

Liverpool
Public Health
Observatory

Professor John Ashton

INAUGRAL LECTURE

30th January 1995

University of Liverpool

A VISION OF HEALTH FOR THE NORTH WEST

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PRE-AMBLE

It is customary on these occasions to acknowledge those who have contributed to the personal journey of discovery which has led to being honoured with a personal Chair such as this. However to do justice to all those who bear some responsibility for my standing here today would take up all the time available. As quite a number of them are present and hopefully know the part they've played – indeed will recognise some of their ideas and inputs – I'll confine myself to three lines of attribution. Sadly, my father to whom this would have been such a satisfying moment has long since passed on.

Firstly, however, having chosen my parents wisely, I seem to have been more than usually fortunate at being in the right place at the right time and in the right company. Whether this observation

applies to my classmates at Mosspsits Primary School must be a matter of opinion. (*Fig. 1*) Some of you may recognise the young girl, 6th from the left in the second row, sitting 2 down from "Big Ears" Ashton as one Edwina Cohen who went on to become a junior minister in the Health Department, and achieved some notoriety in the health field. However it certainly applied to being at Quarry Bank School when Bill Pobjoy was Head and where John Ashcroft introduced me to social history and to political science which are so central to an understanding of public health, to Newcastle Medical School in the late 60's under the red Dean, Henry Miller, and others such as David Shaw, when Newcastle was at the leading edge of community-orientated curriculum development a generation before these ideas reached some of the more

traditional schools. David Shaw is currently responsible for national reform of medical school curriculae; to the London School of Hygiene and Tropical Medicine and the L.S.E. when Jerry Morris, Sidney Chave and Bryan Abel-Smith were continuing and developing a modern social medicine tradition still strongly influenced by Richard Titmuss's clear understanding of the connection between social justice and health, and at Southampton and later with Donald Acheson and his group; to be in working environments with this list of visionaries and innovators was truly to be privileged.

Secondly – being born in Liverpool, the birthplace of industrial public health and steeped in the tradition of the Victorian pioneers must, in my view, give you an acute sense of place and of the possibility to effect change; adding to that



Fig. 2 – St. Peter's Church and Woolton village Liverpool 25.

the richness of growing up at the urban-rural cusp of Woolton Village (*Fig. 2*) in the 1950's which has left me with a fascination for some of the dynamics of urbanisation which I have been so fortunate to explore globally with the World Health Organisation. (*Fig. 3*)

Thirdly, one of the delights of public health is that in touching on virtually every aspect of everyday life you have a carte-blanc to take an interest – some would say to meddle – in just about anything and this brings with it the stimulus, excitement and pleasure of working with an enormous variety of people and disciplines. I am fortunate to work with a superb and extensive team, not only at junction 11 on the M62, but here in Liverpool and across the North West and beyond whose tolerance for the stress I place on them shows almost no bounds; they know who they are and they have my continuing gratitude but those who have had a particular



Fig. 1 – A class at Mosspsits County Primary School Circa 1957. Edwina Cohen Centre

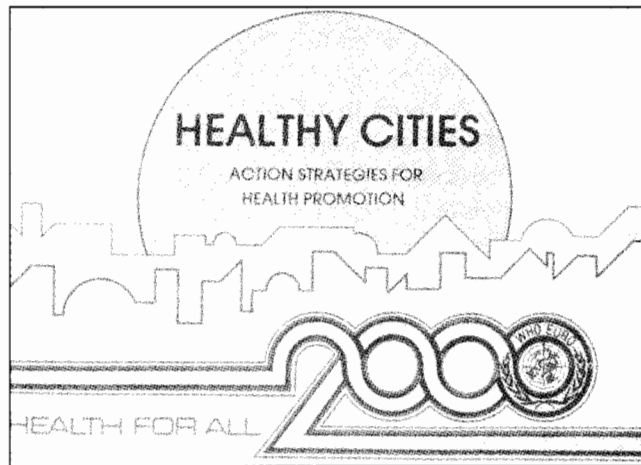


Fig. 3 – The logo of the WHO Healthy Cities Initiative started in 1986 with Liverpool as one of its originators.

input into this lecture include Carol Houghton, Sue Wilson, Debbie Stanistreet, Maggi Morris, Neil Squires, Howard Seymour and Pete Flynn. Lastly, and most importantly, the journey so far has drawn extensively on the daily support of Pam, Keir, Matt and Nick.

And so to the task in hand

BACKGROUND

Since 1st April last year the former Health Region of Merseyside and Cheshire has become part of one of the new 8 Regions which make up the National Health Service in England. (Fig. 4) This new North West Regional Health Authority extends from the Lake District to the Cheshire Plain, from the Irish Sea

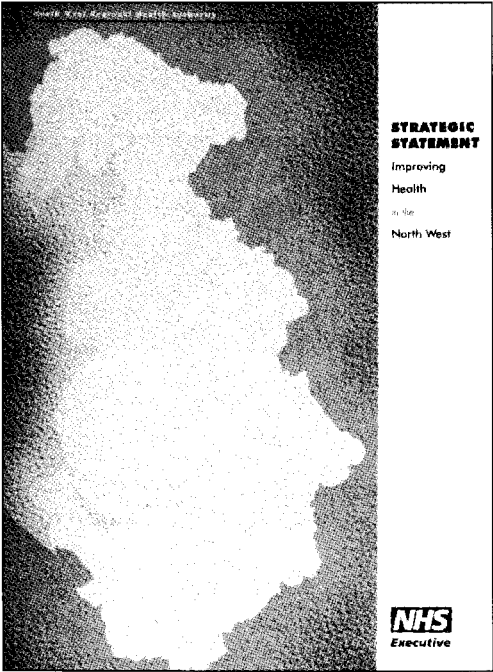


Fig. 4 – The area covered by the new North West Regional Health Authority with a population of 6.6 million people.

to the Pennines. With a total population of 6.6 million people and an annual budget of £3.3 billion, the new Region is approaching the size of a larger Scandinavian country such as Sweden. The roles and responsibilities of the Authority are very different from those of its predecessors and an Inaugural Lecture such as this provides an opportunity to take stock, to review the scope and purpose of such an Authority and the potential that I may have for securing real improvements in the health of the population for which it has responsibility and to explore the contribution of the universities.

The Nature of Health

Our understanding of what we mean by ‘health’ has progressed in recent years and has become much more sophisticated. Whereas traditionally and perhaps rather bizarrely we have measured health in terms of death rates the trend has been towards a search for meaningful ways of capturing the recognition that health is more than just the avoidance of early death. Developing policies to improve health requires a clear and workable definition of what health is¹. One positive definition of health that we have been using at the Regional Health Authority is “the optimal physical and mental functioning that a person is capable of achieving”. A person’s state of health changes over time and there is always a potential to maintain, gain or lose health and well-being. This applies as much to someone who is recovering from a stroke as to someone with no symptoms of ill-health. The implication of this perspective is not only that we are

talking about preventing disability and handicap and the capacity to realise ones biological and social potential but that the endeavour goes far beyond that contained within the parameters of medical care.² Health therefore begins with individuals in their family and social setting and embraces the whole range of human activities from education to culture and the arts, from the provision of safe physical living and working environments to the securing of optimal food supply and safe food and water, from the relationships which we have with each other to those which we have with the environment which sustains us and from personal security to the possibilities of growth and personal development which comes from the successful mastery of challenge and risk. In short it is about the quality of life and more, it is about a system for living. Writing in 1884 William Morris expresses a very modern view:- (Fig. 5)

“At least I know this, that if a person is overworked in any degree they cannot enjoy the sort of health I am speaking of; nor if they are continually chained to one dull round of mechanical work, with no hope at the other end of it; nor if they live in continual sordid anxiety for their livelihood; nor if they are ill housed; nor if they are deprived of all enjoyment of the natural beauty of the world; nor if they have no amusement to quicken the flow of their spirits from time to time; all these things, which touch more or less directly on their bodily condition, are born of the claim I make to live in good health”.³ To have an impact on health as so defined is no small challenge to the new North West! So if this is the

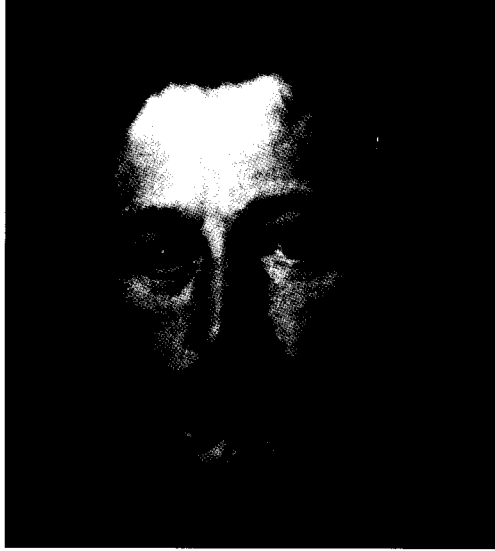


Fig. 5 – William Morris from the portrait by George Frederick Watts published by permission of the National Portrait Gallery.

challenge how are we doing and what must be done?

The Health of Our People

There are three major components to an understanding of the health needs of a population

- (1) the populations structure, characteristics and distribution
- (2) the patterns of health and its determinants within that population
- (3) the capacity and availability of interventions to make a difference.

(1) The Population

Of the 6.6 million people living in the North West, 60% are concentrated in the Merseyside and Greater Manchester conurbations and it is this concentration in the two conurbations as well as the

many quite large towns of Lancashire and Cheshire which gives the Region its urban character.⁴ The North West Region is the third most densely populated in the European Community and is one of only two Regions in the UK with less than 1% of Gross Domestic Product coming from agriculture.

One of the most important features of this population is its concentration in declining urban areas and it is this concentration, together with that of the unemployed and of black and ethnic minority populations, which gives the Region higher levels of deprivation and health need than the national average. In recent decades there has been dramatic movement of the population both within and from the Region with an overall loss of population and a redistribution within the Region away from the conurbations into the more rural areas. Recent forecasts of economic change envisage a continuation of recent trends with Merseyside forecast to have the heaviest population and economic decline.

Comparisons of Health in the former Mersey Region between 1948 when the National Health Service was established and last year when the Mersey Regional Health Authority disappeared (*Fig. 6*) give a flavour of the dramatic changes which have happened across the North West during that time.⁵ In 1948 there were 42,000 live-births in Mersey compared with only 32,000 in 1992, and during this period there have been major changes in fertility rates, family formation patterns and peoples expectations, especially those of women. In 1948 large families were still commonplace, today they are rare. The problem and social

consequences of unplanned pregnancy within established marital unions has been replaced by that of unplanned pregnancy among teenagers who have no intention of having children for many years, if at all. The average age at which women had their first child, even 20 years ago, was about 23 years of age compared to 29 today and on average women today expect to have less than 2.0 children during their fertile life. In 1948 in Mersey the infant mortality rate was 49 out of every 1000 live births; in 1992 this figure was 7. Of this residual toll a majority are now attributable to genetic causes which await breakthroughs in knowledge before further improvements in prevention can be made. And overall of every 100 babies born today in Mersey and the North West,

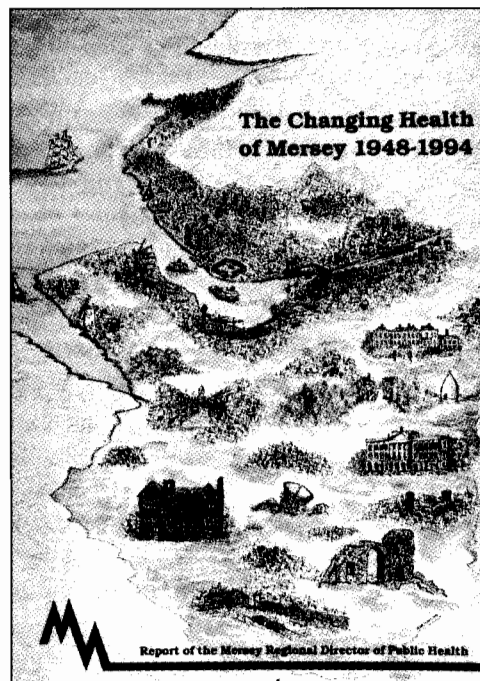


Fig. 6 – Review of the Changing Health of Mersey 1948-1994. Report of the Mersey Regional Director of Public Health

97 have the potential to live a full and long life provided that their health is not undermined by threats from the various environments to which they are exposed (family, economic, social and physical) or from behaviours which they may acquire from them. The remaining three infants have some level of congenital abnormality albeit frequently slight and even for the more severe there are now increasingly remedial measures which can be taken to increase the quality of life. The picture of much smaller numbers of children, born to older women is projected to continue across the North West with the expectation that there will be a further reduction in the numbers of births around 10% during the next 10 – 15 years. A picture then of fewer but healthier children.

On the other hand the dramatic feature of an ageing population is set to continue. Nationally 4% of the population being of retirement age at the turn of the century has come to be approaching 20% today. Regionally the greatest change is in the over 85 age group where rates of brain failure of one-third are commonplace, this group is forecast to double in size numerically between 1981 and 2001. In 1991 the over 75's made up 7% of the population but accounted for 17% of in-patient hospital cases and 46% of hospital beds. Increasingly the issue for the elderly is that of ensuring optimal levels of community-based services to enable them to maintain a high quality autonomous life at home, and to guarantee high quality residential care when that is no longer possible. A particular feature of the elderly population of the Region is their

concentration in retirement coastal areas.

Generally speaking two of the most significant population features which impinge on health are the continuing change in household structure of them. Today the hypothetically normal family unit of two adults plus children makes up less than 30% of the Regions households and the fastest growing household types are lone person, non-pensioner households and single parent households. The relationship between socio-economic conditions and in particular that of poverty and health is clear and unemployment rates are a good proxy of it.⁶ These rates vary enormously across the Region with the highest rate of 21.6% in Liverpool and the lowest of 6.3% in South and East Cheshire. Within the districts of the Region there are even starker contrasts such that in some local government wards unemployment rates in excess of 35% are to be found. *Figure 7* shows the particular concentrations of unemployment rates in our conurbations. In Manchester almost 40% of children live in households with no wage earner. Powerful as some of these stark population based data are in drawing our attention to some of the factors associated with ill-health - numbers, age, sex, race, household type, are themselves increasingly inadequate to allow us to address and come to terms with the processes which underpin the promotion and protection of health and the care which is needed when health is undermined or damaged. Illustrative of the complex changes which are taking place at an accelerating rate are those affecting gender that indicate that on the one hand today's young women have

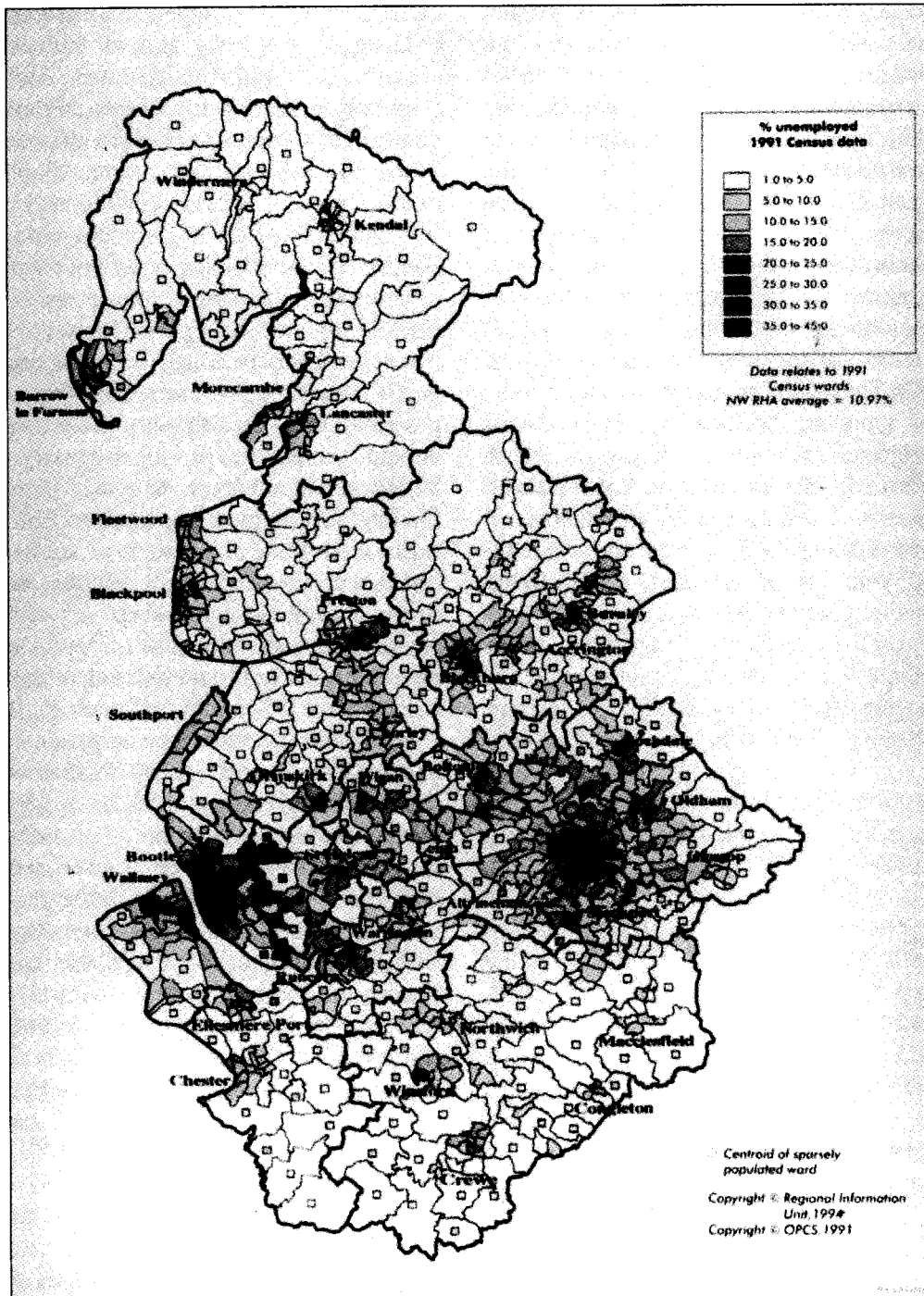


Fig. 7 – Variation in the unemployment rates in the North West of England

very different values than their mothers which have major implications for patterns of social care in the future and on the other that in at least some groups men's health is deteriorating.⁷ For example, the increase in death rates in males aged 15 to 39 which is particularly high in this Region.

Turning to . . .

(2) The Patterns of Health and Disease

In 1948 the infectious diseases were still quite common. Tuberculosis was still regarded as a serious public health issue and epidemics of Diphtheria and Polio still occurred. Today memories of these diseases have receded. They have in fact receded to an extent where we may be in danger of complacency as the recent epidemic of Diphtheria in the former Soviet Union, the resurgence of Tuberculosis in the West in association with poverty and with AIDS and the sometimes poor coverage levels of childhood immunisation, even within this Region should remind us. Fig. 8 highlights parts of Merseyside where there have been particular difficulties in obtaining adequate immunisation coverage. However, today's leading causes of premature death and disability are the non-communicable, chronic and degenerative diseases whose causes lie not with infectious organisms but with lifestyles and other aspects of our environment, alcohol, tobacco and drugs, changes in diet and exercise levels, mediated perhaps by such complicated phenomena as stress, consumerism, poverty, disadvantage and lack of control

over everyday life. Taken together the death rates from all causes in the new North West are about 15% higher than would be expected if national rates applied to our population structure. The distribution of this excess mortality reflects that of those population characteristics previously discussed such as poverty and unemployment. It also reflects other mediating factors such as smoking levels and importantly it reflects our failure to develop the human and health capital of the Region as expressed, for example, by the proportion of 18 year olds who have higher qualifications. Fig. 9 shows the range in the proportion of the 18+'s who go on to obtain higher qualifications - from less than 3% (pale) to 25% (dark). Those parts of the Region with high levels of premature mortality are also those with an excess of disability. Some idea of the extent of avoidable mortality caused by social inequality can be obtained by comparisons between the experience of the better off and the more disadvantaged. Crude calculations would indicate that in the North West Region each year about 3,500 male deaths and 1,200 female deaths are attributable to social inequality, as are about 100 stillbirths and 200 infant deaths. 3,500 excess people under the age of 65 years have long term illness which prevents their living a normal everyday life.

(3) The Capacity of Interventions to Make a Difference

Comparisons of British populations at intervals in time this century such as those between Mersey in 1948 and 1994 or between those from a working class area of London in 1900, 1925 and 1950.

Vaccination & Immunisation : Diphtheria Tetanus.Polio

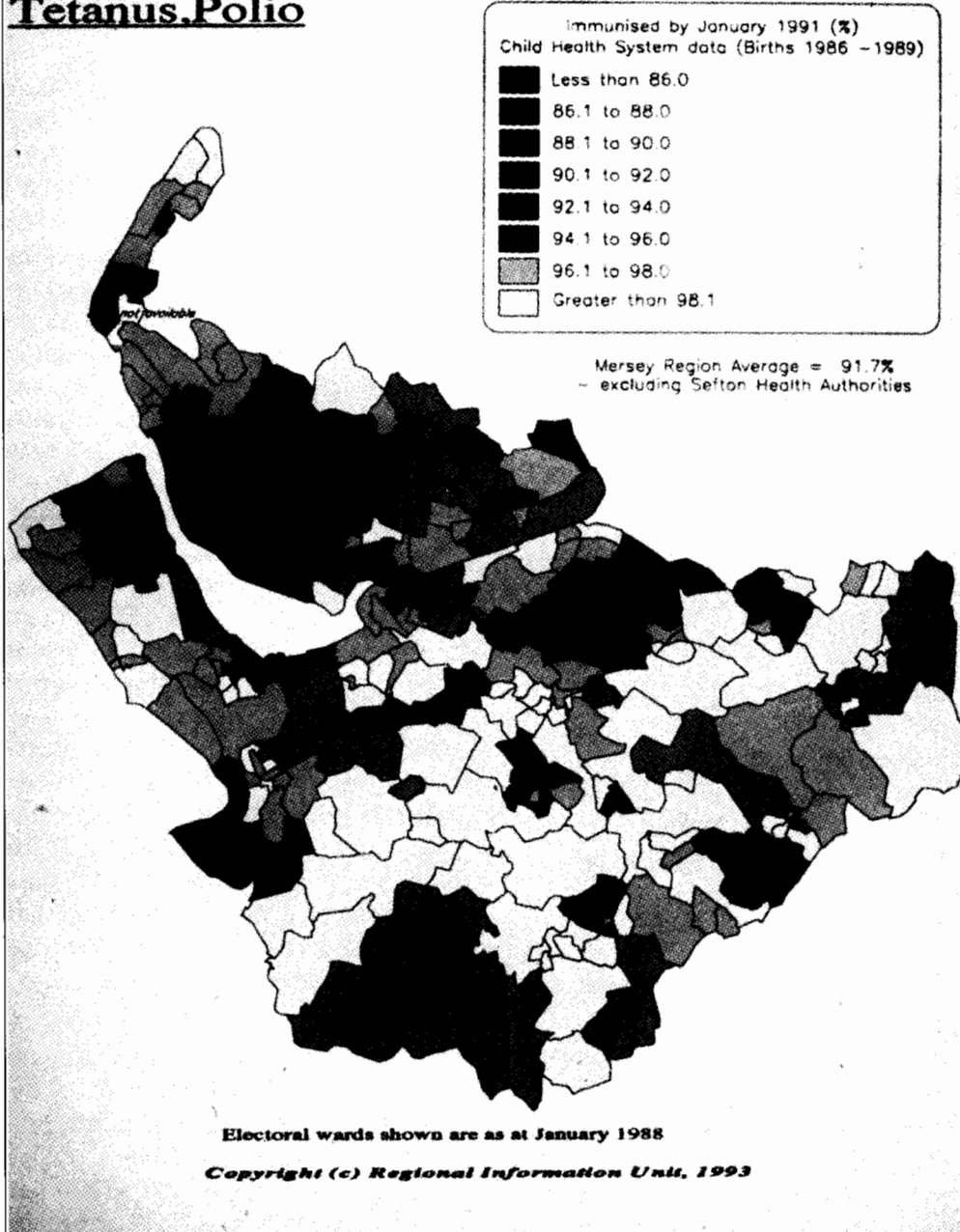


Fig. 8 – Variation in immunisation coverage in the District of Merseyside and Cheshire 1991.

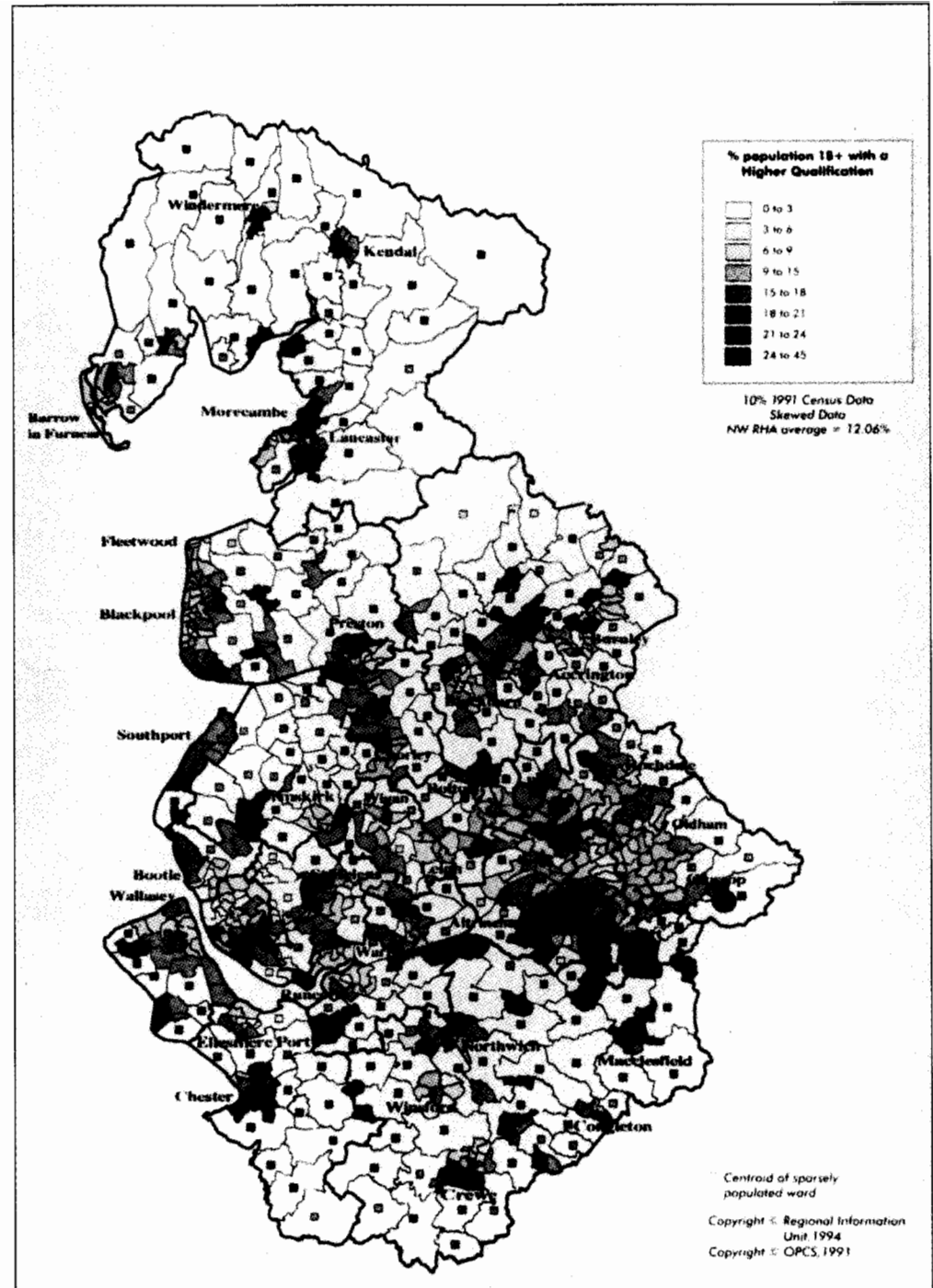


Fig. 9 – Variations in educational qualification levels in the North West of England 1991.

(Figs. 10 - 12) demonstrate enormous improvements in health. One photograph of a school class from Liverpool in 1916 (Fig. 13) serves to raise many questions about the complex pathways which link

poverty and ill-health. The twins in the front row were born to a young woman who had herself been born in the city, but who moved to Woolton when she married one John Ashton, a gardener who was

Fig. 10-12 Comparisons of the same age group at the same school in the East End of London at 25 year intervals showing the improvement in growth, development and health. Photographs bequeathed to the author by the late Dr Sidney Chare Fig. 10-1900



Fig. 11 - 1925



Fig. 12-1950



Fig. 13-Much Woolton Infants School Liverpool c1916

frequently unemployed. Although these twins were born into a household with no wage earn their combined birth weight was about 17lbs. They are my father Ted and his twin brother Geoff. What was it about control over resources for the poor living on the urban-rural fringe which was so different from that of those living in the urban core? Yet it is clear from the work of Thomas McKeown that most of the improvement that occurred before the Second World War had precious little to do with medical care⁸ for example one of McKeown's graphs, that for deaths from TB in England between 1838 and 1970, indicates that about one third of the decline had occurred before we knew the cause and about 90% before we had a treatment (Fig. 14) McKeown concluded from his analysis that:

"In order of importance the major contributions to improvements in health in England and Wales were from limitation of family size (a behavioural change), increase in food supplies and a healthier physical environment

(environmental influences) and specific preventive and therapeutic measures". Although McKeown's analysis has been disputed in some respects, there can be little doubt that it has served to re-focus us on the fundamental determinants of health and the scope for health gain from a wide range of public policies other than those narrowly concerning biomedicine. The corollary is that it has also served to fuel the debate about the role and contribution of medicine and technology to health. In contrast with the past there is little doubt that medicine and technology has a part to play whether it be hard technologies founded in the basic sciences of genetics, biochemistry, physiology, pharmacology and bio-engineering or the 'softer' technologies founded in the behavioural and social sciences. But technologies that make a difference are not only the high tech ones; low tech interventions such as meals on wheels, home helps, chiropody or physiotherapy may dramatically improve the quality of life for an elderly person. In recent years not only has a much wider

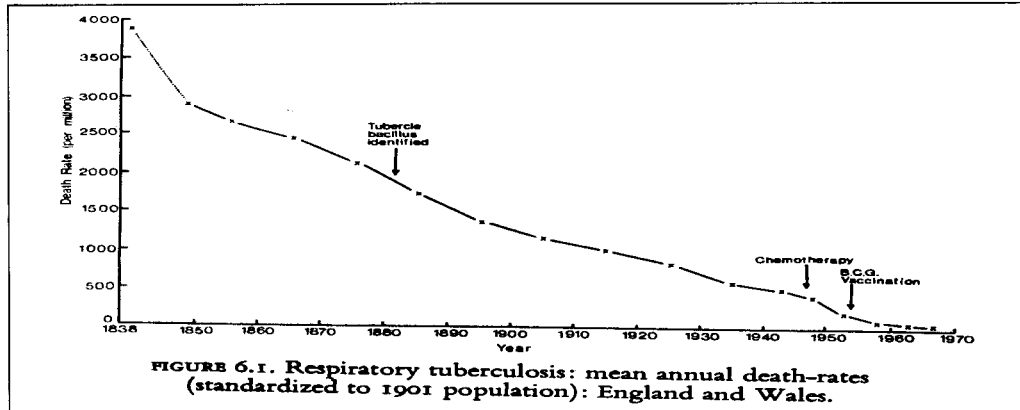


Fig. 14—The decline in deaths from Tuberculosis in England between 1938 and 1970. From McKeown T. 1976 Rock Carling memorial lecture published by the Nuffield Provincial Hospital Trust reproduced by permission of the publisher.

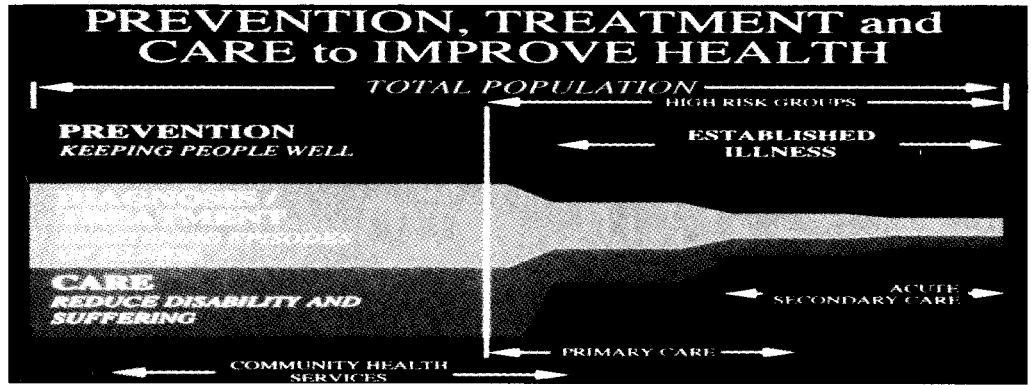


Fig. 15—The North West Regional Health Authority Strategic Framework.

range of interventions become available, but their nature has changed. They have become less invasive in themselves and the total approach to patient care has been re-appraised. Lengths of hospital stay have plummeted and within the North West today a majority of elective surgery is now carried out on a day case basis. These trends are set to continue. The task facing a health authority is to ensure that the resources that are available are optimally deployed to promote and protect the health of the population and that the use of resources is grounded in the scientific evidence of the outcomes which might be expected from specific activities. During the past two years the former Mersey Regional Health Authority and now the North West Regional Health Authority has developed a strategic framework with which to consider that optimal balance. (Fig. 15) The framework represents where the population is to be found in respect of its contact with primary or specialised care for those interventions which promote and protect health and provide for treatment and care in comparison with the overwhelming majority of interventions

which take place at home and within the family with little or no professional input. It provides a tool for examining how we can best support lay health care as well as that provided by professionals.

One task of the Regional Health Authority is to ensure that scarce resources are only made available to effective interventions and that if on the basis of proper scientific evaluation an intervention is deemed to be cost-effective that it is accessible to all of that population which will benefit from it. A comparison of the distribution of heart disease with that of the distribution of investigate cardiac catheterisation used in the investigation of heart disease indicates that this is probably not the case at present. It seems as if those places with lower rates of heart disease – the more affluent areas – have higher rates of investigation leading to treatment. Note for example the low incidence areas on the Lancashire coast (Fig. 16) and compare them with the high investigation levels. (Fig. 17).

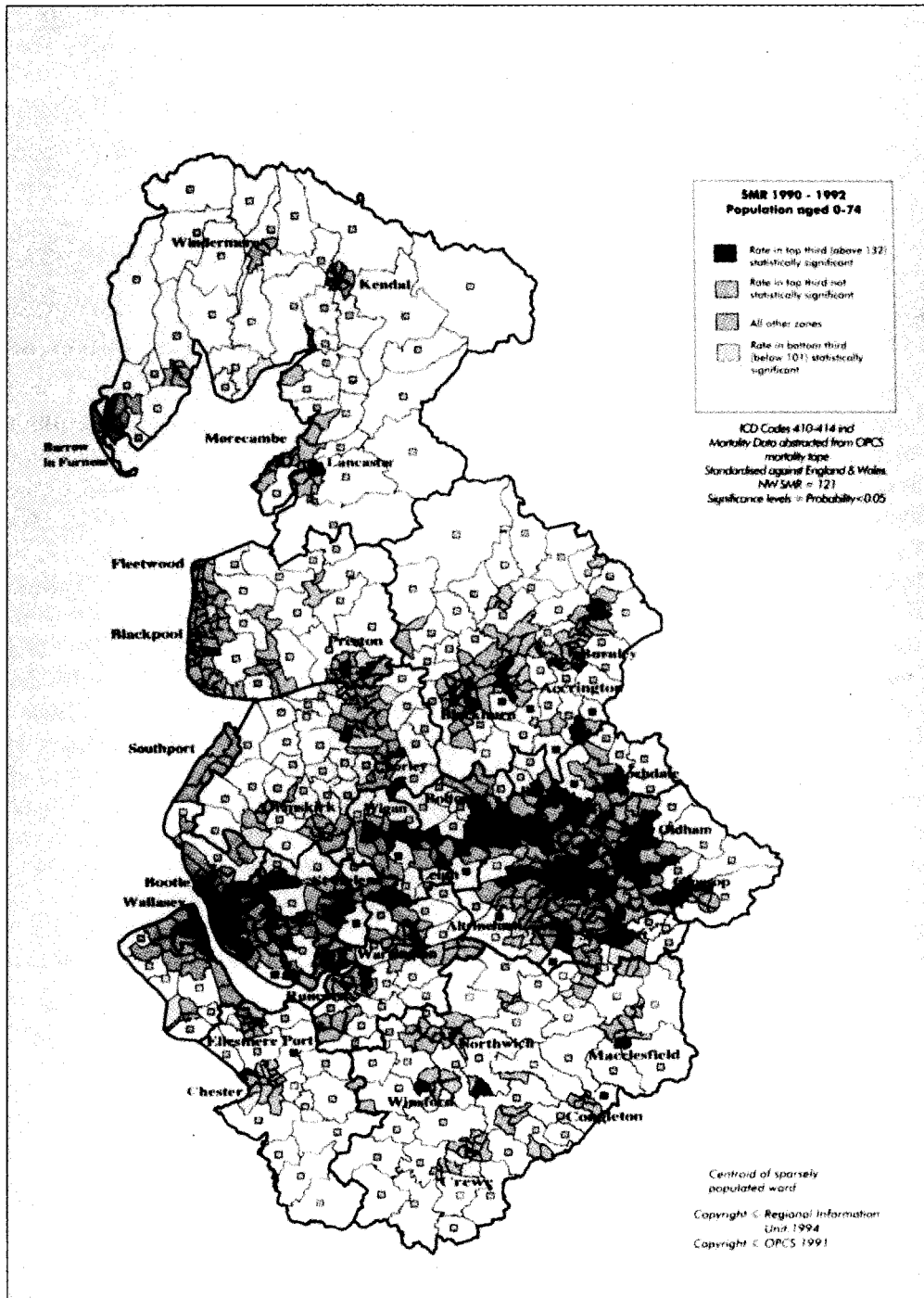


Fig. 16—Variations in deaths from ischaemic heart disease in the North West.

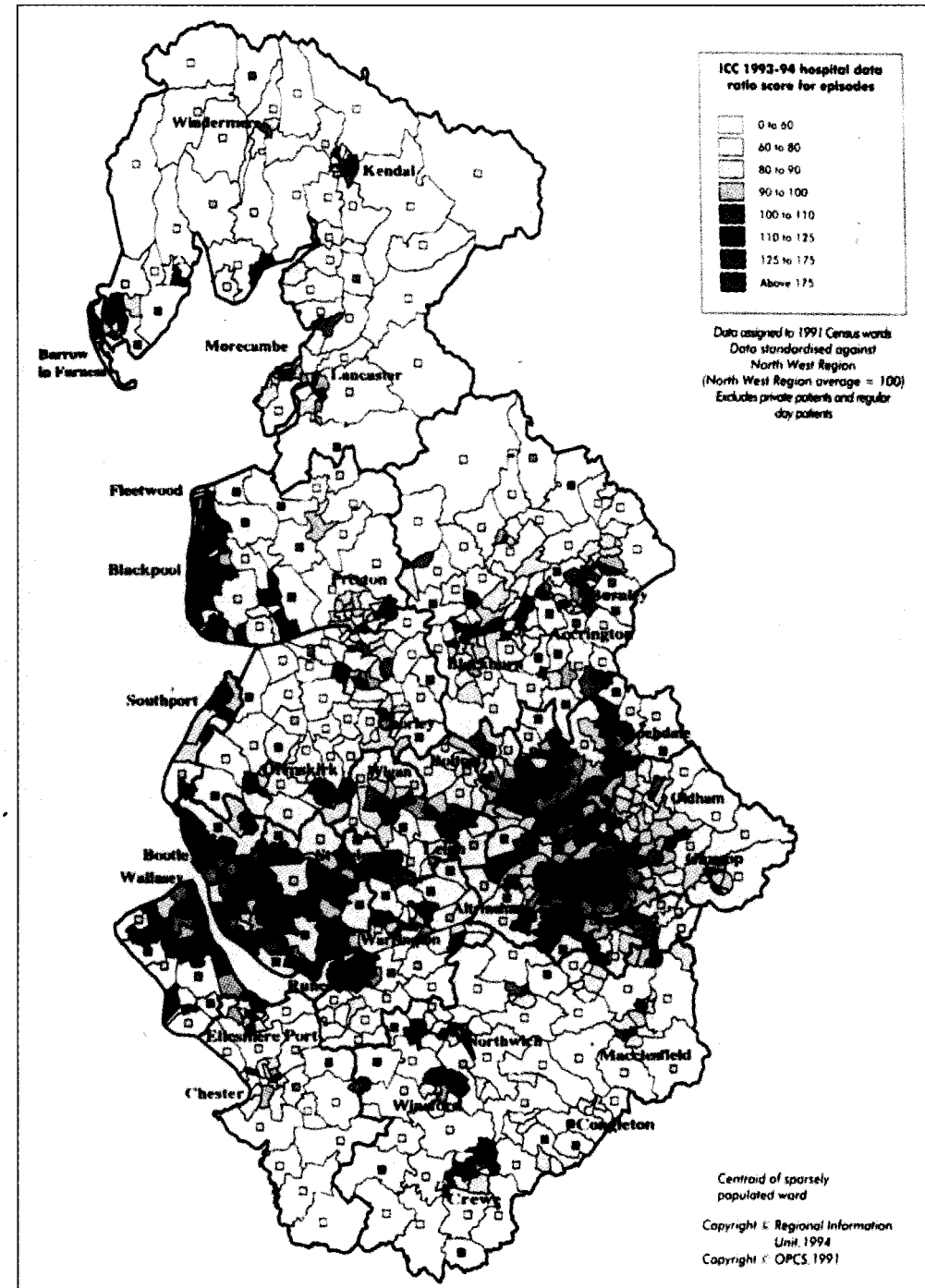


Fig. 17—Variations in the investigative cardiac catheterisation rates in the North West.



Fig. 18 and 19 –Slum housing in nineteenth century Liverpool.

The New Public Health

In the United Kingdom context it is possible to identify 4 phases in public health between the 1840's and the present day.⁹ The first phase, that of sanitary reform began here in Liverpool and in the industrialised cities in response to the appalling toll of death and disease among the working classes living in abject poverty. (Figs. 18-19) The Victorian public health movement was constructed around a powerful motivating concept that came to be known as the “sanitary idea”, the idea that overcrowding in insanitary conditions was at the root of the epidemics that afflicted the great towns and cities.¹⁰ The response in places such as Liverpool was the development of a locally-based public health movement supported by legislation such as the Liverpool Sanitary Act of 1846 and the National

Public Health Acts of 1848 and 1875 in England. The sanitary idea, coupled with the enlightened self-interest of the middle classes in recognising their vulnerability to Cholera spreading from poor neighbourhoods also generated the momentum for adequate housing, safe water and sewage disposal. In retrospect the sanitary idea, which still has a major influence today, may be seen to be flawed and incomplete, a product of mechanistic Victorian thinking that sought to impose technical solutions on natural systems.

2nd Phase - The 2nd Phase began towards the end of the last century when personal prevention began to be a possibility made possible by advances in bacteriology and also early contraceptive technology, but also including the adoption of social measures such as free school meals, school and community health services and social agencies. From

the 1920's onwards the breakthroughs in pharmacology with insulin, the sulphonamides and penicillin, heralded the 3rd phase, a period of about 30 years when the therapeutic model of medicine – magic bullets and a pill for every ill, dominated establishment, educational and scientific thinking. What has since emerged as a 4th phase as the New Public Health following vigorous debate in the early and mid 1970's is a reappraisal of the scope for improved health from environmental change together with appropriate preventive and therapeutic interventions especially for the elderly and disabled.^{11,12} It has particularly emphasised the role of primary health care as the basis for health systems. (Fig. 20)

The emerging paradigm which underpins the New Public Health is one which has revisited and re-interpreted

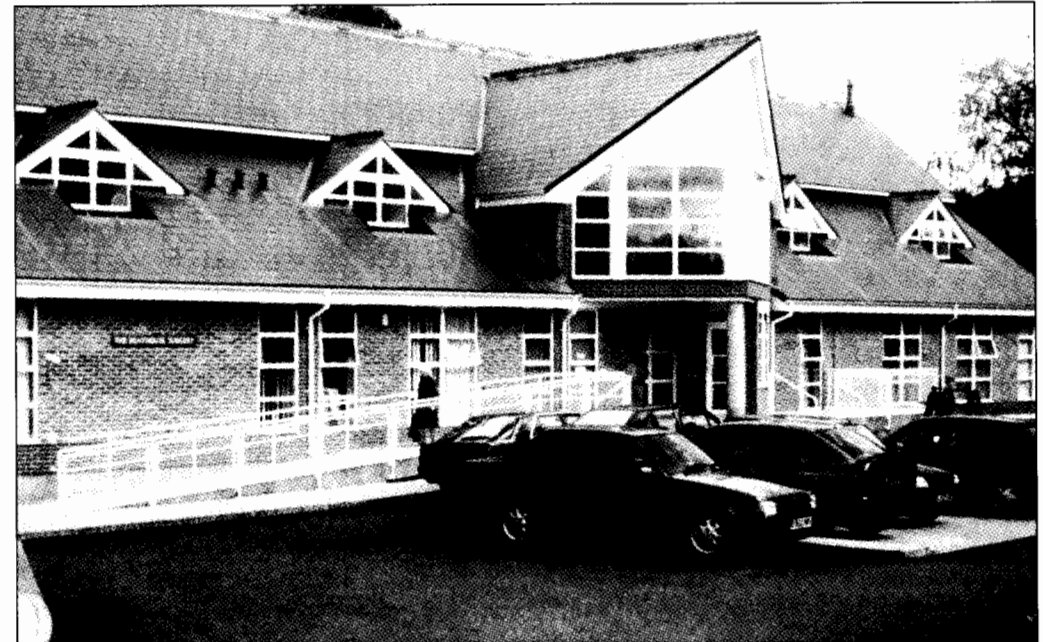


Fig. 20–A modern primary health care centre – the physical basis for a modern health system.

many of the precepts of the old. According to Winslow writing in 'Science 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 personal hygiene, the organisation of medical and nursing service 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".¹³ By implication the public health of the public is an enterprise which is owned by the population as a whole and not by a subgroup or professional sect whether they be public health physicians, engineers or whatever. The challenge is to transform the NHS into a public health organisation and to ensure that it is adequately served by the academic institutions and all those sectors and agencies that have a part to play in safeguarding the public health. Winslow's definition was revived by Sir Donald Acheson in his report on the Public Health Function in England in 1988¹⁴ and reminds us that when the National Health Service was established in 1948 it was but one of the five strands which had emanated from the Beveridge report which "should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack on want. But want is one only of five giants on the road of

reconstruction and in some ways the easiest to attack. The other are Disease, Ignorance, Squalor and Idleness".¹⁵ The elaboration of the welfare state and its subsequent fate do not alter these fundamental premises even if we do need to think differently about them 50 years later. Concern that professionalisation has undermined coping skills and led to escalating costs has converged with contemporary views about empowerment and public participation in modern civil society to challenge the domination of the health field by bio-medicine and at the same time to promote multi-disciplinary responses to multi-factorial issues which are seen to go well beyond the simple germ theories of disease. Our understanding of health has become more subtle. For example, the recent work by Marmot in the U.K. and by Syme in the U.S.A. has focussed in on the levels of control people are able to exercise over the threats to their health.^{16,17} In keeping with the times our understanding has become more ecological with a tendency to look for ways of working with nature rather than on it in the fashion of the sanitarians. The ecological idea of today is perhaps best summed up in the native American idea of looking after the things that look after us be they our bodies, our relationships or our planet, otherwise known as reciprocal maintenance. It is also becoming clear that without social justice the health of everybody is threatened. In Victorian times this was a local threat from Cholera spreading from the slums to the middle class areas. In today's global age HIV and AIDS, drugs and crime and even the Plague, transcend

the local and become global concerns which unite the haves and the have-nots. In his recent analysis Richard Wilkinson has argued that relative poverty has absolute effects and is a much more destructive social force than is generally recognised. Better off countries which tolerate extreme ranges of income differential seem to have worse health statistics than poorer countries with less economic inequality.⁶ There is a growing recognition that trickle-down theories of economic development do not work and a growing body of knowledge pointing to alternative models for the economy which acknowledge the importance of sustainability and social justice.¹⁸ Moreover there is increasing recognition that the idea that health is a cost to government and that ministries of health should be seen as spending ministries whereas those of agriculture and industry can be seen as wealth-creating ministries is naive and partial. This is well illustrated by the recent shift of position by the World Bank to investing in health as an essential part of development.^{19,20}

What then is to be Done?

According to the recent Department of Health Functions and Manpower Review, "Protecting, promoting and improving the Public Health in England is one of the key responsibilities of the Secretary of State for Health under the powers of the Ministry of Health Act of 1919. It is the task of the Department of Health to support the Secretary of State in carrying out this responsibility, including those aspects which go beyond the Department of Health and the NHS." The publication

and implementation of the "Health of the Nation" underlines the need for a pan-Government approach to health.²¹ The range of the work which needs to be done is very extensive, from monitoring the health of the population and developing health strategies and the alliances with which to implement them to producing an informed participating public and ensuring that adequate and appropriate services for prevention, treatment and care are in place in an equitable fashion. It is clear from the analysis that we have carried out so far in the new North West that, while on the one hand things are much better than they were even a few decades ago, on the other hand we are lagging behind the rest of the country and many other parts of Europe and that many of our people have not been benefitting from the improvements to the same extent as others. There is also a strong sense that whilst we may be doing better we may be feeling worse and that the psychological and spiritual aspects of health as judged by the levels of mental distress, alcohol and drug abuse, family breakdown, suicide and violence may in fact be deteriorating.

Creating the Vision of Where We Wish To Be

One of the consequences of the medicalisation of health has been that we have lost sight of its essentially holistic nature and of the contribution that everybody and all sectors have in protecting it. This can be illustrated by the general concern that there is inappropriate use of primary care services and of prescribed drugs by the public; it is



Fig. 21

Fig. 21, 22 and 23 – *The need for vision to improve the population's health.*

suggested that perhaps a quarter of GP consultations would be unnecessary if we had better informed populations able to manage common conditions for themselves and each other and drawing on other community resources such as lay networks, and alternative professionals such as pharmacists. It is also illustrated by a fairly consistent failure to engage the agenda of economic growth and development or as often in the North West regeneration with that of health and social outcomes or well-being. Are jobs created in confectionery, the tobacco industry or aerospace and producing instruments of torture automatically a good thing because they relieve unemployment? Must all breakthroughs in science and medicine be automatically adopted as part of an upwards and onwards imperative of progress irrespective of their negative consequences? All of us should have a voice in this not only the 'experts' whether they be physicians, economists or politicians. One way into this which

has been explored extensively in relation to the World Health Organisation Healthy Cities Initiative (Figs. 21, 22, 23) is the use of vision workshops with community groups, politicians and professionals to consider where we might wish to go so that when we get there we are more likely to be there than somewhere else. That vision however does need to be informed by the facts – demographic facts, facts about the human condition and scientific facts about those things which make a difference. This factual backcloth indicates some of the fixed points in our future which have to be addressed:-

- the avoidance of unnecessary and avoidable disease and suffering which is predominantly borne by the disadvantaged in the Region – which points to policies which address these questions and the challenge of empowering the disadvantaged.

- the challenge of caring for the elderly in humane and acceptable ways which indicates the need for locally based, strong, primary medical care.
- the responsibility within dedicated health services resources to obtain quality and value for money which may mean taking difficult decisions about the configuration of secondary and tertiary services and their location.
- The recognition that ultimately the fate of humans is bound up with that of their habitat and that policies for development which ignore the ecology of that habitat will compromise our well-being. In the end the values of social justice and ecological sanity are a matter of enlightened self-interest.

Within the North West Regions we have already begun to address some of these issues with our strategic framework and our first steps towards reorientating the health service towards one built on primary care and ensuring that secondary and tertiary services are in the right place, have the right relationships to primary care with strong decentralised services and are providing the highest standards. This in itself is a difficult task but in many way is easy compared to the wider task of ensuring the wider public health. There are however many resources for that task if we can only see them.

The Resources for Health

In debates about health the starting point is often the shortage of resources for medical care. Yet this is a misunderstanding of health and its determinants. In the North West Region



Fig. 22

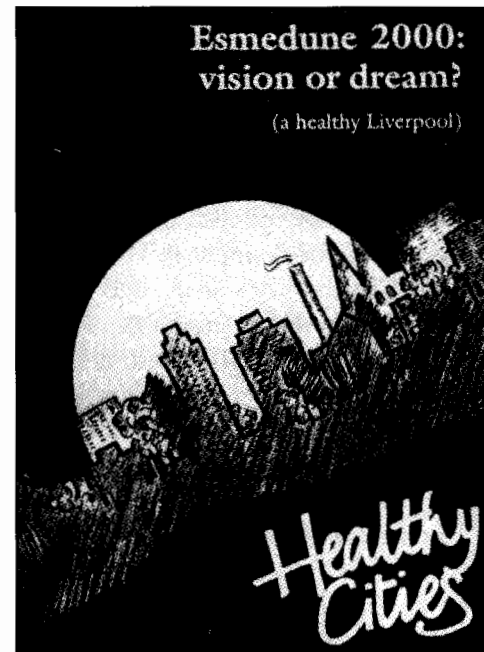


Fig. 23

we have an annual budget of around £3.3 billion to spend on health services for our population of 6.6 million. This is about £500 per head and is our share of the 6.6% of the Gross Domestic Product which the Government spends on health services. Some of us might feel that it should be higher and on a personal level may be willing to pay higher rates of tax to enable that to be the case, perhaps more like the 8% that the Swiss pay or 8.8% like the Swedes, although public surveys suggests that while 70% of the public opposes restrictions on the availability of NHS treatment, 44% are opposed to any additional taxation to fund improvements.²² But to assume that that would lead to better health services or indeed to better health services or indeed to better health is a big jump. It certainly wouldn't put an end to the demands for more resources for the medical sector.

The starting point for a consideration of the resources of our health within the Region lies with the inherent health capital of our 6.6 million people, their family and social networks and their relationships with each other and with the environment. The real task as opposed to the diversion of seeing health primarily as being about training large numbers of health professionals is to create social conditions which mobilise those resources to ensure and protect that inherent health capital. Education has a central role in that task as does the paying of attention to the provision of environments which are, on the one hand safe and on the other are not ecologically compromised. Those environments are

living, working and recreational ones which shape and influence the lifestyles and opportunities of our people. They have physical, social, psychological and economic dimensions. These are the prerequisites of health as touched on in the Ottawa Charter for Health Promotion.²³ What binds them together is the very stuff of culture and values – how we choose to organise and run our bit of the planet and to relate to each other in it. Recent developments on the environmental front with mass opposition to further motorway development, the beginnings of an acceptance of the need to tackle traffic generated air pollution and asthma, and with respect to a backlash against modern animal husbandry, indicate that in the UK the vein of underlying values still runs deep. More locally the response to the Hillsborough disaster demonstrated the enormous strength and resilience of the social networks and there are now many examples of partnerships in community development and public involvement in primary care, not least here in Liverpool with partnerships between the universities, the public and the health services. As, for example, in Vauxhall and West Everton or with the highly successful approaches to harm reduction with regard to HIV/AIDS and drugs and with the launch of the city health plan developed collaboratively by the health and local authorities together with many other partners, including the universities. Taken together these phenomena indicate something of how we may progress; they hint at the possible role of institutions such as our universities and public bodies

as enablers, facilitators and resources. The resources for health in the North West then begin with the 6.6 million people and in progressive waves include family, neighbourhood, community and the voluntary, private and public organisation which go to make up our society – yes, there is such a thing! They take in at the latest count, 13 universities including two medical schools, a well developed infrastructure, a resilient and heterogeneous cultural mix and a great deal of skill and expertise. We have the potential as a European Health Region to not only revitalise ourselves economically but to place ourselves at the forefront in terms of quality of life and of health – if we only get our act together.

The Challenge

The liberation of the inherent resources for health in a population such as ours requires vision, a degree of single-mindedness and the capacity to provide leadership. The vision of health as a resource for living which has spiritual, social, physical and social dimensions and where people have an understanding of their relationship with each other and with the environment needs to be articulated widely and owned by the people themselves. In the last century the perspective was very much a local one and focussed on the emerging mechanisms of governance which were to be found in the town halls and the more established ones in Westminster. Today the issues have become global whilst retaining strong local aspects as evidenced by the emergence of localities of 50-100,000 people as the building

blocks for delivering personal health and social services; the challenge really has become to think globally and act locally.

However, within the European context the rational strategic level now appears to be the Regional one and we need to consider how we develop and make use of our position within one Health Region in a mosaic of perhaps 60 or 80 on the European stage. The point about this is that within our own Region we are, despite appearances to the contrary, rich in resources. When Liverpool's MoH, William Henry Duncan, (*Fig. 24*) was asked by the Town Clerk in 1851 to submit a nominal roll of his staff, Duncan replied "the following list comprises the whole of the officer in my department

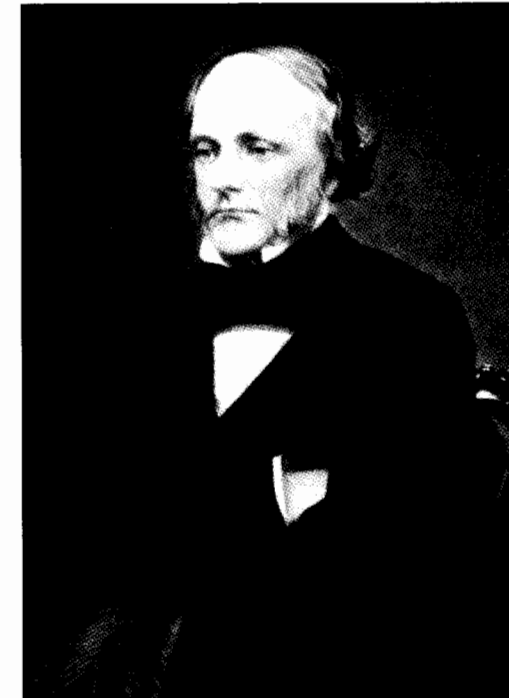


Fig. 24—William Henry Duncan. Medical Officer of Health for Liverpool 1847-1863. The First Medical Officer of Health. Published by permission of the Duncan family.

paid by the Corporation, William Henry Duncan MD, Medical Officer of Health".²⁴ In effect Duncan's task was to galvanise the resources of the town to tackle the pressing issues of squalor and disease and this he did with vigour and single mindedness. The notion of great man, public health pioneer leadership style which is sometimes attributed to the more effective medical officers of health is not the style of leadership which is appropriate for the 21st Century in a highly literate society where power could, and should, be increasingly disseminated and distributed among the citizenry and where global telecommunications and the information super highway have created the potential for a real participative democracy and for everybody to be their own health expert. Nevertheless an examination of Duncan's work and influence provides some clues as to how we need to go about the contemporary task. The following messages emerge from such an analysis:—²⁵

- An independent voice for public health and health advocacy
- The carrying out of appropriate research including, "Shoe Leather Epidemiology"
- The production of reports on the health of the population
- Populism and a willingness to engage in debate in the public area
- Resourcefulness and pragmatism

- The legitimacy of working locally even though the glory tended to be reserved for those operating on the national stage. Scrutiny of the later work of the other Medical Officers of Health who were appointed around the country reveals some further clues:
- Humanitarian motives and a strong moral tone
- Recognition of the cost-effectiveness of prevention
- The need for organisation.

The effectiveness of the Victorian public health reformers is a matter of record and also of argument. In the course of time they developed strong organisational infrastructures including academic and professional ones and including our own University Department of Hygiene, now once again the Department of Public Health, which is due to celebrate its centenary in 1997. However I have argued elsewhere that many of these organisational arrangements and the universities, medical schools and schools of public health have essentially become fossilised, sluggish and not responsive to the changed agenda of health as we approach the Year 2000. I would argue too in support of Kerr White's views on the need for reform of our medical schools to embrace a multi-disciplinary remit, to ground themselves in the real world of their local and regional populations and in effect to transform themselves into Schools of Health.²⁶⁻²⁸ Such a concept is

not a new one, it was tried before by Michael Auguste Thouret in France when he established an Ecole de Santé; unfortunately the doctors renamed it the Ecole de Medicine in 1796. It is of interest to remind ourselves that the tradition in Liverpool that began with Duncan was that the City Medical Officer was also the Professor of Public Health. That tradition ended after Andrew Semple in the 1970's.

Implications for Government

This analysis has implications for Government, for our regional and local institutions and not least for the people of the Region. 150 years ago in Germany when the great debates were raging over industrialisation and social change, the responsibility of government for the populations health was a matter of contention. According to Neumann arguing for an extended role for the state in public health over the provision of medical care. "The state argues that its responsibility is to protect people's property rights. For most people the only property which they possess is their health; therefore the state has a responsibility to protect people's health".²⁹ To a large extent Neumann's view prevailed and lay behind the thinking which led in due course to the welfare states which developed in the Western Democracies. Today in the aftermath of the Thatcher inspired upheavals of the public sector and the health reforms we are struggling for a new formulation and understanding of the meaning of the state's responsibility in a modern democracy. I would suggest that

its responsibility remains the same but that its role has changed from paternalistic provider to enabler and guarantor. Part of that enabling must be to ensure that the capacity exists within each of our regions for everybody to have equitable access to the opportunity to realise their own health capital. One part of this is for policies to be in place which are coherent and which optimise health benefits to the population and minimise disbenefits. This coherence might be easier to achieve if there was a clear commitment to Regional development and to Regional empowerment, maybe even Regional government, certainly to the retention of the Regional Health Authorities.

Implications for Regional and Local Institutions

The implications for regional and local institutions are no less challenging. There is a need for a general critical self-examination in the light of the new agenda. Deeply entrenched structures and working practices may need to be changed and above all the issues of mission and the fundamental question of qui bono? – who benefits from the organisations activities needs to be asked. Parochialism, professional restrictive practices, tribalism and outdated organisational arrangements need to be addressed. Looser, more flexible, more adaptable arrangements that can be task orientated and responsive to a rapidly changing environment are what is needed. A commitment to collaboration, networking and getting alongside the public to ensure that

their needs are being addressed rather than those of providers is central.

Implications for Citizens

The implications are no less radical. The downside of paternalism is dependency. The challenge of a mature democracy or, in this case, a mature approach to health development is to achieve partnership in the co-production and co-protection of health. On the one hand this is about empowerment and on the other it is about responsibility – about individuals, families and groups taking responsibility for their own part in what is ultimately a social enterprise. If the message of our new understanding of health is that the key variable is one described by Richard Titmuss as “command over resources through time”³⁰ – personal resources of knowledge, materials and behaviour, social resources of facilities and support, technical resources of professional intervention and the like. The corollary is that in a new social contract between Government as the enabler of the “organised efforts of society” and the individual as an autonomous seeker of self-realisation, there are responsibilities to be borne on both sides of the equation. To demand on the one hand that the Government be wet-nurse on 24 hour call, but on the other to abdicate personal responsibility is no longer a tenable position.

Signs of Hope

The World Health Organisation’s Strategy of Health for All by the Year 2000 was adopted by the WHO in 1981.³¹ Fourteen years later its influence has been

felt around the world and not least in the UK through such policy directions as those in Care in the Community, Caring for people and the Health of the Nation. The Health for All Strategy emphasises the need to re-orientate health systems to one based on primary care, to increase public participation in health and to develop intersectoral, partnership approaches which recognise and mobilise the contributions of local government, the voluntary and private sectors to health. The strategy also stresses the importance of having health outcome objectives and targets rather than planning health services on the basis of norms for providing and staffing services which are detached from any impact they may have. All these shifts and developments are well under way not at least in the North West Region.

However, in my view, the task in hand will take 5 to 10 years to complete and of course in one sense with the speed of change today it will never be completed. I would like to say a few final words about the indications that the University of Liverpool could be in a position to play a key part in providing real leadership in the Region with the agenda that I have outlined.

Starting with the Medical Faculty itself. The Faculty’s deliberate decision with the establishment of a School of Health Sciences to embrace a multi-disciplinary remit is a bold and I believe essential step towards transformation of the Faculty into a Faculty of Health. The radical curriculum changes which are imminent should place Liverpool at the forefront of education for health

professionals. The establishment of the Health and Community Care Research Unit, the Public Health Observatory, and a whole range of recent initiatives which connect the University to the real world agendas of the population and the Region’s Health Authorities is very encouraging. The proposed Clinical Skills Laboratory and work which is being done on producing a Liverpool version of the Hippocratic Oath which is relevant to today’s multi-professional situation where women are coming to play at least an equal part with men is a welcome sign.

But there is a wider world to connect to both within and outside the University. I think that too often Brownlow Hill has acted as a frontier and barrier between the Medical School and others who have a rich range of skills and perspectives to contribute from education, the social and environmental, biological and physical sciences, from Arts and from the Law. In Civic Design we have the oldest department of town planning in the world which had its roots in the Victorian public health movement. And down along the road, and North, South and East of Liverpool in all the Region’s universities, new and old, there are jewels beyond measure just waiting for the right initiatives to liberate productive collaboration. With the collective brain power which the 13 universities represent surely the Research Assessment Exercise should not be a barrier to placing the Region at the forefront of global health academia to the benefit of our population.

I said at the beginning that I would review the scope and purpose of the new

Regional Health Authority in securing real improvements in the health of the population and to explore the contribution of the universities. I hope that what I have said gives an indication of that scope and purpose – as one of partnership in understanding the issues and supporting the education and training and continuing education and the research and development agenda of responding to those issues. However, it goes wider to embrace a partnership with the many strategic agencies across the region and to create a real sense of the North West as a coherent effective region, to get beyond the parochialism of the past. It is also a challenge to the Health Authorities, the local authorities, private and voluntary sectors to provide collective leadership for what Disraeli (quoting Cicero) call the highest law – “The Health of the People”. (Fig. 25).

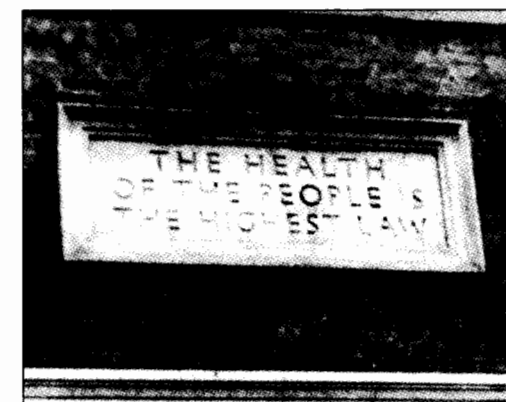


Fig. 25—*The Health of the people - Cicero plaque above the public health department in Southwark, London.*

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