hoists, which can be loaned to wards or used for assessment. A range of hoists is available in each health district for training purposes.

The health authority's home loans equipment service may have a small stock of mobile hoists available on temporary loan. When a person who needs a hoist is to be discharged home from hospital this service should be considered. The provision of the more common hoist and universal sling for long term use is normally through the social services department. When a more specialised hoist or sling is necessary social services may have to consider the cost implication.

The time taken to supply these aids varies from district to district, with inordinate delays occurring in certain areas; sometimes, too, the hoist provided is not the one requested.² Occasionally a charity such as the League of Friends, Round Table, or Rotary Club may help in providing a hoist.

Before he buys a hoist privately a patient should seek the advice of a qualified person not connected with the manufacturer and insist that the hoist is demonstrated in the environment in which it is to be used.

A well maintained hoist is rarely the cause of an accident. Accidents usually occur through misuse, incorrect assessments, or inappropriate fittings. Some community services are so acutely

concerned about these avoidable accident risks that they limit their hoist and sling provision to a very narrow range.

Conclusion

A hoist is a valuable aid for carers when lifting a heavy or disabled person becomes difficult. But hoists are expensive, occupy a lot of space, and may initially cause anxiety to patient and carer. Hoists should therefore only be provided when alternative strategies (lifting techniques, other equipment) have been considered.

The role of the occupational therapist in assessment and training is crucial. Only by careful assessment of the patient, family, and home environment can the appropriate hoist and sling be chosen; only by careful instruction can users overcome their fears of hoists and become confident and competent in their use.

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Conference Report

First United Kingdom Healthy Cities conference, Liverpool

TONY DELAMOTHE

Liverpool has a standardised mortality ratio 29% above the national average and was identified in the Black report as one of 10 health districts with high concentrations of ill health. Merseyside has had the highest rate of unemployment of any English conurbation in every decade since the 1950s and the city the worst economic problems of any in England. The European Community gave Liverpool the highest "problem" score of 103 European cities.

Healthy cities

The main purpose of this first United Kingdom Healthy Cities conference was to bring people from towns and cities already committed to the principles of healthy cities (fig 1), such as Coventry, Leeds, Manchester, Oxford, and Sheffield, and other interested parties to help set an agenda for the new public health in urban areas. Local health authorities, councils, the University of Liverpool, Liverpool Polytechnic, King's Fund, Health Education Authority, and the World Health Organisation all participated in the conference's planning. (Most of these constitute Liverpool's "intersectoral" committee.)

There is nothing new about attempts to reform cities. In Britain in the 1840s many towns (including Liverpool) joined the Health of Towns' Association, which was responsible for some of the sanitary reforms of the nineteenth century.¹ That was the "old" public

health—paternalistic, hierarchical, "top down," its agenda set by experts. The "new" public health, which the healthy cities movement represents in an advanced form, differs in that community participation is expected and health promotion is used to help

- The right to health
- Equity in health
- Community participation
- Intersectoral collaboration
- Health promotion
- Primary health care
- International cooperation

FIG 1—Principles of health for all (from the Liverpool Declaration).

people increase control over their health. As Sir Donald Acheson, Chief Medical Officer of the Department of Health and Social Security, told the conference, "Behaviour conducive to health and effective medical interventions even working together are not enough. Social and environmental policies which support health are also needed."

A belief that the health of people in cities cannot be divorced from

"Lady Madonna, children at your feet; Wonder how you manage to make ends meet." (John Lennon and Paul McCartney, 1968.)

the health of cities underpins the healthy cities project—the strategy adopted by the World Health Organisation's Regional Office for Europe to implement WHO's principle of "health for all by the year 2000." It is the logical choice for Europe: three in four Europeans will be living in cities by then.

The project was begun in 1986 with the hope of creating a network of cities that place health high on their social and political agendas. WHO's participation is intended to last for five years, by which time the organisers hope that practical models of urban health promotion based on "health for all" will be commonplace. WHO has so far designated 24 project cities (fig 2), with Liverpool and Gothenburg responsible for providing resources for participating cities and evaluating the project. These project cities are meant to help with the introduction of national networks.

Some versions of local

Much of the impetus for the conference came from Dr John Ashton, senior lecturer in community health at the University of Liverpool, director of WHO Healthy Cities Supporting Centre at the University of Liverpool, and one of the founders of the healthy

<i>Austria</i> Vienna	<i>Hungary</i> Pécs
<i>Belgium</i> Liège	<i>Israel</i> Jerusalem
<i>Bulgaria</i> Sofia	<i>Italy</i> Milan Padua
<i>Denmark</i> Horsens	<i>The Netherlands</i> Eindhoven
<i>Federal Republic of Germany</i> Bremen Düsseldorf Munich	<i>Spain</i> Barcelona
<i>Finland</i> Turku	<i>Sweden</i> Gothenburg Stockholm
<i>France</i> Rennes Montpellier	<i>United Kingdom</i> Belfast Bloomsbury—Camden Glasgow Liverpool
<i>Greece</i> Patras	<i>Yugoslavia</i> Zagreb

FIG 2—WHO project cities.

cities initiative. In his speech explaining the healthy cities project Dr Ashton suggested that although consensus may have broken down at a national level, it had increased locally. Elsewhere (with others) he has argued that "the city is often the lowest administrative level which can marshal the resources and has the political mandate and authority to develop and implement intersectoral approaches to health." This emphasis on the "local" recurred in several speeches.

Professor Graeme Davies, Vice-Chancellor of the University of Liverpool, spoke of how the philosophies of universities were changing with a return to roles more in keeping with the ethos of their foundation, which in the case of his university was explicitly local.

FIG 3—Relation between deprivation and health for Liverpool's 33 wards. The health index combines standardised mortality ratios for the under 65s and figures for permanent sickness and low birth weight. The deprivation index covers unemployment, car ownership, overcrowding, and owner occupation. The gap between the most and least deprived areas in Liverpool is growing, as is that between Liverpool and more affluent parts of the country. (Courtesy Liverpool City Planning Department.)

Localism as a philosophy was developed in a paper presented by Dr David Morris, director of the Institute for Local Self Reliance, Washington, DC. He argued that the way we have organised our economies has disorganised our communities. His suggested solution was EF Schumacher's goal of self reliance: local production for local consumption from local resources. "We can still look outward for good ideas," Dr Morris said. "But many of our best ideas will come from our own communities for the obvious reason that we ourselves know what works best in our unique conditions."

Dr Rod Hackney, president of the Royal Institute of British Architects, and Mr Tony McGann of the Eldonian Community Association showed what that might mean when put into practice. Dr Hackney is a pioneer of "community architecture" in this country—he believes that when it comes to buildings the experts are the locals. Community architects should live on site, acting as sympathetic enablers for those without access to power or influence. "Younger architects have a debt to repay society," he said.

The housing cooperative of which Mr Tony McGann is a member is in Vauxhall, which suffers from the poorest health in Liverpool (fig 3)—"It was the worst environment in Europe. It didn't matter

who was in power: everyone forgot us." A tenants' association was formed in 1978 when the city council declared that all pre war tenements would be demolished and refused to say where their occupants would be rehoused. Having watched other city dwellers being relocated to the outskirts of Liverpool, the people of Vauxhall refused to move. Many fights later, with High Court cases, Alsations, and the stacking of local council wards all featuring, Vauxhall has preserved its community and replaced its housing stock—providing jobs for its inhabitants in the process. It is now the largest "new build" housing cooperative in Europe and has just started its first business venture—a plant nursery on the approaches to the Mersey Tunnel.

The model that community architecture offers—of a community deciding its own needs and then inviting in professionals for their skills on the community's terms—is of relevance to the healthy cities project, and for more than just housing. Some of the benefits are obvious, but so too are the problems it produces, and these problems emerged as the themes of most of the half day workshops.

The world outside

The new emphasis on seeing both problems and their solutions in local terms has its limitations, as many speakers pointed out. There is a wider context that needs to be addressed—that of national government policies.

Ms Sheila McKechnie, director of Shelter, argued that this government's current housing policies are further dividing British society. "Those on low incomes or state support have now fewer and lower quality housing options than they had 10 years ago. Some have no options at all. The effect of this will be further to compound the health divide in Britain as poor housing again emerges as one of the major negative health determinants of the poorest sector of society."

Other speakers argued that sound government policies promoting health were a prerequisite for any local initiatives. Mr Bob Tanner, chief executive of the Institution of Environmental Health Officers, said that, although the relation between unleaded petrol, environmental lead level, and its consequences for health were all well established, it had taken until this year's budget to introduce a price differential between leaded and unleaded petrol (which is smaller than in some other European countries). He was also concerned by the prospect of water metering—plentiful water supplies are a prerequisite of good public health—and "the concept that city residents should have available to them that quantity of water they can afford to buy seems quite preposterous."

Dr Mayer Hillman, senior fellow of the Policy Studies Institute, argued that current transport policy did not sufficiently recognise its impact on health; governments have favoured an expansion of

Health for all

- 1 Equity in health
- 2 Adding life to years
- 3 Better opportunities for the disabled
- 4 Reducing disease and disability
- 5 Eliminating measles, polio, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis, and indigenous malaria
- 6 Increased life expectation at birth
- 7 Reduced infant mortality
- 8 Reduced maternal mortality
- 9 Combating diseases of the circulation
- 10 Combating cancer
- 11 Reducing accidents
- 12 Stopping the increase in suicide

Lifestyles conducive to health for all

- 13 Developing healthy public policies
- 14 Developing social support systems
- 15 Improving knowledge and motivation for healthy behaviour
- 16 Promoting positive health behaviour
- 17 Decreasing health damaging behaviour

Producing healthy environments

- 18 Policies for healthy environments
- 19 Monitoring, assessments, and control of environmental risks
- 20 Controlling water pollution
- 21 Protecting against air pollution
- 22 Improving food safety
- 23 Protecting against hazardous wastes
- 24 Improving housing conditions
- 25 Protecting against work related health risks

Providing appropriate care

- 26 A health care system based on primary health care
- 27 Distribution of resources according to need
- 28 Reorientating primary medical care
- 29 Developing teamwork
- 30 Coordinating services
- 31 Ensuring quality of services

Support for health development

- 32 Developing a research base for health for all
- 33 Implementing policies for health for all
- 34 Management and delivery of resources
- 35 Health information systems
- 36 Training and deployment of staff
- 37 Education of people in the non-health sector
- 38 Assessment of health technologies

FIG 4—Targets for health for all by the year 2000 (WHO's European strategy).

Just off Upper Parliament Street. This car had been stolen, stripped of everything of value, and then set alight.

road traffic (car and motorcycle mileage have increased by 40% in the past 10 years). This has a large impact on health—100 000 deaths and serious injuries on the roads each year and noise and air pollution. According to Dr Hillman, "The underprivileged—the poor, the unemployed, children and old people—tend to be more dependent upon public transport, the service characteristics of which are generally in decline, and on walking and cycling, which is less safe in the present man made environment."

The most trenchant attack on government policies came from Professor Peter Townsend, Professor of Social Policy at the University of Bristol. He said that in the past regional studies of a population's health and the relation between health and social class have had a powerful influence on government policy. Not only did this government fail to recognise more sophisticated and comprehensive scientific evidence than put together either in the mid-nineteenth century or the 1930s and show signs of relating that evidence to the construction of health policies, but it "has been actively promoting the growth of poverty—and therefore ill health."

If, as the Black report had found, material deprivation played a major part in explaining the very unfavourable health record of the poorer sections of the population, then elimination of that deprivation should have become a national objective for action, Professor Townsend argued. Instead 1988 had brought a reform of social security benefits, a budget, and the threat of a poll tax—all of which threatened to increase the economic, and therefore health, divide of the population. On the other hand, the government is one of 33 European countries that has signed the European Health for All declaration in 1984, and from Sir Donald Acheson's opening address clearly the Department of Health and Social Security takes many of its targets (fig 4) seriously. Mr David Trippier, parliamentary undersecretary of state, Department of the Environment, detailed the grants that the government has made to improve the environment and job prospects for the people of Liverpool.

The future

The first Healthy Cities were nominated in 1986: progress towards achieving the 38 targets of health for all have been understandably modest in such a short time. Ways of ensuring that the community's voice is heard and setting up intersectoral committees have so far taken up much time and effort, both here and elsewhere. Turning principles into actions is the next step.

If one of the purposes of the conference was inspirational then Liverpool was the right place to come. Not only does Liverpool have a foot in both camps—as a European project city and as part of the national network, it is, as two speakers from Liverpool pointed out, the best place to appreciate what happens when the voice of local people is ignored.

There were good historical reasons for coming to Liverpool. In the 1840s Liverpool was found to be the unhealthiest city in the country and within a few years of this discovery Liverpool had the first medical officer of health, public wash houses, and district nurses in the country. The forerunner of the National Society for the Prevention of Cruelty to Children began in Liverpool, as did

Down town.

municipal housing and public parks. Liverpool's example was a great influence on the "old" public health; with this conference it seems poised to exert a similarly important influence on the "new."

The proceedings of the conference will be published by the King's Fund and in the autumn a series of films on the healthy city movement "Cities fit to live in" will be shown on Channel 4.

Photographs by Chris Schwarz.

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Medicine and the Media

TO ENTERTAIN is usually the first objective of most writers for television, with education often coming far down the list of priorities. But *World of the Unborn* (Channel 4, 13 April) confirmed that human fetal development can be as fascinating as Sir David Attenborough's wild life. The main theme was that every baby is special and different because of a unique genetic cell composition, and the stages of development were shown at times when new characteristics were developing.

Genetics including cell division were explained by simple but effective animated diagrams. Superb photography of living tissues showed the release of the ovum, passage down the Fallopian tubes, and fertilisation. The development and life history of spermatozoa with flashing tails at one stage and docilely waiting in a line the next made pictures in textbooks seem obsolete. The photographer was clearly intrigued by the picturesque fern like appearance of cervical mucus at the mid-cycle. Time delayed photography showed the differentiation of cells into specific tissues and it would have helped the layman if the commentator had mentioned the names of the tissues on the screen. We saw a few cells that were the precursor of the heart performing synchronous contractions.

The opportunity to educate was used effectively when it was pointed out that nicotine and alcohol pass from the mother to the fetus and that rubella contracted by the mother could cause deafness, cataracts, and heart disease in the fetus. We saw fetuses at

the eighth, 12th, and 24th week of gestation and learnt that at the 24th week the fetus could hear the mother's heart beating and stomach rumbling. The fetus could also hear noises from outside, including the mother's voice, with which a special bond was formed. Diagrams showed the chromosomal abnormalities in Down's syndrome, Duchenne muscular dystrophy, Turner's syndrome, and Klinefelter's syndrome.

The film ended as it began with the vaginal delivery of a normal baby and here was the only jarring comment that "the mother needs support if she is to push her baby out." The ethereal music produced a mysterious atmosphere which initially enhanced the film but later sounded like a gimmick.

A lot of material was transmitted almost subliminally by the soft voiced commentator. The scientific content was accurate, and many doctors who learnt about these ideas in their student days will have found the film a useful refresher. Dr Derek Bromhill wrote and directed the film; he is to be congratulated on his skilful coordination of the work of so many colleagues in different departments. They used the latest laboratory and technical skills to record an outstanding visual insight into this "daily miracle." I hope that *World of the Unborn* will be made available commercially: it would be ideal for teaching schoolchildren, mothers, medical students, and midwives.—BERNARD VALMAN, consultant paediatrician, Harrow, Middlesex.