



Governance, Health and the New Citizenship



Inaugural Lecture by
Professor John R Ashton CBE

Liverpool John Moores University

25th October 2000



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Vice-chancellor, Dean, friends and fellow citizens of Liverpool and the North West. It is an honour and a pleasure to address this audience this evening at one of our two great Universities here in Liverpool, which together represent such a major resource to the people of Merseyside, the North West and beyond.

I have chosen for my title tonight 'Governance, Health and the New Citizenship' (Fig 1) and over the next hour or so, I hope to demonstrate the essential unity of these three key concepts and their link to sustainability. I intend to show how, together they can be used to mobilise the many resources for health, both human and environmental which we have at our disposal and which include the whole range of types and levels of educational institution.

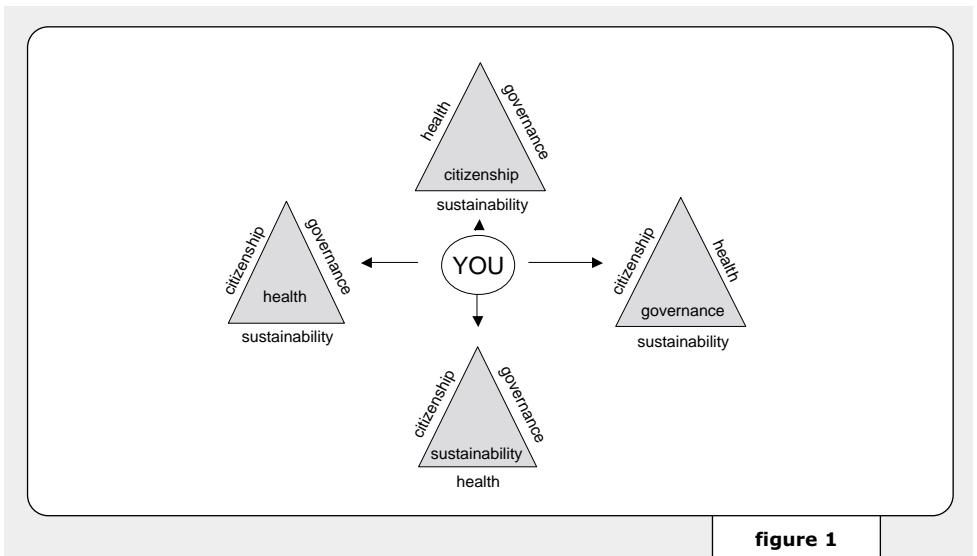


figure 1

Our two Universities have rather different origins and represent somewhat different traditions. Liverpool John Moores University (Fig 2) began life as the Liverpool Mechanics and Apprentices' Library founded by a group of local businessmen in School Lane in 1823 to provide much needed skills training for the rapidly increasing Liverpoolian population.



figure 2



Over the years, that institution grew and gave birth to several new colleges such as the Mechanics' School of Arts, founded in 1825 and the Liverpool School of Pharmacy established in 1849. Many of these colleges merged in 1970 to form the Liverpool Polytechnic which in turn became John Moores University in 1992, with its acclaimed commitment to the regeneration of Liverpool's physical and human capital and with a particular emphasis on the vocational - on access - and on developing local resources.



figure 3
Royal Institution, Colquitt Street



figure 4
The University of Liverpool

The University of Liverpool on the other hand had its origins in the Royal Institution in Colquitt Street, (Fig 3) and was established by the merchants of the town the 'Liverpoolians' for their own edification and enlightenment. The Royal Institution was established in 1814 for the 'Promotion of Literature, Science and Arts', and germinated the seed for the development of the 'University College' in 1881, and the establishment of 'The University of Liverpool' in 1903. (Fig4) The medical school itself can trace its origins to the Royal Institution where the first anatomy classes were held by anatomist and illegal trafficker in dead bodies William Gill.

It is perhaps not unfair to claim that The University of Liverpool with its various professional cadres of students has until recently focussed more on higher education for professionals and on research than on access and regeneration.

I have argued elsewhere that the activities of the 'Royal Institution' symbolise a transition in the medical world during the nineteenth century from generalist to



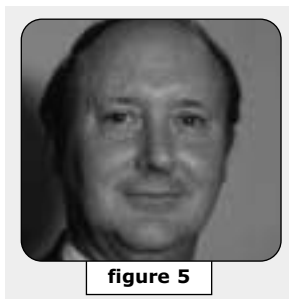
specialist¹. The earlier physicians ... had an interest in both liberal arts and natural sciences and sought to practice in a holistic, non – interventionist and negotiative way with their patients.’ By contrast, the later specialists represent a more interventionist and reductionistic approach. Ironically, by the 1970’s, when medical school curriculum reform was moving back towards the integrated teaching of biological systems, students were increasingly required to have high entry grades in chemistry to enter medical school. One consequence of this was that the alternative path into medical school via the humanities fell away. With this change, the glimpse of opportunity of access from all social groups was progressively eroded with some seventy to eighty percent of medical students themselves now coming from professional family backgrounds.²

It is interesting to speculate what historians will make of this in the future in relation to the huge cultural gap which seems to exist between doctors and many of their patients and the succession of medical scandals which have hit the headlines over the past year.

Maybe locally we should be looking to greater partnership between the two Universities to obtain that diversity of access for the whole range of health professionals undergoing training.

One personal anecdote brings into relief the extent of the problem. On one of his regular visits to the North West, the previous Chief Medical Officer Sir Kenneth Calman (Fig 5) began the day by walking along a section of the Trans Pennine trail in Reddish Vale into a housing estate on the edge of Stockport.

There the Chief Medical Officer was in his element, meeting with local residents of a housing co-operative and a community centre, drinking tea and chatting. The remainder of the day’s programme involved visits to health centres and hospitals finishing in a specialist centre of clinical excellence. During the afternoon one senior medical consultant commented that he thought Sir Kenneth must have



had a most interesting day but that he couldn't understand what the Chief Medical Officer was doing going on a walk through a housing estate! When the day was over the Chief Medical Officer said to me that we needed to have a conference on community development and health to give this important field a platform and to encourage the dissemination of good practice. The innovative conference 'Developing Communities for Health ' held over two days at the University of Salford in Greater Manchester in September 1999 was the result.

I have dwelt for some minutes on these aspects of the origins of John Moore's University and the Medical School and medical training because they are relevant to the argument, which I now wish to develop of the indivisibility of our systems of governance from citizenship and health.

Turning to the issue of Governance. According to Jan Smithies and Georgina Webster quoting Osborne and Gaebler, Governance is defined as 'The process by which we collectively solve our problems and meet society's needs. As such it is different from Government which is the instrument we use. The instrument is outdated and the process of reinvention has begun.'³

The United Nations Development Programme (UNDP) has promoted a sustainable human development approach since 1990. Their approach has been greatly influenced by recent changes in the global perception of governance providing for greater flexibility for involving elements of the civil society – a society that has a rich pattern of public involvement; voluntary organisations as well as state institutions.

UNDP suggests that there is no single definition of good governance, but it defines governance as 'The exercise of political, economic and administrative authority to manage a society's affairs.'⁴



UNDP uses the following as core characteristics of good governance:

Participation: All men and women should have a meaningful voice in decision-making.

Rule of law: Legal frameworks should be fair and enforced impartially, particularly the laws on human rights; where public security and safety are given high priority.

Transparency: Transparency should be built on the free flow of information, with enough information being provided to understand and monitor public processes and institutions.

Responsiveness: Institutions and processes should serve all stakeholders.

Consensus orientation: Differing interests need to be mediated to reach a broad consensus on what is the common good, in the best interests of the organisation, community or country and, where possible, on policies and procedures. This seems especially relevant in relation to the recent fuel crisis and the debates on pensions and marijuana.

Equity: All men and women should have opportunities to improve or maintain their well-being and the vulnerable and excluded should be targeted to ensure security of well-being for all.

Effectiveness and efficiency: Processes and institutions should produce results that meet needs while making the best use of resources.

Accountability: Decision-makers in Government, the private sector and civil society organisations should be accountable to the public and specific constituencies, as well as to institutional stakeholders.

Strategic vision: Leaders and the public should share a broad and long-term perspective on the good society, good governance and human development, along with a sense of what is needed for such development.

Legitimacy: There should be an established legal framework for public policy making and action.

Resource prudence: Resources should be managed and used with a view to optimising the well being of people over several generations, without mortgaging the future.



Ecological soundness: The environment should be protected and regenerated to ensure sustainable self-reliance.

Empowering and enabling: All citizens should be empowered to pursue legitimate goals and environments should be created to optimise their prospects of success

Partnership: Governance must be seen as a whole-system responsibility that cannot be discharged effectively by Government alone, but involves other mechanisms and processes for working in partnerships with public, private and civic actors in conducting the business of governance at all levels.

Spatially grounded in communities: People should be at the centre of systems of Government and be empowered to be self-reliant, self-organising and self-managing, building on the autonomy of local communities.

Clearly there is a relationship between governance and Government which can be seen in the origins of our own local Government here in Liverpool and the significant impact of the Cholera epidemics of the 1840's and 50's in galvanising that collective response. As is familiar to this audience, the exploding population of the great towns led to burgeoning slums that created ideal conditions for epidemic disease.

Here in Liverpool, local dispensary physician William Henry Duncan (Fig 6) investigated the link between housing conditions and early and high death rates. His findings were publicised in his pamphlet on 'The



figure 6
William Henry Duncan





figure 7
Edwin Chadwick

Physical Causes of the High Mortality Rate in Liverpool⁵ and publicised in lectures at the Royal Institution and around the town.

His work closely followed the publication of Edwin Chadwick's (Fig 7) landmark report on the sanitary conditions of the labouring population of Great Britain, published in 1842⁶.

One of the consequences of this activity was the establishment of the Health of Towns Association for sanitary reform with branches in many of the provincial towns. (Fig 8) The Liverpool branch was formed at a meeting called by the Mayor in April 1845 and attendance was described as 'not large but highly respectable'⁷ including leading members of the council and both Protestant and Catholic clergyman, in addition to several members of the medical profession.

The Liverpool Mercury described those present as 'Gentlemen of all sects in religion and all parties in politics.' The meeting passed unanimously the resolutions defining the sanitary objects to be aimed at and called for



figure 8
Health of
Towns
Association



legislative action. An important early consequence of the activities of the Liverpool Health of Towns Association was the 'Liverpool Sanatory Act' of 1846⁸, which enabled the town to appoint Duncan as the first Medical Officer of Health in the country in 1847. The Association played its part in the national campaign, which resulted in the 1848 Public Health Act⁹.

However, perhaps of more importance from the point of view of this evening's talk is that when Dr Duncan set to work (as Gerry Kearns describes it,¹⁰) within the constraints of the public institution of the time, there was a creative and joined up approach to the challenges to public health. We have recently begun to emulate this approach with both the Healthy Cities initiative and more recently Health Action Zones as part of the Government's public health strategy.

Innovations in housing, water supplies, sanitation and sewerage, street cleansing, food hygiene, education and recreation and policing began to follow each other in rapid succession. And here is the crux:

Whereas until now the town council had been not much more than a gentleman's club, elected by an urban elite of property owning males, to meet in the splendid palladian villa in Castle Street (Fig 9) and discuss business matters; the Council had few civic powers over the conditions of life, health and well being of the proletariat. Although many individual councillors did wield considerable feudal power and influence over the lives and well being of employees working for their businesses. This was still very much feudal England. (Fig 10)



Evolution of systems of civic governance in England

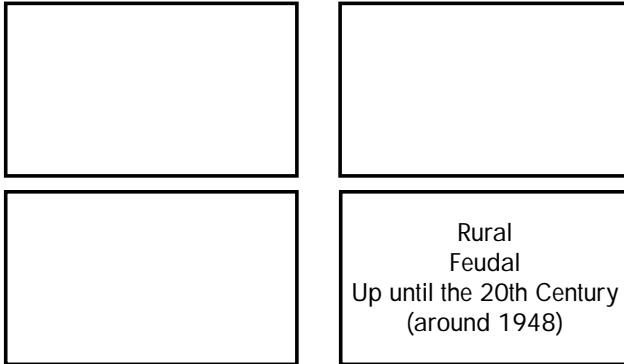


figure 10

It was the success of the civic leaders in defining a practical agenda for improving the living and working conditions and life chances of the people which gave credibility and legitimacy to the involvement of the town council in an ever expanding range of public services and activities. Reference to the special volume produced for the Royal Institute of Public Health congress held in Liverpool from July 15th to 21st 1903 includes information on the following public services and areas in the public realm¹¹:-

- Aviaries
- Bacteriological analysis
- Baths and washhouses
- Chemical analysis
- Corporation dwellings
- Various City hospitals
- Electricity supply
- Markets
- Palm houses and parks
- Police and Fire Brigade
- Public libraries
- Public museums



- Refuse destructors
- Schools
- Sewage farms
- Tramways
- Water supply

Not to mention numerous civic buildings and joint ventures with voluntary organisations and businesses.

By the end of the Second World War the City could boast one of the biggest and strongest systems of Local Government and public services not just in the country but internationally. The Medical Officer of Health presided over a public health department, which included community nurses and health visitors, social workers, environmental health officer and others. According to Fraser, altogether this totalled a staff of 6,500 persons of all grades including doctors, nurses, clerks and technicians.¹²

One clear feature of the structure of the public services at this time was their rigidly hierarchical nature. Equally clear was the still paternalistic value system, which underpinned it. You had good done to you partly for your own benefit but also to ensure that there was good order and that business was efficient and successful. The threat of unemployment and the workhouse kept people in line. Self realisation, if it occurred at all, was incidental.

This was in sharp contrast to the aspirations that the landed and business classes held for themselves as demonstrated here in Liverpool. Bishop Jones has recently drawn attention to the Liverpool City's motto¹³ 'Deus nobis haec otia fecit' – 'God has made this leisure for us', which is derived from the writings of Virgil and refers to Rome. This motto simultaneously pins down Liverpool's aspirations as the Rome of the British Empire and for the goal of working in order to be able to enjoy the cultural activities and leisure that a world class City has to offer.



As late as 1931 Ted Ashton could be required to canvass in the general election for his employer who was the Conservative Member of Parliament for Wavertree. My father as a life long Labour supporter had no choice in the matter. This is the certificate he received for helping the Member of Parliament win the election. (Fig 11)



figure 11

More recently (and to keep the anecdotes within the family) my son Matthew was stripping down the railings on his house prior to repainting them, when he discovered that in a prior incarnation the railings were green rather than the current black. And it reminded me that at the height of its Corporate estate and services, the Corporate colour of Liverpool was green – houses, buses, bus-stops, litter bins. You name it - it was green. Corporation tenants could have any colour front door provided it was green – and they were not allowed to keep dogs or cats.

This represents a paternalistic form of what we would now call 'branding' but in this case people were expected to accept the identity of tenant and citizen as a package and had little control or choice over their own lives. (Fig 12)



Evolution of systems of civic governance in England

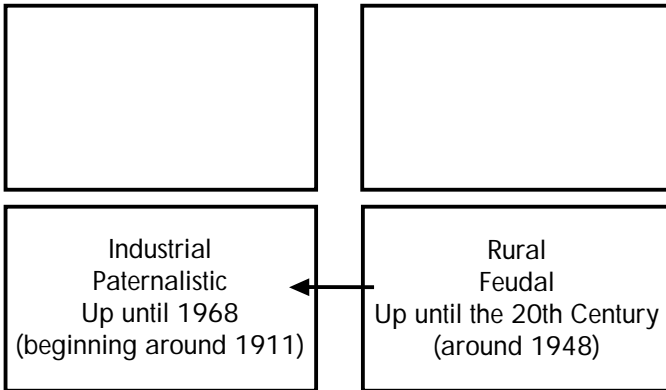


figure 12

If we now fast-forward to the 1970's, certain trends and developments are in evidence. For one thing, the workforce directly employed by the town hall has peaked at something over 30,000 at the same time as the City's population has begun to plummet on the back of major economic structural change and out-migration. We also see dramatic falls in fertility rates (in this most Catholic of cities) contingent on the increasing availability of contraception, not least the oral contraceptive pill, and changing expectations of women. But perhaps above all, we see the beginnings of the end of industrial paternalism, with the growth of consumerism vividly symbolised here in Liverpool by pop-culture and the Beatles. (Fig13)



figure 13



Between 1961 and 1991 the population of Liverpool went from 745,800 to 474,500 and the annual number of births from 16,500 to 7,000 and by 2001 is estimated to go down even further. (Fig14)

Change in Liverpool population 1961 - 1991 and projected population for 2001

	1961	1991	2001 estimated
Population of Liverpool	745,800	474,500	456,400
Number of births in Liverpool	16,500	7,000	5,100

figure 14

On the other hand, local Government was being centralised into the Town Hall and Dale Street and away from the urban district councils and Town Halls that existed within the City such as that in Wavertree. There was also a move away from locality service provision which had been such a feature of for example; district nursing, health visiting and district environmental health officers along with the disappearance of dedicated site specific staff such as the park keeper, school groundsmen, cockie – watchmen etc.

In the early 1970's with the implementation of the Seebohm report (1968)¹⁴, and Local Government reorganisation in 1974¹⁵, Social Services departments that were formerly under the jurisdiction of public health were hived off. The same fate befell the remainder of the public health functions as the Medical Officer of Health himself (sic) disappeared to crop up later as a short lived community physician who seems to have had little to do with the community and was unrecognisable as a physician. As has so often happened in our history, we threw the baby out with the bath water – just think about the overhead railway, (Fig 15) which was demolished just when the need for an urban mass transit system was appearing on the horizon.



Environmental health departments were created, and health visitors and community nurses began a nomadic existence with a range of homes over the next couple of decades. What began as a problem of emergent professionalisation of different groups struggling to escape the hegemony of the Medical Officer of Health was answered by the creation of a range of compartmentalised empires and a fragmentation from which we have yet to recover over twenty five years later.



figure 15
The
Overhead
Railway



figure 16
The medical
Officer of Health
as Humpty
Dumpty

Since the 1970s we have seen the privatisation of water and sewerage, public transport, housing, refuse collection and leisure services. We now have local management of schools, policing is at the county level with the loss of the local watch committees. Other major aspects of municipal public health have been eroded or lost, sometimes with serious implications for the public's health

Humpty Dumpty in the shape of the Medical Officer of Health had truly fallen off the wall. (Fig 16)

The challenge in the 1970s was that of multidisciplinary working, as it remains today. The sense of accountability for public services to the local population was slipping away in the 1970s and has accelerated since then. Not just within the local system, but Regionally to Europe and as part of the accelerating globalisation of trade that has since run on without checks and balances.



Locally this situation was compounded by centralisation and a growing confusion about whether the purpose of public service was to provide services to the public or public sector jobs. Here in Liverpool in the early 80's the refuse collection had become one of the most expensive in the country and one of the least efficient and effective, with the same number of men employed as when the City had had a population some 25-30% larger.

However, at the same time, average household waste had grown from one dustbin of rubbish per week to two, three or more. The average household now produces approximately 16kg of rubbish each week¹⁶ and the Department of Transport, Environment and the Regions (DETR) estimates that the amount of household waste we all produce is increasing at a rate of approximately 3% per year, a symptom of the ecological crisis threatening the planet. One cannot help but speculate that one hundred years earlier this issue itself would have been tackled with more vigour.

If ever a great City had lost its way compared with the magnificence and creativity of its earlier efforts and reputation it was Liverpool during those bitter days of the early years of the Conservative Government of the early 1980's.

Yet when the definitive history is written, the interaction of a proud, seriously wounded, militant but increasingly nostalgic local population with an intransigent and determined national Government must surely be part of the analysis. And the notion that what was going on in Liverpool was different in kind rather than extent from what was happening in other towns and cities not just in England, but internationally will surely be challenged.

White Papers from the new administration on Modernising Government¹⁷ and those from the Department of the Environment Transport and the Regions (DETR) on local democracy and community leadership;¹⁸ together with more local reports such as the report of the Liverpool Democracy Commission 'The Future leading of Liverpool' and the final report of the North West Constitutional Convention¹⁹ proposing new ways of strengthening systems of governance within the North West; indicate that at last these problems of local governance are being recognised and are beginning to be addressed. There is a new sense of purpose in Liverpool and on Merseyside.



figure 17
Voter Turnout in Liverpool Wards - 2000

Ward	Turnout as % of electorate	Ward	Turnout as % of electorate	Ward	Turnout as % of electorate
Abercromby	11	Fazakerley	17	Valley	21
Smithdown	11	Anfield	17	St Mary's	21
Granby	13	Dovecot	18	Tuebrook	22
Arundel	14	Melrose	18	Croxteth	22
Kensington	14	Clubmoor	18	Netherley	22
Pirrie	14	Old Swan	19	Allerton	23
Everton	16	Aigburth	19	Vauxhall	23
Breckfield	16	Speke	19	Church	25
Warrbreck	16	Dingle	19	Childwall	26
Picton	16	County	20	Grassendale	27
Gillmoss	17	Broadgreen	20	Woolton	28

The extent of alienation of the public from the institutions which purport to work for them is however indicated by the almost surreal levels of turnout in the most recent local elections (Fig 17) and the European elections, not to mention the recent fuel protests and political furore over pensions. (Fig 18)

Interestingly Woolton ward with the highest voter turnout has the lowest standardised mortality ratio. The link between voter turnout and health is significant and is clearly demonstrated in these graphs. (Figs 19, 20, 21)

Whilst the higher turnout in the 1997 elections can in part be seen as a protest vote against a very unpopular administration, the overall trend in voting participation levels is all in the same general direction – down.



figure 18
Pensioner Protest



Correlation of voter turnout with housing stress score for Liverpool wards

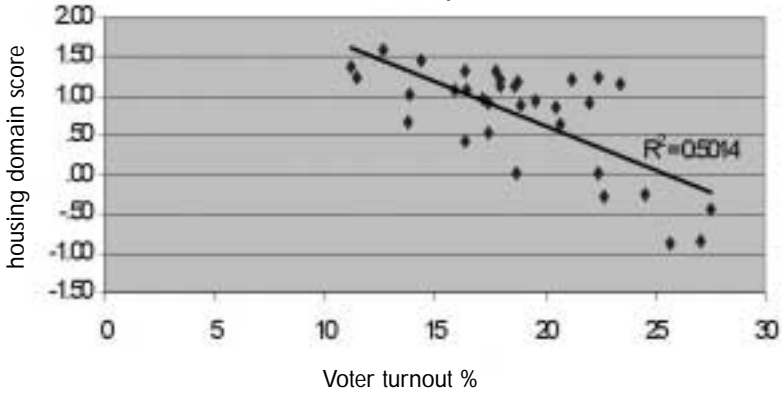


figure 19

Correlation of voter turnout with child poverty index for Liverpool wards

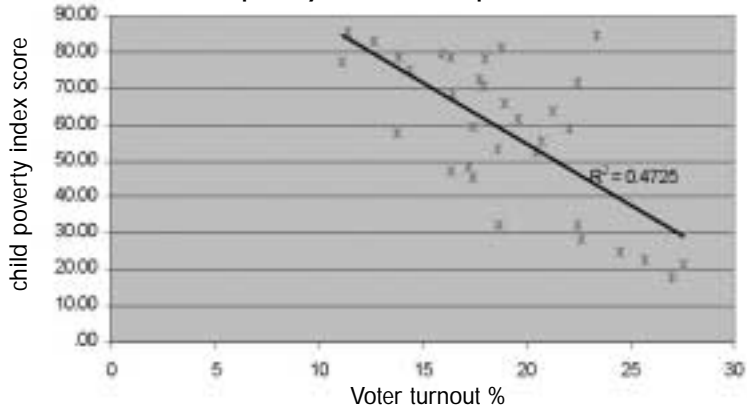


figure 20

Correlation of voter turnout with natural logarithm of standardised mortality ratios for Liverpool wards

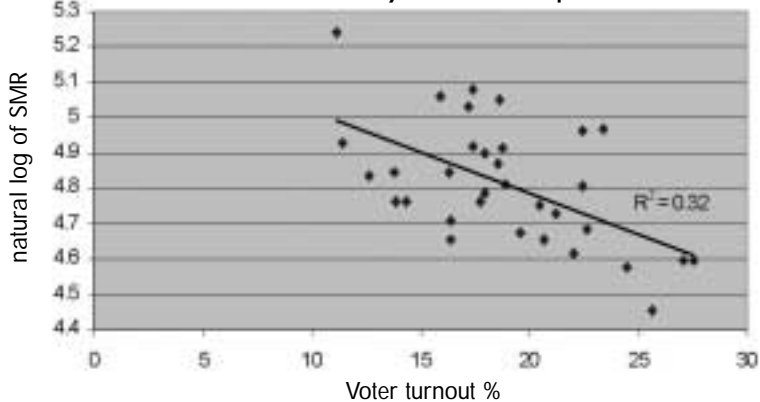


figure 21



This is in sharp contrast to the phenomenal turnout in the first democratic elections in South Africa, which returned Nelson Mandela as President. Where the disadvantaged felt that they had some prospect of benefiting from participating in the democratic process.

But at the heart of these accelerating events was a truth which had yet to be grasped – the world was changing fast and institutions that had been fit for purpose for one hundred years or more were falling behind. Structures had come to dominate function. Democracy, accountability and the processes of governance were themselves heading for crisis. The simplistic notion of a return to unregulated markets as a panacea was only going to compound the threats not only to the health of the poor but to the protection of the population's safety as a whole

(Remember Hillsborough, (Fig 22) Kings Cross, Piper Alpha, Herald of Free Enterprise etc.)



figure 22
Hillsborough Football Ground





figure 23
Inscription above the door of the public health department in Southwark, South London

We found a whole new meaning to 'jerry building' with housing standards abandoned to the market and to speculative builders. The integrity of the environment upon which all our health depends was under threat (privatised

water, cowboy animal husbandry and food hygiene practises, chemical cocktails deposited in disused mine – workings and landfill sites, the destruction of the quality of life and of the ozone layer by greenhouse gases, the list goes on and on).

If Disraeli, quoting Cicero had been able to claim that “the health of the people is the highest law” (Fig 23) and if the Victorians had a clear understanding of both the determinants of health and of the need to build good public health on municipal governance and accountability, his inheritors 100 years later had fallen for the most fundamental confusion between health and health services. If professional and trade union considerations had come to dominate and threaten the collective arrangements to promote and protect the health of the population in the town hall, they were no less of a threat when public health was entrusted to the National Health Service as it was now construed - one dominated by an infatuation with the germ theory of disease; magic bullets for all illnesses and a rush to construct ever larger more technical and increasingly unaccountable acute hospitals. And all threatened by untrammelled commercialisation – in the aftermath of the collapse of communism. David Korten's warning of a world dominated by a small number of global corporations and brands and a new feudalism has come to seem a distinct possibility.²⁰

The Health of the People

We know from the work of Thomas McKeown and other earlier work that the primary determinants of health lie outside health services.²¹ For example the definition of public health used by Sir Donald Acheson in his 1988 review of Public Health in England²², prompted by the most fundamental failure of public health protection measures; two major outbreaks of communicable disease – salmonella food poisoning at a Hospital in Wakefield in 1984 and Legionnaires' Disease at Stafford in 1985, was a reworking of the definition put forward by Charles Edward Winslow, . The Dean of Yale School of Public Health in 1920 – “Public Health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the education of the individual in principles of hygiene, the organisation of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.”

This understanding was clearly widespread in the nineteen thirties and forties with the medical historian Sigerist noting in 1941²³ that any national health programme should include:-

- Free education including health education
- The best possible living and working conditions
- A system of health institutions and medical personnel available to all responsible for the population's health, ready and able to advise and help them in the maintenance of health and in its restoration when prevention has broken down
- Centres of medical training and research.





figure 24
Beveridge fighting the five giant evils

Beveridge's report in 1942, (Fig 24) representing as it did a consensus about the appalling effect of the recession in the 1930's and the sacrifices of war specified 'Five giant evils; Upon the physical Want with which it is directly concerned, upon Disease which often causes Want and brings many other troubles in its train, upon Ignorance which no Democracy can afford among its citizens, upon the Squalor which arises mainly through haphazard distribution of industry and population, and upon the Idleness which destroys wealth and corrupts men, whether they are well fed or not, when they are idle.'²⁴ And when the National Health Service came in 1948 the form it took had three arms:-

- The hospital services
- General practice, dentistry, pharmacy etc
- The wider range of Local Authority Public Health Services (already specified)

It is the last of these which has been so overlooked in recent years since the sloppy use of language has equated health with health services, and the health care system with the much wider health system which supports and protects our health. This system includes our environment as a habitat, which provides for our daily needs of shelter, safe food and water, clean air and our social networks of support.



John Kretzman, speaking at the recent conference on Communities Developing for Health at Salford University in a paper entitled 'Building Capacity from the Bottom up' captures the essence of the error we have made....

'...We asked the epidemiological question of our friends in the medical school at North Western University (Chicago) where does health come from?'

They said that if we wanted to boil down the millions of pages written about this, these five things would determine whether or not people were healthy:-

People's personal behaviour. Do we eat well? Do we exercise? Are we stopping smoking?

Our social relations. Are we part of a network, extended kin, community – for both mental and physical health? Are there supportive sets of relationships in our lives?

The state of the physical environment. Can we breathe the air? Drink the water? Is the food safe to eat?

Our economic status when we need to enter the market place, can we do so in a powerful enough way to get what we need?

Access to therapy. When we are sick do we have access to doctors and nurses, clinics and hospitals and so on.

And Kretzmann tentatively proposes a sixth, spiritual dimension, by which he does not appear to be talking about organised religion, which so often seems to be at the heart of hatred abuse and war.

He goes on to make the point that when asked which is the most important determinant of health there is confusion but that there is a general recognition among epidemiological researchers that health services are the least important yet they account for 95% of policy deliberations.





figure 25
Advertisement for
Sunlight Soap

To conclude this section I would return to Thomas McKeown. What emerges from McKeown's analysis is that the environmentalism of the 1840-1870 period, rooted as it was in the town hall gradually gave way to an emphasis on personal hygiene and preventive measures (Fig 25) in which much more partnership with the public was necessary but then to a therapeutic domination in which the professionalisation process and domination by acute institutions was more apparent. What Illich described as the appropriation of health by professionals. Of course GB Shaw saw into this much earlier when he said that 'All professions are conspiracies against the laity'²⁵

I now wish to say a few words about the renaissance of public health which has been taking place both here and abroad since the 1970's and to consider the challenges posed not just by the specific issues we face but by the dilemma of the marginalisation of the public from the broad public health agenda which will take us full circle to issues of governance and citizenship.

There is a litany to the New Public Health, which began to emerge about the time of McKeown's Nuffield lecture on the Role of Medicine, published in (1976)²¹. It includes the work of Julian Tudor-Hart on the inverse care law (1971)²⁶; that of Peter Townsend on Inequality and the Health Service (1974)²⁷; Jerry Morris asking whether Health services are important to people's health (1980)²⁸ but in particular Marc Lalonde's report, 'A new perspective on the health of Canadians'²⁹ published in 1974 and which paved the way for a renaissance of prevention leading to the concept of health promotion and in due course to actual strategies for health rather than just treating illness. In 1975, Ivan Illich famously challenged medicine suggesting that it was more a part of the problem rather than a part of the solution.³⁰ And most importantly when that most bureaucratic of organisations, the World



Health Organisation sponsored the conference on Primary Health Care at Alma Ata in Kazakhstan in 1977 which distilled the emergent critique of the hi-jacking of health by the acute hospital into three strands³¹

The Alma Ata declaration argued that what was needed was;

1. The re-orientation of Health Services towards Primary Care (within a public health framework)
2. Partnerships between different sectors and agencies
3. Public participation and an emphasis on community development

The colonialistic export of inappropriate models of public health; with the marketing of acute hospitals and professionalised staff to the detriment of traditional systems for public health and public health care was challenged. And before long it was realised that this challenge was as relevant in the so-called developed world as in the so-called developing.

Strategic shape was given to the new thinking when WHO adopted its strategy of 'Health For All by the Year 2000' in 1981 and the i's were dotted and the t's crossed of what the new public health practice should look like with the Ottawa Charter for health promotion³².

- Build policies which support health (or healthy public policies as Peter Draper and Nancy Milio had been describing them)^{33,34,35}
- Create Supportive environments (economic, social and physical)
- Strengthen community action
- Develop personal skills
- Reorientate health services. The role of professionals is seen to encompass advocacy, enabling and mediation for health.



The advent of the Healthy Cities initiative in 1986, with Liverpool as a founding City and Manchester later joining in, resonated with the work of the Health of Town Association making the connections of joined up politics, policy, governance and practise.³⁶ Sadly to me as one of its protagonists, I feel that it has still not realised its potential despite a great deal of hard work by many people. Too often the rhetoric is spoken and the boxes ticked whilst the practise seems to remain the same. When we began Healthy Cities in 1986, it was intended to mark the point when the ideas of 'Health for All by the Year 2000' were 'taken off the shelves and into the streets of Europe.'

Taking our cue from the charismatic author of 'Health For All', Dr Halfden Mahler we envisaged 'Healthy Cities' initiatives as 'Health Virus Factories' programmed to infect all main work areas, not just of City Councils, but also of the private and voluntary sectors which can and do impact on health. Reorientation, Health Impact Assessment and mainstreaming were key ideas. So too were ideas about creating the great debate about health within the City using all the avenues available to do so – schools, art galleries and museums, shops, cinema and theatres and public open spaces. Eventually reconnecting to that Victorian understanding of how the whole urban system affects health.

If we were to run 'Healthy Cities' across a template that included Objective 1, partnership working, Local Agenda 21 and sustainable transport, to test the real incorporation of public participation, explicit use of health impact assessment and real front line empowerment of public servants to make a difference. How far have we really come? How influential has 'Healthy Cities' been in bringing a holistic perspective to bear on all these areas of everyday life, which affect health? To what extent have professionals and public bodies that affect health changed their style of working?

A small example, but one of the apparent success stories of the Merseyside Health Action Zone – the Alley Gates, (Figs 26, 27) has resulted in reduced crime and increasing security and cleanliness. But have we missed the opportunity to go beyond the functional and to enhance the built and living environment and human spirit through imaginative and high quality design?



Alley Gates



figure 26



figure 27

Would this happen or have happened if citizens were truly empowered as opposed to being consulted somewhere near the bottom of Arnstein's ladder of participation;³⁷ (Fig 28) perhaps with neighbourhood groups working with design students from Liverpool John Moores University

1 Manipulation and 2 Therapy. Both are non participative. The aim is to cure or educate the participants. The proposed plan is best and the job of participation is to achieve public support by public relations.

3 Informing. A most important first step to legitimate participation. But too frequently the emphasis is on a one way flow of information. No channel for feedback.

4 Consultation. Again a legitimate step with attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window dressing ritual.



figure 28
Arnsteins Ladder of Participation



5 Placation. For example, co-option of hand-picked 'worthies' onto committees. It allows citizens to advise or plan ad infinitum but retains for power holders the right to judge the legitimacy or feasibility of the advice. Is this the core British approach, with the great and the good running every committee and quango?

6 Partnership. Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.

7 Delegated power. Citizens holding a clear majority of seats on committees with delegated powers to make decisions. The public now has the power to assure accountability of the programme to them.

8 Citizen Control. Have-nots handle the entire job of planning, policy making and managing a programme, e.g. the neighbourhood corporation with no intermediaries between it and the source of funds.



We have some real examples of citizen control, particularly with co-operatives in the housing sector such as the Eldonians in Vauxhall, as well as other projects in West Everton, the Dingle, Speke, Garston, Norris Green and Croxteth. They seem further away when it comes to the health services themselves.

And how often do our public organisations venture beyond manipulation and therapy? How real are our partnerships and how frequent is delegated power? How rare is citizen control?



Where on Sherry Arnstein's ladder do we place our Liverpool Vision and the proposals for Chavasse Park? (Fig 29) Or the bid for Liverpool to be the City of Culture in 2008?

Is this a breakthrough in citizen control or merely a clever device for design and build developers to wrap themselves in international design, open their carpetbags and toss out some scraps of consultation?

So we have moved on. We had the Health of the Nation³⁸ and now we have the Public Health Strategy for England, 'Saving Lives; Our Healthier Nation'³⁹ and we have the NHS plan⁴⁰ which begins to identify a new Regional agenda for Public Health to be set alongside the evolving agenda of Regional development, regeneration and devolution.

'By 2002 there will be new single, integrated public health groups across the NHS regional offices and Government offices of the regions. Accountable through the regional director of public health jointly to the director of the Government office for the region and the NHS regional director, they will enable regeneration of regions to embrace health as well as environment, transport and inward investment.'

As Regional Director of Public Health, I relish this challenge.

We also have a plethora of area and group based policy initiatives from different Government departments, which have implications for public health. (Fig 30)

This is but a sample of the initiatives, which need to be brought together and made to count in improving the lot of ordinary citizens. We also have challenges ahead which differ from those in the past whilst resonating with them.



Department	White Paper	Date
Home Office	Time to Reform: Proposals for the Modernisation of our Licensing Laws Cm 4696	April 2000
Ministry of Defence	Modernising Defence	Dec 1999
Department of Trade and Industry	Choking Risks for Children under four from toys and other objects	Nov 1999
Department of Trade and Industry	Modern Markets: Confident Consumers Cm 4410	Oct 1999
Department of Health	Saving Lives: Our Healthier Nation Cm4386	July 1999
Department of Social Security	A new Contact for Welfare: Children's Rights and Parent's Responsibilities Cm 4349	July 1999
Foreign and Commonwealth Affairs Office	Partnership for Progress and Prosperity Cm 4264	Mar 1999
The Cabinet Office	Modernising Government Cm 4310	Mar 1999
Ministry of Agriculture Fisheries and Food	Food Standards Agency - Consultation on the Draft Legislation Cm 4249	Jan 1999
Department of Trade and Industry	Our Competitive Future - bridging the knowledge driven economy Cm 4176	Dec 1998
Department of Health	Smoking Kills, A White Paper on Tobacco Cm 4177	Dec 1998
Department of Health	Modernising Social Services Cm 4169	Dec 1998
Department of the Environment, Transport and the Regions	A New Deal for Transport; Better for everyone Cm 3950	July 1998
Department of the Environment, Transport and the Regions	Modern Local Government; In Touch with the people	July 1998
Home Office	Fairer, Faster & Firm - A Modern approach to immigration and asylum Cm 4018	July 1998
Department of Trade and Industry	Fairness at Work Cm 3968	May 1998
Ministry of Agriculture Fisheries and Food	The Food Standards Agency - A force for change Cm 3830	Jan 1998
Department of Health	The New NHS - Modern Dependable Cm 3807	Dec 1997
Home Office	Your Right to know Cm 3818	Dec 1997
Department for International Development	Eliminating World Poverty Cm 3789	Nov 1997
Home Office	No More Excuses - A new approach to tackling youth crime in England and Wales. Cm 3809	Nov 1997
Home Office	Rights Brought Home: The Human Rights Bill Cm 3782	Oct 1997
Department for Education and Employment	Excellence in Schools Cm 2681	July 1997

figure 30
Recent White Papers



The New Citizenship

So where does this leave us when it comes to health and citizenship? We know what the menu is if we are to enjoy a long, full and healthy life.

- Planned parenthood
- High quality food and clean water
- The elimination of child poverty
- Good educational opportunities for all
- Safe, life enhancing affordable housing
- Full and satisfying employment
- Access to recreational and cultural diversity
- High quality personal medical and social care

Set in the context of;

- Good personal relationships and supportive social networks
- Sustainable environments
- Freedom of information
- Social solidarity, valuing diversity and a commitment to equity

How can we ensure that there is empowerment, participation and accountability with regard to the determinants of these matters, what Richard Titmuss called 'control over resources through time.' Staying with Titmuss for a moment, there is clearly a clash of ideologies between Titmuss's 'gift relationship' which recognises the essential interdependence that people have on each other. Whether it is in providing blood donations, or ensuring supply lines of fuel, or of the intergenerational solidarity that provides education for children on the one hand and pensions with health and social care for the elderly on the other and the 'no such thing as society' school of thought based on the ugly values of 'dog eats dog'. Recent events such as the fuel strike, the pensioner protests and the row over marijuana have brought into focus just how fragile our social institutions are when it comes to dealing with the competing claims of very disparate groups. In a world of multiple choices for some and occasionally for the many, where many young people choose to use



marijuana in the same way that older people use gin and tonic, malt whisky or good red wine, it is important to clarify the legitimate intervention in individual behaviour by Government and public servants. Writing in the middle of the nineteenth century, Neumann argued strongly that the State had a duty to protect people's health, as this was the only property that most people had. And there was a general acceptance by all political parties that the State had a role in protecting property. On the spectrum for legitimate public health protection to meddling 'nanny state' and intolerance, where do we place;

- Policies to tackle global warming, including comparatively high fuel taxes
- Ensuring safe streets
- Protection from BSE and variant CJD (sustainable agriculture)
- Fluoridation of water supplies versus dental caries
- Policies on genetically modified foods
- Initiatives to tackle teenage pregnancy
- Personal use of marijuana?

When the gin and tonic users criminalise the 'spliff' users and the workers are reluctant to stomp up for pensions, how do we mediate and find consensus?

Changing Demographic factors such as;

- greater longevity,
- increased mobility with its urban drift - which starts in the rural villages of the third world and finishes in the cities of the developed world,
- differences in values and faiths, including now many with no formal religious beliefs,
- huge economic disparities,

mean that we now exist in a society with multiple heterogeneous groups, each with competing demands and seemingly little in common.



The changes in expectations that have been brought about by;

- material advancement,
- the massive extension of higher educational opportunity,
- the globalisation of trade,
- increased travel, knowledge and information

mean that traditional relationships have all been thrown up in the air and the result is manifest in a variety of forms.

Whether it is;

- ethnic cleansing, genocide and war, as in Kosovo (Fig 31,32,33,34)

Kosovo Refugees



figure 31



figure 32



figure 33



figure 34



- the antagonism expressed towards refugees, asylum seekers, rough sleepers or beggars.
- The fear hatred and intolerance shown by residents of the Paulsgrove estate this summer.
- the unresolved bitterness and grief of the Hillsborough families;
- The grief and anguish and demand for answers by the Alder Hey families (Figs 35, 36)

Alder Hey makes the headlines



figure 35



figure 36

- the outrage felt by many about nuclear power, genetically modified foods, BSE; location of mobile phone masts or incinerators
- the militant attitudes towards induced abortion and contraception that translate into bombed clinics or murdered doctors and which surfaced on Merseyside this year.
- the dire state of many farmers in the aftermath of the BSE scandal and the collapse of much of British Agriculture, coupled with the reckless and antisocial behaviour shown by farmers and hauliers in September. (Fig 37)



figure 37
Arrest of a Haulier



- the apparent impotence of citizens and Government to act in the face of global warming and environmental degradation.
- the progressive privatisation of public space and of the worlds commons which include the oceans, outer space and the airwaves, as well as traditional commons, footpaths, sports grounds and coastlines.
- the emergence of new and frightening diseases.
- The threat of the return of the workhouse in virtual form wherein people live in poverty behind closed doors unable to participate – the socially excluded.

Some of the strands which link them all are;

- the loss of a shared ethical framework and set of common values,
- the sense of powerlessness,
- the loss of sense of community and control,
- fear of a changing world,
- jealousy, envy and pride,
- poor leadership in many quarters,
- lack of accountability of our institutions and of powerful professional and other groups,
- no adequate systems to mediate between conflicting groups, interests and needs,

And as a result, hatred and conflict are on the march again;

- In Northern Ireland
- The Balkans
- Jerusalem
- And on our own streets and in our cities.
- In Paulsgrove, at Stanlow, in Seattle and Prague at the World Trade Organisation meetings. With recurrent incidents of racist attack, including the now notorious murder of Stephen Lawrence.



We seem to have found new people to hate and new ways in which to hate them. We have lost sight of the central importance of tolerance in co-existence that is so important if we are to avoid hatred and maintain peace and security at home and globally as the fundamental prerequisite for life and health.

As Helen Keller pointed out in *Optimism* in 1931; 'Tolerance is the most important consequence of education: in earlier times people fought and died for their convictions, but many centuries had to pass before they understood another form of courage; that is – to recognise the convictions of their close ones and their right to freedom of conscience. Tolerance is the highest law of each community and it is that spiritual factor which protects all that is best in the thinking of people. No loss from flood, no fire, neither destruction of cities and churches by the inimical forces of nature – has not robbed humanity from so many noble lives and intentions as it was destroyed by mutual intolerance⁴¹'

My good friend and colleague from Croatia - Slobodan Lang has called for the establishment of 'Hate Watch.'

And as Piet Hein succinctly put it in one of his grook poems;

'Co – existence or no existence'

It seems that everywhere people are struggling to have their voices heard and that frequently there are no mechanisms for that to happen. The danger to all of us is that the ensuing frustration will spill over into anger, hatred, violence and war.

We urgently need to find ways to have the benefit of all these voices.

In the end it comes down to a matter of enlightened self interest that we should on the one hand live and let live, but on the other that we should all do so within a framework that protects the weak, does not tolerate injustice and which does not prejudice the integrity of our habitat, the planet earth. To paraphrase Charles Dickens 'it was the best of times, it was the worst of times.' On the one hand we have never had it so good or had more knowledge or power at our fingertips, but on the other as Schweitzer presciently pointed out forty years ago 'man has lost the capacity to foresee and to forestall, he will end by destroying the world'.



In the section entitled 'And no birds sing' of her treatise 'Silent Spring,' Rachel Carson poignantly described the impact that agribusiness and chemistry was having on bio-diversity⁴². Epidemic obesity and the demise of the garden sparrow and other species are part of the price we are paying now for not listening in 1962.

As an optimist, as the one who always prefers to see the glass half full rather than half empty, I do see light at the end of the tunnel in the form of a convergence of agendas, but there often seems to be a distinct lack of urgency at all levels. The philosophy of 'above all – do no harm' whether through personal or collective actions should be central to all policy – economic, environmental and social as well as biomedical. The imminent publication of the Phillips enquiry into BSE will forcefully remind us of what happens when simplistic science and commerce collude in the absence of strong public scrutiny and adequate governance systems.

We must as the Native American Indians knew and have told us 'look after the things that look after us;' reciprocal maintenance and the precautionary principle - 'Above all do no harm.'

We will not be able to shop our way out of the impending ecological crisis and its impact on our public safety and health.



The Future

The future will be different from the past. 'Upwards and onwards' (Fig 38) as the 'Whigs' liked to describe life has rarely been the reality of the human journey.

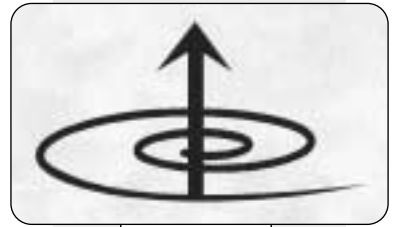


figure 38

At the very least, history is a helix rather than a pendulum, returning to a further point in time to a changed environment rather than just swinging back and forth. But it is also increasingly discontinuous. Not just the 'Spinning Jenny', but also the oral contraceptive pill and the Internet have all produced discontinuous changes of dramatic proportions. Our systems are not fit for purpose; for World Citizens with multiple roles and identities, needs, demands and claims.

It is my belief that we are in the early stages of gestation of something new and qualitatively different, which could put fit for purpose systems into place

Chris Gates, President of the National Civic League, an organisation established one hundred years ago in the United States 'in opposition to corrupt, inefficient or slothful governance;' to build capacity in governance, has talked about the concept of 'civic infrastructure' and asks the question 'Why do some Cities ... succeed in solving their problems while others don't?'⁴³

According to Gates a community must have strong leaders from all sectors who are able to work together ... to reach consensus on those strategic issues that face the community and the **Region** around it. Gates emphasises the importance of regional citizenship. Do citizens have a sense of living in a Region as well as in a City / Town or State? That is do they think of themselves as Regional Citizens?

Gates goes on to claim that 'leadership increasingly resides in the many rather than the few; in joint rather than individual endeavours; and in the

empowerment rather than in the control of others ... Improvement (in leadership) will occur as position are attained by more persons who have a strong sense of self, a large philosophical value system and the ability to empower others to learn and contribute individually and together as co-leaders.'

Under Gates' leadership the Civic League has proposed a ten component Civic Index for use in assessing the fitness for purpose of municipal governance.

- 1) Citizen participation
- 2) Community leadership
- 3) Government performance
- 4) Volunteerism and Philanthropy
- 5) Intergroup relations
- 6) Civic education
- 7) Community Information and sharing
- 8) Capacity for co-operation and consensus building
- 9) Community vision and pride
- 10) Intercommunity co-operation

Behind this list of elements, there exists a rich and powerful tool for measuring the fitness for purpose of a City's governance systems and structures.

This framework is based on an analysis of the crisis in democracy and citizenship that is familiar and has the ring of truth to it. That there is cynicism about political leadership and an assumption about politicians that they have ulterior motives;

- That traditional politics doesn't work any more. It is seen as a defender of the status quo; of people in power versus people not in power and is seen as a conspiracy between the media and political parties not to inform or engage citizens but to manipulate, exploit and use them.



- That we are struggling to move from representative democracy in which we vote (- or don't vote) for people who make all our decisions for us for the next 'x' years, to one in which power and decision making is shared and that there are multiple mechanisms for participative democracy. According to Gates 'We have grown beyond the notion of Government being the sole owner of the public agenda.'

The way ahead

It should be clear by now that the processes by which we collectively solve our problems to meet societies health needs are not fit for purpose. Public health governance is in crisis at whatever level we wish to look.

Within this country, the accountability for housing, water and sanitation, education, policing, public transport, food hygiene and safety, recreation personal health services and many other aspects of everyday life which have major impacts on health have passed out of local democratic hands to shareholders, professionals, civil servants and others. The genie is out of the bottle and it will not go back in. We have moved from a one size fits all parochial world to a multiple option glocal world (global + local = glocal) one where global and local considerations must be given equal time and where local is increasingly either neighbourhood or regional.

The struggle for the new citizenship (local, regional and global) will be dependent on finding multiple ways and opportunities for people to participate and to share both the responsibilities and the benefits of social endeavours. We must redefine the relationship between professionals and the public to bring in advocacy, enabling and mediation.

The mechanisms to support that citizenship may include a range of methods for debate, dialogue and decision making (electronic, more traditional re-empowered forms such as neighbourhood councils, moot courts and reinvented town halls. New roles for co-operative forms of organisation for different communities of interest and devolved powers and control over resources through time)



- At Dartington Hall school the pupils made the rules according to need; with the support of all the staff through a process of moot courts. The need could be identified by any of the stakeholders in the school community. The moots consisted of debate, dialogue, policymaking and rules. They tended to govern community issues and personal and social behaviour including discipline. The students were on the whole very committed to enforcing the policies that they themselves owned.
- In Seattle, as part of the Healthy Cities initiative, KIDSPLACE surveyed the children to find out their views about how Seattle could be improved; a children's mayor for the day was elected and a children's policy committee set up, to scrutinise council policies from a children's point of view.
- In Zagreb, the Medical Officer of Health was available in the Town Hall for one afternoon each month to hear complaints and the voice of citizens on health matters.
- In Vizaghatnam, in India, the Governor and his senior officials were available for one hour each day to be petitioned by citizens on any matter affecting City life.
- In California, local referenda are used to decide many controversial issues.

We need new ideas to enable participation but some of these old ones may yet have life in them. Not least to take Town Halls back into the public domain. For example, at the moment, all Annual General Meetings of Merseyside hospitals are held on hospital premises, some during the daytime. Perhaps not surprisingly, few members of the public attend. Yet we know, from recent events involving Alder Hey and elsewhere, of the enormous interest in health services as well as wider public health issues. Perhaps it is time that meetings of all organisations that affect the public health including for example the water, rail and bus companies, the police authorities and others were held in public locations such as the Town Hall; readily accessible and accountable to the public.

But this agenda runs from the neighbourhood level to the level of the planet itself. Corporate brand logos whether the purple Wheelie bins (Fig 39) or the Starbucks cup of coffee are inadequate to encompass either the variety of





figure 39
Purple Wheelie Bin

individual needs, aspirations and behaviours or the unity of purpose which is needed to safeguard humanity from war and environmental catastrophe. Fortunately it seems that the public is fighting back against a world of brands. We urgently need to develop the new systems of governance based on principals of openness, empowerment, sharing, inclusivity, tolerance of diversity and commitment to equity and sustainability.

I am sure this University, together with the other resources for education and learning in Merseyside and in the North West will have a crucial role in bringing this about.

Liverpool John Moores University has already made a start with its 'Foundation for Citizenship' programme and 'Good Citizenship' awards and the 'Roscoe Century 21 Lectures'. Throughout Merseyside there is a new sense of urgency, optimism and forward thinking in contrast to the cloying nostalgia that so recently had us trapped. But there is still much to be done by all of us; and it cannot be left to a small number of elected or nominated people or self appointed developers. The new citizenship needs to be an active one, and people need to have ways of playing their many parts. Some years ago when the BBC ran a series about the Domesday Book they described a village in the South West of England; out of less than one thousand population, several hundred had active community roles all those years ago.



Evolution of systems of Civic Governance in England

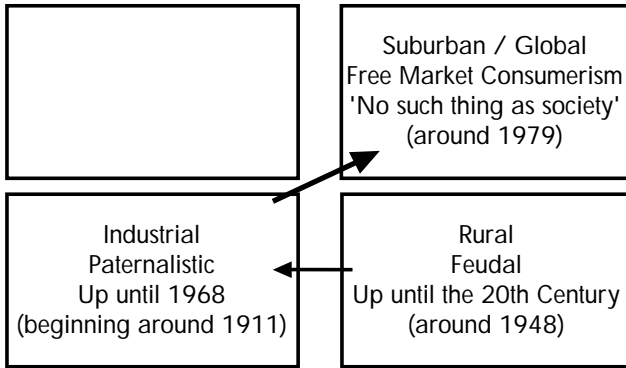


figure 40

I believe that the future will be one which is not about little Liverpool (Fig 40) but Metro – Merseyside; collaborating together with Greater Manchester as part of a vibrant European North West Region (UKNW.) A place where citizenship is as meaningful within your own neighbourhood as in the Town Hall or in the Regional Assembly. (Fig 41)

Evolution of systems of Civic Governance in England

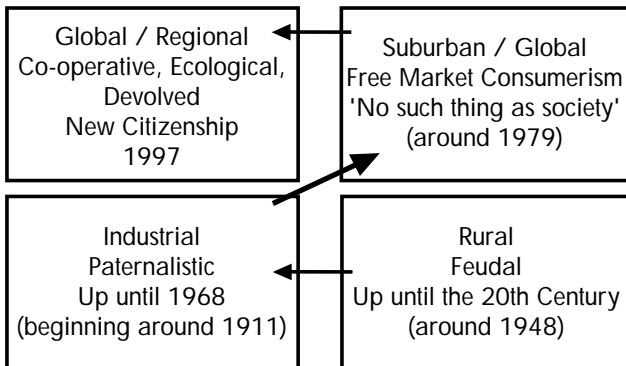


figure 41



Postscript

Many of you will know of some of the recent problems at Alder Hey and that I recently published a report on cardiac surgery at this Liverpool Children's Hospital. (Fig 42) In producing that report our team endeavoured to be open and transparent about something which greatly concerned many parents and Alder Hey staff. The loss of an infant is a terrible tragedy from which many families never fully recover. What we can hope to do is through openness and support provide the possibility of grieving properly. We were trying to set a new tone in public accountability based on the principles, which I have discussed earlier this evening.

I am passionately committed to this way of doing things and intend to press ahead with as much openness as we can achieve about health and health

services in the North West, including making available information about the outcomes of clinical care. But in changing the way we go about our business, we must go forward together. It is much easier to change our own behaviour than to change that of somebody else. The future for public health means that we all need to change our behaviour about our relationships to the environment and to the disadvantaged. That is not going to be easy and we will need suitable governance arrangements to help us at all levels, local, regional, national and global.

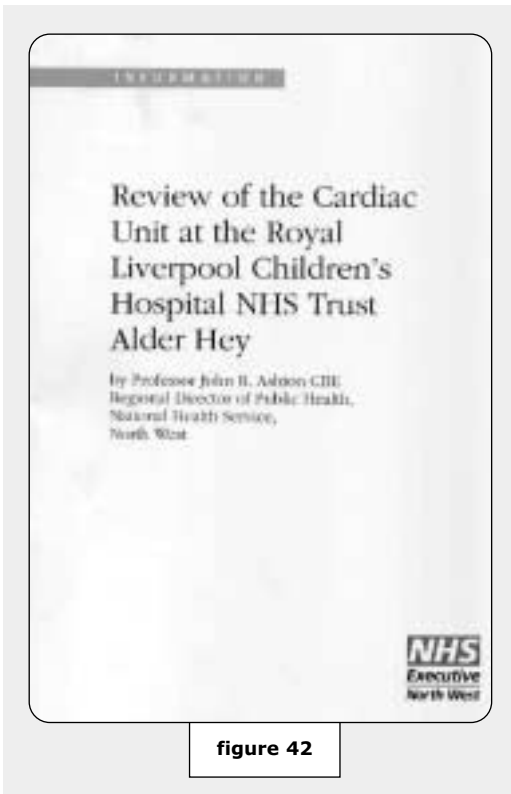


figure 42



When it comes to the areas of everyday life, including health services, which affect health, we must strive for openness accountability and shared responsibility. This has implication for all of us including professionals, private firms, public organisations and members of the public, but not least for those journalists and lawyers who claim to be committed to the search for truth rather than sensationalism or personal prosperity to the detriment of those they purport to help. (Fig 43)



figure 43

I am going to conclude with a poem by Liverpool poet Brian Patten⁴⁴

I would like to thank Brian Patten for the use of his poem.



A blade of grass

You ask for a poem,
I offer you a blade of grass
You say it is not good enough,
You ask for a poem.

I say this blade of grass will do,
It has dressed itself in frost,
It is more immediate
Than any image of my making.

You say it is not a poem,
It is a blade of grass and grass
It is not quite good enough.
I offer you a blade of grass.

You are indignant,
You say it is too easy to offer grass,
It is absurd,
Anyone can offer a blade of grass.

You ask for a poem,
And so I wrote you a tragedy about
How a blade of grass
Becomes more and more difficult to offer,

And about how as you grow older
A blade of grass
Becomes more difficult to accept.



References

- 1 Morris M & Ashton J R (1997) *The Pool of Life; a public health walk in Liverpool*
- 2 Moore W (1996) Like Speaking Unto Like. Medical Education section *Health Service Journal* 3 Oct 1996
- 3 Osborne & Gaebler (1991) *Reinventing Government*. Cited by Smithies J & Webster G in *Community Involvement in Health ; from passive recipients to active participants*. (1998) Ashgate publishing :Ltd Hants England
- 4 Bureau for Development Policy (1997) *Strengthening Capacity for People - Centred Development*. Decentralised Governance Programme, United Nations Development Programme <http://magnet.undp.org/docs/dec/decen923/decenpro.htm>
Accessed on 5th September 2000.
- 5 Duncan WH (1845) '*The Physical Causes of the High Rate of Mortality in Liverpool.*' (Pamphlet based on two lectures delivered in 1843 to the Liverpool Literary and Philosophical Society. Contents are practically identical with the summary of Duncan's evidence to the Commissioners inquiring into the State of Large Towns and Populous Districts.)
- 6 Chadwick Sir E. (1842) *Sanitary Conditions of the Labouring Population of Great Britain* Facsimile edition, edited by Finn MW. Edinburgh: Edinburgh University Press, 1964.
- 7 Liverpool Mercury (1845) Description of the first Liverpool meeting of the local Health of Towns Association.
- 8 GB Parliament. (1846) Liverpool Sanatory Act. Liverpool Town Council Private Bill Quoted in Frazer WM *Duncan of Liverpool*, Second Edition May 1997
- 9 GB Parliament. (1848) The Public Health Act. Quoted in Frazer WM *Duncan of Liverpool*, Second Edition May 1997
- 10 Kearns G & Laxton P (1997) *Doctor Duncan Sets to Work*. Lecture to inaugurate 150 years commemoration and celebration of the work of William Henry Duncan. Liverpool Medical Institute, January 1997.
- 11 Hope EW (Ed) (1903) *Handbook compiled for the Congress of the*



- Royal Institute of Public Health*. Issued by the local executive committee City of Liverpool. Lee & Nightingale, Liverpool.
- 12 Liverpool City Council (1947) *100 year war against squalor and disease*. Local Government Chronicle.
- 13 Liverpool Daily Post (1999) 23rd September
- 14 House of Commons. (1968) *Report of the Committee on Personal and Allied Social Services* (Known as the Seebohm Report.) Cmnd 3703 HMSO London.
- 15 House of Commons. (1972) *National Health Service Reorganisation: England*, Cmnd 5055 HMSO London.
- 16 Tidy Britain Group *Going for Green*. (2000)
<http://www.tidybritain.org.uk/ppreEubank2.htm> Accessed on 10th October 2000.
- 17 Cabinet Office. (1999) *Modernising Government* Cm4310. The Stationery Office, London.
- 18 Department of the Environment, Transport and the Regions. (1998) *Modern Local Governemnt; In touch with the people*. The Stationery Office, London.
- 19 North West Constitutional Convention. (2000) *New Way Forward – No Way Back*. North West Constitutional Convention Final Report, September 2000. Co-ops business Centre, Wigan.
- 20 Korten DC (1995) *When Corporations Rule the World*. Kumarian Press, Connecticut, USA.
- 21 McKeown T. (1976) *The Role of Medicine; Dream, Mirage or Nemesis*. The Rock Carling Fellowship. The Nuffield Provincial Hospitals Trust, UK.
- 22 Department of Social Services. (1988) *Public health in England. The report of the Committee of Inquiry into the future development of the Public Health Function*. A report by Sir Donald Acheson, Chief Medical Officer. Cm 289 HMSO London.
- 23 Sigerist H (1941) *Medicine and Human Welfare*. Oxford University Press, Oxford.
- 24 Inter-departmental Committee on Social Insurance and Allied Services. (1942) *Social Insurance and Allied Services* (A report by Sir William Beveridge.) Cmd 6404 HMSO London.



- 25 Shaw GB. (1906) *The Doctor's Dilemma*, Act I
- 26 Hart JT. (1971) The Inverse Care Law. *Lancet*;i: 405 - 412
- 27 Townsend P (1974) Inequality and the Health Service *Lancet* 1(7868): 1179 - 90
- 28 Morris JN (1980) Are health services important to the people's health? *British Medical Journal*, 280, 167 – 8.
- 29 Ministry of National Health and Welfare, Government of Canada. (1974) *A new perspective on the health of Canadians*. Report by Marc Lalonde, in Ottawa. Minister of National health and Welfare. <http://www.hc-sc.gc.ca/hppb/healthpromotiondevelopment/pdf/perintrod.htm> Accessed on 19th September 2000.
- 30 Illich I (1975) *Medical Nemesis – The Expropriation of Health*. Marion Boyars, London
- 31 World Health Organisation (1978) *International Conference on Primary Health Care* held at Alma Ata, Khazakstan . WHO, UNICEF, Geneva.
- 32 World Health Organisation (1986) *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, Canada, 17 0 21 November 1986. <http://www.who.dk/policy/ottawa.htm> Accessed 19th September 2000
- 33 Draper P (1984) Promoting health through public policy. *Lancet* 2(8416): 1387 – 8
- 34 Milio N (1983) Next Steps in Community Health Policy: matching rhetoric and reality. *Community Health Studies* 7(2): 185 – 92.
- 35 Milio N (1981) Promoting Health Through Structural Change: analysis of the origins and implementation of Norway's farm – food – nutrition policy. *Soc Sci Med A*. 15(5): 721 - 34
- 36 Ashton J (Ed) (1992) *Healthy Cities*. Open University Press, Milton Keynes.
- 37 Arnstein SR (1969) A ladder of citizen participation *Journal of the American Institute of Planners* 35: 216 - 224
- 38 Department of Health (1991) *The Health of the Nation*. A consultative document on a health strategy for England.



HMSO,London

- 39 Department of Health (1999) *Saving Lives: Our Healthier Nation* Cm 4386 The Stationery Office, London. <http://www.official-documents.co.uk/document/cm43/4386.htm> Accessed 7th July 1999
- 40 Department of Health (2000) *The NHS Plan A plan for investment A plan for reform.* Cm 4818-I The Stationery Office, London.
- 41 Keller H. (1931) *Optimisan*, Quoted in Lang S & Ashton J (1999) Tolerance and reconciliation: the spiritual prerequisites to health. *Journal of Epidemiology and Community Health* August Vol 53 No 8
- 42 Carsons R (1962) *Silent Spring* Houghton Mifflin Co. USA
- 43 National Civic League (nd) *The Civic Index; a new approach for improving community life*
- 44 Patten B (1983) *A Blade of Grass* Published in Mersey Poets, Penguin, UK

