15. Production by the masses

Professionals and postindustrial public services

Charles Leadbeater

Public service professionals seem stuck. Recruitment and retention to professions has become more difficult, as relative pay and status has declined; morale in many professions is low. Professionals in many public services complain they face more paperwork and bureaucracy, rules and regulations. They feel their jobs are being made more difficult and less rewarding as they drift further from the ideal of the independent skilled professional, making judgements, providing expertise, trusted by both clients and funders to do a good job. Yet public service clients do not seem to feel more in control, even though these constraints on professional discretion – the national curriculum, codes of best practice and risk management guides, inspection regimes – have been introduced in the name of serving people better. As a result many public service professionals feel at odds with the systems they work within.

We need a new account of what professionals do for society and the kinds of institutions in which they work, a set of new design principles to guide public service reform over the next two decades. Our aim should be to create postindustrial public services, which are more collaborative, networked and distributed. Public institutions and professionals should educate us towards self-help and self-reliance as much as possible. Modern society trains us to be workers and consumers. Postindustrial institutions should train us for self-management and self-assessment. That means restoring a proper

balance between professional service and self-help. Resources, skills and tools have to be much more distributed, out of top-heavy, inflexible institutions and into communities and homes. We turn to professionals for their knowledge and judgement but we need far more than that. Postindustrial public services must promote motivation and cultural change. Motivation is the new medicine: motivating and equipping people to look after themselves better. Motivating children to want to continue exploring and learning should be one of the chief aims of the education system. That would mean the role of professionals in future would be to act as persuaders, counsellors and campaigners, not delivering a service, but encouraging people to acquire the skills to look after themselves more effectively.

Only a sustained programme of radical redesign, to shift public services and their professionals away from a perverted, semi-industrial format, in which they attempt to deliver solutions to waiting consumers, will deal with the deep sense of malaise that now afflicts most public service professions.

Social work is perhaps the prime example of this malaise. The goals of social work are enshrined in the International Federation of Social Work's definition, with its emphasis on prevention and unlocking personal potential. It says the mission of social work is to 'enable all people to develop their full potential, enrich their lives and prevent dysfunction'.[1] The Federation's definition goes on to describe the values of social work as based on 'respect for the inherent worth and dignity of all people', which entails respecting the right to self-determination; promoting the right to participation; treating each person as a whole within his or her family or community; and identifying and developing strengths, not just focusing on correcting for deficits or weaknesses. A leading academic study of social work concluded:

> *Good social work is doing with people and their families not to or for them. It requires a partnership between people and workers based on: mutual respect and trust; keeping the person*

> *at the centre of the work; seeing the situation in the round; enabling them to define desired outcomes and supporting them to develop and own their own solutions.*[2]

Yet professionals, care staff and clients say the social work system rarely delivers on these goals. It is not just the high-profile cases of neglect and abuse. A sense of demoralisation seems to afflict the entire profession. Professionals complain they can focus only on the most difficult cases – such as children and families at risk – where their role is to manage risk and police clients' behaviour rather than help to change it. They do not have enough time to attend to the complex issues and history that lie behind a client's need. They have become gatekeepers to the system, managing access and entitlement to help rather than engaging directly with clients. There is little or no time for preventative or community-based work. As a result many social workers feel they have no 'therapeutic' role and they are unable to deliver on the values that drew them into the profession. The mismatch between the avowed goals of the profession and the reality of social work is a breeding ground for cynicism, disaffection and demoralisation among professionals and clients alike.

Social work may be an extreme case. But that gap between the public service professionals' avowed aims and the reality of their work is gnawing away at all public service professions. Piecemeal reforms seem to create as many problems as solutions. Workforce reform, the creation of para-professionals, such as teaching assistants, to take some of the burden off full professionals, provoke worries that control is being diluted. Professionals could relinquish their role as gatekeepers of resources, with all the angst and paperwork that goes with that, but probably only by giving the consumers – patients, parents, children, clients – more choice over how they want to spend the resources allocated to them, perhaps in the form of direct payments or individualised budgets. This makes many professionals defensive. They argue that their clients often lack the knowledge and skills to make intelligent choices. Professionals do not like being managers, nor do they want to be managed. So in social work, for

example, the best professionals are often promoted into management, losing direct contact with their clients and working peers. Meanwhile, schemes designed in part to divert demand away from professionals, such as NHS Direct, seem to have made little difference to the sense of pressure.

Declining trust has also gnawed away at professional relationships with clients. Doctors and social workers have lost the ability they once enjoyed to speak without challenge about their patient's ills. Misdiagnosis, maltreatment, cover-ups of malpractice and political mobilisation by aggrieved patients combined mean that third-party regulators are now often inserted into the relationship between professional and client. But as a result feedback loops from dissatisfied users back to the professionals tend to be very extended; they go via inspectors and ombudsmen. Professionals feel less trusted, but users do not necessarily feel more empowered.

Many professionals have responded by reaching out to their clients in new ways. We turn to professionals primarily for their specialist knowledge, to provide us with diagnosis and explanation, to guide us to the best course of action if we want to learn maths, get our knee fixed or become a better parent.[3] Power is the ability not to have to explain what you are doing, or at least to do so in language so esoteric that it renders the listener dumb or makes them feel slow. Some people are attracted to professions because they have a vocation to serve, others because being a professional confers status and power. So it seems that many professionals – especially doctors perhaps – have been trained to give explanations in a way designed to keep the patient at bay. Yet consumer culture, combined with the spread of alternative sources of information and knowledge, now means that people do not want to be talked down to. They want to be treated as intelligent participants in a conversation, which takes place at a speed and in a language that allows them to contribute. People like metaphors and simple stories of cause and effect. Yet professionals often lapse into specialist codes, probabilities, risks and technicalities. Translating technical issues into accessible language is a skill that not all professionals have. Promotion and advancement within pro-

fessional communities comes from talking the language of the profession rather than that of the clients. Academics who are good at communicating publicly, and so acquire a popular following, do not always find that improves their professional standing.

All these supposed remedies – better communication, more support staff, improved consumer information – attempt to reform the professional's relationship with their clients, to make them fit for a more demanding and less deferential age. All have some merit. But there may be a deeper problem they fail to reach: the professional service model itself may be ill suited to tackle many of the issues we face as a society.

Health is a classic example of where employing many more professionals and paying them more does not guarantee results. Despite a doubling of health spending since 1997, waiting times for routine operations are set to climb in 2006/07 because of the funding crisis within the NHS. Much of the additional spending has gone to employ and pay for more nurses and doctors. The 2002 Wanless Review of the future of the NHS, commissioned by the Treasury, suggested that on current trends health spending would have to double again in the next 20 years to keep pace with demand.[4] That is inconceivable. The problem is rooted deep within the professional model of public service delivery.

A modern health system, built around hospitals, is working efficiently when the beds are full as much of the time as possible. The aim must be to fill up the hospital. Yet a healthy society is one in which people do not need to go to hospital nor to see doctors. The best definition of health is not needing to see a doctor. The fact that we associate good health care with hospitals that are full is a sign of just how skewed our thinking has been by systems of industrial production applied to social issues. The more that hospitals can produce high-quality, personalised, mass, customised treatment, along a more or less linear patient pathway that looks something like a production line, the better health care we will get, we think. The patient goes in at one end ill, is worked on by doctors and nurses, and emerges out of the other, like a finished product, well again and, if

they are lucky, they get some after-sales service from social services.

The hospital-focused health care system emerged in response to the spread of contagious and acute disease born by urbanisation and industrialisation in the late nineteenth century. The aim was to provide a place where specially trained people – doctors and nurses – could repair people who were ill, a bit like a garage repairs a broken-down car. But now this system of professional diagnosis, prescription and monitoring has to face a challenge for which it was not designed: an epidemic of chronic disease, in a society in which people live for longer.

In the UK, 45 per cent of the adult population have one or more long-standing medical condition. Among those 75 years old, the fastest-growing group of the population, the figure is 75 per cent. By 2030 the proportion of 65-year-olds with a long-term condition will double. In 1900 circulatory diseases, like heart conditions and cancer, were responsible for 19 per cent of deaths: most people died too young to be troubled by a chronic condition. In 2004 circulatory diseases and cancer were responsible for 63 per cent of deaths. About 80 per cent of consultations with a general practitioner are about an aspect of a long-term condition. Another 10 per cent are for minor ailments and conditions that are best dealt with through self-treatment and over-the-counter drugs.

Chronic conditions are often linked together: people with five long-term conditions generally get more than 50 different prescriptions a year. About 650 million prescriptions a year go to people with long-term conditions. Chief among these conditions is diabetes. In the UK more than two million people are diagnosed diabetics and a further one million are diabetic without realising it. If type II diabetes, which is linked to lifestyle, is caught early its development can be kept in check. But a system in which expertise is inside clinics and hospitals does not allow us to diagnose diabetes early enough. Between 40 per cent and 50 per cent of diabetes is not diagnosed until it is too late. Then people become dependent on regular insulin injections, which in the UK involves repeat visits to the doctor and difficult changes to what they eat, how they cook and the

rest of their lifestyle. The hospital-based health system, designed around professional expertise to treat contagious disease and cure people, is ill-designed to prevent and manage chronic long-term conditions.[5]

This mismatch between a professionalised hospital-focused health service and the needs of society will not be solved by employing more para-professional nurses, tighter regulation of medical ethics or doctors talking in the vernacular to patients, though all have their place. We need a much more radical rethinking of the role of professions, their relations with their clients and the organisations that bring them together. We have created systems for the mass production of public goods through schools, hospitals and social work departments run by professionals. In future more of the emphasis will have to be production by the masses not for them. Which is where Ivan Illich comes in.

Ivan Illich was a nomadic and iconoclastic Catholic priest and arch critic of industrial society in the 1970s who in a series of polemical and passionate books – more like pamphlets – set about the failings of modern institutions and the professionals who organise them: *Deschooling Society*, *Limits to Medicine*, *Disabling Professions* and *Tools for Conviviality*.[6]

As he put it in *Deschooling Society*:

> *The pupil is 'schooled' to confuse teaching with learning, grade advancement with education, a diploma with competence, and fluency with the ability to say something new. His imagination is 'schooled' to accept service in place of value. Medical treatment is mistaken for health care, social work for the improvement of community life, police protection for safety, military poise for national security, the rat race for productive work. Health, learning, dignity, independence and creative endeavour are defined as little more than the performance of the institutions which claim to serve these ends, and their improvement is made to depend on allocating more resources to*

> *the management of hospitals, schools and other agencies in question.*[7]

Illich was ahead of his time by being behind the times: his critique of industrialisation harked back to pre-industrial, communal forms of organisation, as well as foreseeing a world of networks and webs long before the internet. For much of the 1970s he was a darling of the left, sharing some intellectual common ground with Herbert Marcuse and the Frankfurt School's critique of a one-dimensional society, run by large corporations. He was an environmentalist before the movement had been born and lived a spartan life with few possessions. Yet Illich was no lefty. Although he was deeply at odds with the Vatican, he never left the Catholic priesthood. He dismayed many of his left-wing fans with a withering attack on Castro's Cuba and his defence of the traditional gender roles, which enraged feminists. Illich was both radical, profoundly conservative and yet also a libertarian, an early advocate of a version of education vouchers and individual choice in public services. Illich died in 2002 and towards the end of his life his writing became more apocalyptic, at times melancholy and pessimistic.

Yet in a short, golden period in the mid-1970s, Illich set out not just a critique of industrial-era institutions and their professionals but also some highly suggestive ideas on how they might find a more supportive, realistic and balanced role in society. Those ideas now have even more relevance.

After Ivan Illich trained as a priest he went to work in a poor Puerto Rican neighbourhood in New York City and he was struck by how many other institutions seemed to be modelled on the church and how many professions seemed to take their cue from the priesthood. Illich's argument against the church was that it turned the charity and mutuality evident in the tale of the Good Samaritan into a kind of social machine. The church became not just a source of care and solace, but a source of power and doctrine, in which the priesthood determined who was holy. For Illich this perversion of care into the exercise of power was the fate of all institutions and

caring professions. Mutual support and care mutated into the institutionalised welfare state with its rules and entitlements. Curiosity and a desire to learn, for the sake of living a more fulfilled life, became an education system that grades people by how well they learn what the system decides.

The triumph of modern industrial society, according to Illich, is the creation of institutions on a vast scale, which provide services such as education, health and policing that might have once been limited to just a few. These universal systems aspire to deliver services that are fair and reliable. Yet that in turn requires codes, protocols and procedures, which often make them dehumanising. These institutions and the resources they control become the power base for the new priesthoods: the public service professionals.

The original, liberal professions were independent, small-scale and localised. They worked in a society where knowledge was scarce and difficult to access and so people had no option but to cope themselves. The liberal professions become dominant professions, according to Illich, with the institutionalisation of their knowledge and power into systems. Dominant professions do not just provide services and solutions, they also define what we need and what we lack. Not only are the professions a powerful vested interest in society, attracting resources and prestige, they also dominate the way we think. Even though most improvements in health have come from changes in lifestyle, the way we work, public health and food, in the public imagination health is indelibly associated with doctors and hospitals, men and women in white coats.

The dominance of professions creates two big problems according to Illich: counterproductivity and a dependency culture.

Professional institutions become counterproductive: the more resources that are poured into them, the more problems and ill effects they create, often outweighing the benefits. A hospital that provides a cure for a specific medical condition – an elderly person's broken hip – can quickly disorient the patient and rob them of self-confidence, as they are passed from doctor to doctor, ward to ward. It takes only a few days for an elderly person in hospital to lose their self-confidence

in their own capacity to cope. They are likely to emerge with their hip cured but their self-confidence shattered. The apparent omnipotence of doctors, the mystique of the profession, excites people to expect cures that cannot be delivered. When the doctor cannot dispense the expected cure, it breeds a sense of frustration and disappointment that leads to a loss of trust.[8]

This counterproductivity also afflicts education, he argues. The school system is meant to be a route for social mobility and opportunity. Yet any system of ranking and grading is bound to produce failures and dropouts as much as successes. Indeed far from encouraging people to learn, formal schooling trains people to turn off. School creates the impression that learning is the product of teaching and something we do only in special places, like schools, at special times in our lives, with the help of special people: accredited teachers. Education is seen as unworldly; to learn is to be cut off from the day-to-day world. But by extension the world – where we live most of our lives – cannot be about learning. Education is seen not as a personal project but as a process of certification to show you have learned what the system expects.

As people become more dependent on professionals so they lose faith in their own capacity to act. The rise of professional power is mirrored by a loss of individual responsibility. We become cases to be processed by the system rather than participants. Education and health come to be commodities to be acquired rather than capabilities we develop in ourselves to live better lives.

For Illich, professionalised institutions are nightmares forged out of good intentions. The professions that serve us disable us at the same time. As Charles Taylor, the philosopher, puts it in the introduction to *The Rivers North of the Future*, a collection of Illich's last writings:

> *Ours is a civilisation conceived to relieve suffering and enhance human well-being on a universal scale, unprecedented in human history. It's what we think we ought to be able to do and yet we also feel that those very systems can imprison us in forms that turn alien and dehumanising.*[9]

Many public service professionals may feel confused, aggrieved and astounded by Illich's critique, which is easy to dismiss as utopian and naïve. However, because he was prepared to think fundamentally his analysis also yields suggestive ideas about how professionals might repair their relations with the people they serve.

As he put it in his most optimistic book, *Tools for Conviviality*:

> *I believe a desirable future depends on our deliberately choosing a life of action over a life of consumption, on our engendering a lifestyle which will enable us to be spontaneous, independent, yet related to each other, rather than maintaining a lifestyle which only allows us to produce and consume.*[10]

Postindustrial, convivial institutions would work through conversation rather than instruction; co-creation between users and producers, learners and teachers, rather than delivery; mutual support among peers as much as professional service.

In *Deschooling Society*, first published in the UK in 1971, he provided some principles for how a more convivial education system would work, for example, by providing all who want to learn with access to resources at any time, in airports, factories, offices, museums and libraries as well as schools; making it easy for those who want to share knowledge to connect with those who want to learn from them through skills exchanges and directories of classes that people could choose from; allowing those who want to propose an issue for discussion and learning to do so easily. In 1971 that sounded radical and far-fetched. In the era of Wikipedia and eBay, blogs and Slashdot, Monster.com and MeetUp it sounds more like the conventional wisdom of the social networks created by the internet. Illich's argument was that education should be a delicate blend of the personal and the collective: learning should be driven by what a person feels motivated and curious about and they should be able to draw easily from common resources to achieve their ends.

Illich's proposals in *Tools for Conviviality*, *Deschooling Society* and *Limits to Medicine* yield the following six design principles for public services and professionals in a postindustrial society.

First, public institutions and professionals should educate us towards self-help and self-reliance as much as possible. Modern society trains us to be workers and consumers. Postindustrial institutions should train us for self-management and self-assessment. As Illich put it in *Deschooling Society*: 'Good institutions encourage self-assembly, re-use and repair. They do not just serve people but create capabilities in people, support initiative rather than supplant it.' In *Limits to Medicine*, he argued: 'Better health care will depend not on some new therapeutic standard but on a level of willingness and competence to engage in self-care.' Almost 30 years later the Wanless Review of health spending reached exactly the same conclusion. We will become a healthy society only if we restore the proper balance between professional service and self-help. Illich's golden rule was that formal instruction must never outweigh opportunities for independent learning.

Second, this means public services need to build our capacity for self-assessment and self-evaluation, starting with education. The modern, professional state spends massive sums on assessing need, especially in social care, where perhaps a third of the budget goes on assessment of need by professionals. First professionals assess what we need, whether we are entitled to state support and then they determine how that should be delivered. Then more professionals, in the form of inspectors, come along to check it has all been done properly. We need much greater emphasis on intelligent self-assessment and self-evaluation. That is already the lynchpin of the tax system and should play a greater role in education and health. Experiments with self-assessment in social care show that people generally do not over-claim benefits and are more likely to see how they could address their needs without turning to the state. The education system schools us to think of assessments as exams, something we do at the end of the pipeline, checked by a professional. We need an education system that builds up capacity for intelligent self-evaluation, so that we are better equipped to assess and solve problems under our own steam, with the help of our peers and professionals if needed.

Third, as well as imparting knowledge, postindustrial public services must promote motivation and cultural change. Motivation is the new medicine: motivating and equipping people to look after themselves better. Motivating children to want to continue exploring and learning should be one of the chief aims of the education system. Schools instil a deference to professionals from an early age.

Whenever someone comes into contact with a public service it should not just deliver something to them, but also try to create the motivation for the person to look after themselves more effectively. For Illich this meant turning away from a consumerist account of public services in which we are served by others or acquire an education. Instead of having, acquiring, possessing, we should want a society that encourages action, doing, being. As he put it in *Limits to Medicine*:

> *In an intensely industrialised society, people are conditioned to get things rather than to do them; they are trained to value what can be purchased rather than what they themselves can create. They want to be taught, moved, treated or guided, rather than to learn, to heal and to find their own way.*[11]

That would mean the role of professionals in future would be to act as persuaders, counsellors and campaigners, not delivering a service, but encouraging people to acquire the skills to look after themselves more effectively. Such professionals would almost have be like molecules in the bloodstream of society, rather than waiting in their institutionalised boxes for the public to present their problems.

In *Limits to Medicine*, Illich described the goal of making health a personal task, which people take responsibility for, this way:

> *Success in this personal task is in large part the result of the self-awareness, self-discipline, and inner resources by which each person regulates his own daily rhythm and actions, his diet and sexual activity. . . . The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population.*[12]

The implication is that the chief goal of professionals should be to serve people in a way that helps to build up this distributed capacity for coping. Service users need instead to see themselves as contributors, participants, investors in and taking responsibility for their own wellbeing.

Fourth, we will learn as much from our peers as from professionals. Postindustrial public services will not just provide professionals to be consulted but mobilise knowledge and expertise from a wide variety of sources. Professionals will still be the most knowledgeable and the best-resourced players in any field. But they will increasingly find themselves playing alongside alternative practitioners, para-professionals, peers and pro-ams.[13] Enlightened professionals will realise their jobs are made a lot easier if they relinquish their claim to a monopoly on knowledge and encourage people to turn to other, reliable sources. Thanks to the internet and new generations of search engines, people will increasingly find their way to the sources of news and information they trust. Professional monopolies on knowledge, painstakingly established in the twentieth century, will erode rapidly in the twenty-first century. Professionals will still provide expertise and judgement but they will also encourage exchange and encounter between peers.

Fifth, resources, skills and tools have to be much more distributed. *Tools for Conviviality* is a defence of simple, easy to use, vernacular tools that help people achieve things more easily, as opposed to complex tools that only professionals can understand and operate. Illich mainly wrote before the advent of the personal computer, the internet and the mobile phone. In later life he was no great fan of them. Yet in many ways these are great examples of the convivial, easy to access tools that allow people to collaborate and communicate. We have only just begun to tap their potential. Kent County Council is just starting trials of new home-based sensors to allow remote monitoring of the movements and health of elderly people, which should allow more to live in their own homes rather than move into care homes. In Korea a mobile phone came onto the market in 2006 that allows a person with diabetes to check their blood sugar levels

and communicate the results to a doctor. Or take a thrombosis prevention service run in north London, which has 5,000 patients taking drugs to reduce blood pressure and risk of clotting. They have weekly blood tests, which are administered locally by nurses and GPs and sent in centrally for assessment. The unit writes to anyone who needs to change their dosage; if it is urgent they call them on the phone. The system works efficiently: tests are done by 11am and the results are back by 1.30pm. But in Germany the patients do all this themselves with a small machine that costs about £400. They do the test whenever they like. They analyse the results and change their dosage accordingly. In north London only ten of the 5,000 patients use this machine. The unit employs scores of nurses to do tests at industrial scale which could easily be done by the patients themselves.

Finally, it is not just tools that need to be distributed but finance as well. In the autumn of 2005 I spent an afternoon with a group of inspiring parents in Wigan who were all participating in the Department of Health's 'In Control' pilots to allow families caring for young people with learning disabilities to have individualised budgets. The group said that when they had been consumers of public services, they tended to complain to get things changed; they were often at odds with service providers and rarely shared ideas and resources among themselves. Once they became budget holders they started to look for ways to make the money go further; they worked more collaboratively with their care workers and with one another. Individualised budgets turned them from passive and often disempowered consumers into participants and players; they took responsibility for how their budget was spent.

Even now, three decades after Illich first sketched these design principles, they can sound utopian. It is certainly far-fetched to hope that public services could be reformed, in a single bound, to adopt this highly distributed approach. Public services and their professionals have developed through a process of sedimentation.

Schools, hospitals and welfare institutions started through acts of charity or faith. Professionals began life as independent advisers. They were brought together in the twentieth century into systems that

could deliver public services at national scale, for everyone, at reasonable costs and standards through an uneasy truce between professional discretion and industrial process. Since the 1980s that has been overlaid by the growing weight of the 'McKinsey state' of performance management, targets, contracting out and quality standards. Current initiatives to extend choice will provide a thin topsoil of consumerism to systems that are still largely planned, rationed and dominated by professionals. Public spending programmes, by default or design, entrench and embed this industrialised model of service delivery. Despite a doubling of spending since 1997 the current crisis in hospital funding is squeezing out resources for preventative and social care. In education a massive capital programme is 'Building Schools for the Future', many of which will look alarmingly like schools of the recent past, with jazzier architecture. We incarcerate more people than ever, in prisons that look very like Strangeways, opened more than a century ago.

At the edges of these vast, asset-heavy, inflexible systems we can see the first signs of what postindustrial public services might look like: Kent's home-based social care programme; the 'In Control' initiative to give services users individualised budgets; the development of distance and peer-to-peer learning; and the 2006 social care white paper, which foresees the creation of a stronger infrastructure of community-based services. More important still, many of the most dynamic emerging business models are highly collaborative, peer-to-peer and distributed, from eBay and Craigslist to Linux open source software and computer games such as the Sims.

Postindustrial public services offer more than a new layer of sediment. They would reconfigure the geology of public services. That will not happen in a single comprehensive spending review, nor even a single parliament. But over 20 years it should be possible, indeed it will become a necessity, because our inherited, inflexible and often impersonal models of service will not be able to cope with projected levels of demand. Public services for the coming century, in the developing world even more than in the developed, should be distributed, collaborative, peer-to-peer, co-created and motivational.

Professionals will play a critical role in them dispensing advice, supporting clients, campaigning for cultural change, navigating access to resources and promoting self-help. They should become campaigners, counsellors and advocates rather than priests. Ivan Illich's genius was that 30 years ago he could already see this would not just be desirable but it would become a necessity.

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Notes

1 International Federation of Social Work, see www.ifsw.org (accessed 26 May 2006).
2 C Leadbeater and H Lownsbrough, *Personalisation and Participation: The future of social care in Scotland* (London: Demos, forthcoming).
3 C Tilly, *Why?* (Princeton, NJ: Princeton University Press, 2006).
4 D Wanless, *Securing Our Future Health: Taking a long-term view*, final report (London: HM Treasury, April 2002).
5 H Cottam and C Leadbeater, *Health: Co-creating services*, Red paper 01 (London: Design Council, 2004).
6 Illich's books have been reprinted many times and are published in the UK by Marion Boyars Publishers, www.marionboyars.co.uk (accessed 21 May 2006), and distributed by Central Books.
7 I Illich, *Deschooling Society* (London: Marion Boyars Publishers, 1970, reissued 2002).
8 I Illich, *Limits to Medicine* (London: Marion Boyars Publishers, 1995), first published as *Medical Nemesis: The expropriation of health*, originally published in January 1975.
9 *The Rivers North of the Future: The testament of Ivan Illich*, as told to D Cayley, foreword by C Taylor (Toronto: House of Anansi Press, 2005).
10 I Illich, *Tools for Conviviality* (New York: Harper Row, 1973).
11 I Illich, *Limits to Medicine*.
12 Ibid.
13 C Leadbeater and P Miller, *The Pro-Am Revolution: How enthusiasts are changing our economy and society* (London: Demos, 2004).