healthy populations as a starting point and how they might be nurtured and sustained. We train people to be health service managers or we train them to be local authority managers or housing managers; we don't train them to be managers of health. What we might want to think about is how do you create a managerial epidemiology? How do you create managers, and leaders for that matter, who have as their responsibility the health of a defined population? Not the management of an institution – the health of a hospital, for example, or the health of a primary care facility or the health of a community facility or a housing estate – but how do you begin to broaden that focus of what managers, practitioners and leaders should be concerned about in their localities in terms of a broader epidemiological population based approach? Again, it's not rocket science, but we don't train managers for the most part to be successful in terms of looking either at healthy populations and health outcomes or how they can contribute to nurturing and sustaining that population. And again this, I think, takes us to what increasingly in some English discussions are, and maybe here too, around the place shaping role of local government; that health is often a feature of people's connection with place whether it is the workplace, the place where they live, their community, or whatever. The place shaping role means talking about the importance of public space and the environment rather than talking about health or ill health. It may be the way to begin to confront this obsession with the downstream agenda by beginning to shift upstream to looking at the importance of place and people's connection with place.

Interestingly, we seem to have reached a point where some of this thinking has been rediscovered. If you go back to those early visionary WHO documents in the '70s and '80s, notably the Ottawa Charter and Alma Ata Declaration they were passionate about health being not just what health services do, but about the contribution made by other sectors. Interestingly, the Finnish presidency of the EU which ended in December put this topic on the EU agenda in terms as its major health theme. The view held is that we need to think about health in a quite different way and the Finns coined the phrase 'Health in All Policies' (HiAP) to capture it.

The notion of HiAP isn't new, but the fact that we've had to reinvent it, welcome though this is, demonstrates how far we've still to go and how little progress has been made given the scale of the health challenges facing us. But the fact that HiAP is making something of a come back could be a development that we might want to begin to think about in terms of the new approach to governance and policy making I am arguing is needed. The elements of that approach are these: that we need to think not vertically but horizontally in terms of improving population health by looking at what goes on in other policy areas whether it is housing, education, transport, regeneration activities, and so on. In all of them, health should be central. The approach takes into account the health impacts of other policies when planning policies, deciding between various policy options, and implementing policies in other sectors. Through such an orientation, health is viewed as being at the centre of others' agendas. It echoes the Institute of Medicine's notion of the public health system mentioned earlier: a public health system embraces all of the policy sectors that have an impact on health and they go way beyond health care departments or health care administrators. Finally, it aims to clarify links between policies and interventions, and determinants and consequent outcomes. So in a sense it's almost the glue that begins to put some of these policy streams and policy interventions together around the notion of health improvement. The ultimate aim is to create evidence based policy making, so the evidence base is still important but you've got to see that in the context of where you're going to get the biggest pay off in terms of interventions by looking at the policy implementation issue much more broadly across government departments and ministries and levels – not confined to the national level, but also taking in the subnational level. This isn't just about health impact assessment, although it's clearly one of the tools we might want to use. What it's really about is putting health at the centre of what governments seek to do because if you look at the stewardship role of government, one of its key elements is the protection of the population's health and its furtherance.

The task is hard, the road difficult. We've been here before. But unless we acknowledge the difficulties and failed attempts and learn from them we are unlikely to make progress. I remain unconvinced that we've truly learned those lessons or understand the nature of the challenge to our present systems and reform attempts. I am reminded of J K Galbraith's memorable phrase 'the culture of contentment'. The comfortable vested interests will not readily move from their comfort zone unless or until they have to, by which time it may be too late. The future of public health is therefore unpredictable and a great deal will depend on the political climate which is difficult to foresee. The trick will be to find ways of conceptualising and communicating the public health message and for this we need new skills but also ways of getting health into all policies and out of health departments. Maybe we can learn from the military at a time of crisis and uncertainty because that is what it confronts all the time. Three lessons may be worth highlighting:

1. Command not control (i.e. is libertarian paternalism so bad?)
2. Leadership not management – sometimes doing nothing or doing less requires strong leadership rather than more of the same
3. Education not training – are skills and competencies really what workforce development should be about? At times of crisis and constant change how to do things differently is the issue, not repeating what we've always done only better.

The hope must be that we have reached a stage in the cycle of despair in public health where we begin to accept that we can no longer continue to go on as we are and we need to do something different to bring about that paradigm shift I mentioned. There are levers out there, there are tools out there, but at the moment we're not

seizing those in a way that we could to make that difference. We are once again at a crossroads. We are always at a crossroads in public health, but I think we may be at the ultimate crossroads in terms of either repeating all this history yet again, or beginning to say look, if we're serious about health in it's broadest sense and about seeing Health In All policies then how do we make that a reality.

My final parting message is this: can we use the crisis public health is in to break out of what has gone before, which is more of the same, and begin to move onto a different plane leaving behind what Donald Schon called 'dynamic conservatism' where we simply fight like mad to stay in the same place? Can the crisis trigger a journey to a different place?

Thank you very much.

[Applause]

Dr Linda de Caestecker:
Thanks very much. That was very thought provoking.

Could I just finish by thanking David for his very thought provoking presentation and for the leading of the discussion and thank you all of you for contributing to that.

So thanks very much.

[Applause]