BLOCK 2 FAMILY, GENDER AND WELFARE

UNIT 10 NEW FORMS OF DOMESTIC LIVING
Prepared for the course team by Robert Bocock

UNIT 11 THE BODY POLITIC, HEALTH, FAMILY AND SOCIETY
Prepared for the course team by Pamela Abbott and Roger Sapsford
AIMS AND STUDY GUIDE

This unit aims to
1. Introduce the problem of the relations between social facts and moral values with specific reference to the area of marriage and the family.
2. Outline some research into the problems people experience in modern marriages, and on alternative forms of domestic living to traditional marriage.
3. Consider a set of moral values which challenge the mainstream of modern, Western, liberal values towards marriage and the family.
4. Examine a recent example of philosophical analysis of sexuality, marriage and the family.

At the end of the unit you should
1. Be more aware of your own feelings and moral values about marriage and the family.
2. Be more aware of the range of value systems that people in modern Britain hold and try to practise.
3. Be aware of one recent moral and philosophical intervention into the area of sexuality, marriage and the family.
4. Be more critical about the relationship between ‘social facts’ and moral values, seeing the ways in which moral values affect how various groups of people, including yourself, perceive marriage and new forms of domestic living in a modern society.

Set reading
Nicky Hart, ‘Mental breakdown as a personal crisis’ (in the Block 2 Offprints Booklet).
Roger Scruton, ‘The politics of sex’ (in the Block 2 Offprints Booklet).

Optional reading
Carol Smart, ‘Securing the family: rhetoric and policy in the field of social security’ (Chapter 7 in the Course Reader).
1 INTRODUCTION

A set of social issues about the family, marriage, divorce, the socialization of children, the gender roles of women and men, and sexuality has become a significant area of political debate since the 1950s. Some of these issues have been debated and contested by groups in Britain and in the United States, including members of all political parties, as was discussed in Unit 7. Social movements which have grown up outside the main political parties, such as the women’s movement, the gay movement, and groups made up from members of the Churches, have also contributed to these debates and tried to achieve changes in laws and in general social attitudes towards these areas of concern.

‘Sexual politics’ was initiated by those seeking reforms of the law in a more liberal direction, but the area is now one to which many on the political right contribute. It is neither a left, centre nor right area of political debate, but one in which many organizations and pressure groups of all political persuasions now participate. Sexual matters have been seen as belonging to the private sphere and were not considered to be a part of public political debate and contestation until the growing women’s movement began to argue for a change. The claim advanced by many women was that ‘the personal is political’. Many liberals in all political parties still operate with what they regard as a fundamental distinction between the private sphere and the public sphere. Others on the right, whilst holding that there is a private sphere of family life, argue that the rules and laws governing behaviour within the private sphere are matters of legitimate public political debate. The activities of people in private are, it is held by some politicians, legitimate areas of concern to the state (see Unit 7).

By this stage in your study of the course, you will be familiar with the idea that ‘the family’ is not a biologically given, natural unit but a socially constructed institution. ‘The family’, in the sense of the modern nuclear family, is best seen as an historically evolved set of social relationships, and not as a static, fixed and unchangeable arrangement. The modern nuclear family is still changing and evolving in contemporary Britain and in other similar societies. As was mentioned in Unit 6, for example, the development of sexual monogamy, on a large scale, is a recent development affecting one-third of all married couples. ‘Sexual monogamy’ is the term used to describe a situation in which one person is married to one other person, but that person may have more than one such marriage during his or her life-cycle. This pattern exists side by side with those married couples who have stayed together all their lives, many of whom belong to the generations which grew up before divorce was acceptable among ‘respectable’ people.

Changes in marriage and family patterns are not acceptable to everyone and, as was shown in Unit 7, there is considerable ideological and political debate about ‘the family’. A number of political pressure groups have been formed in recent years which seek to achieve change, or to preserve changes already made, in the broad area of family and sexual politics. These pressure groups range, for example, from those groups which oppose abortion, divorce and artificial means of birth control, to pressure groups monitoring equal opportunities for women at work, and gay rights groups seeking to build up more legal, social and general cultural acceptance of male and female homosexuality.

Such pressure groups sometimes work within one or more of the main political parties, or they may operate outside of such structures in new ways, as the women’s movement has tended to do with the use of discussion groups to air women’s thoughts and feelings.

Changes in men’s and women’s gender roles were discussed in Units 8 and 9 of this block. These changes are complex, still evolving, and affect views of ‘the family’. For instance, working mothers may or may not have a househusband at home doing the shopping, cleaning, baby and child-care activities, and the cooking. If both parents are in paid work outside the home, they may have a paid housecleaner, cook, nanny or au pair, they may have considerable help with housework from one or more of their children or parents, and they may share responsibilities for shopping, cooking, child-care, cleaning and laundry chores when they are not out of the house doing paid work.
In this unit you are going to be reading about the traditionalist patriarchal ideology of the family as it has been articulated both by some writers and some traditionalist social institutions in recent years. You will also examine some research on the problems some people have experienced during marital breakdown and consider the development of new forms of domestic living arrangements in modern Britain. These themes reflect the experiences of some people who have internalized many, or all, aspects of the pervading ideology of the family, one which is substantially modified from that of the traditional version considered in Section 4 of this unit. Many people grow up accepting that getting married, having children and bringing them up is a perfectly natural process for them, and that they will not encounter too many problems along the way once they have found the right husband or wife.

However, some people find that things do not work out quite as they had expected. They seek a second try with a new husband or wife. One or other of the parents of the first marriage will usually take the children of that 'failed' marriage into their second one, thus creating a new nuclear family in which not all the children are the biological children of their new socially defined 'parents'.

Not everyone does this, however. Some women decide to live alone, or with their child or children for considerable lengths of time, or for the rest of their lives, without remarrying. Some women choose to live with another woman: either because they love each other, or because it is simply more practical to do so. Others may return 'home' to live with their mothers for a time. Any of these choices may or may not be long-lasting ones.

Similarly, men leaving a marriage and family are faced with a number of options which may be chosen by different individuals for varying lengths of time: living alone, living with another woman, living with another man, returning to the parents' home, living with children, or living in a group. Some men may try a variety of these living situations during their lives. The important point is that the domestic living situations for women and men change during the course of their lives.

For both men and women, the breakdown of a first marriage can be experienced as a relief and a release when it finally happens. It may also cause a great deal of pain and suffering, both emotionally and physically, before the final breakdown is reached. Many people go through a period of re-appraisal of their ideas about themselves, their sexuality, their expectations about other people, the opposite gender, and about marriage during such an experience. Others opt quickly for a new marriage. A few may try quite different forms of domestic living from that of the nuclear family.

It is not the private domain alone that is involved here. State agencies may intervene at a number of points in such situations. Social workers may become involved with a particular family if the children are being neglected as a result of both parents being out of the house at work. Children may also be affected by the converse situation of both parents being in the home, since both parents may become demoralized by the lack of money and the husband's loss of a sense of self-worth whilst unemployed. The children in some families may play truant from school frequently enough to bring the family to the notice of the local education authority. Children from families in which the mother and father are experiencing problems may sometimes play truant from school as a way of gaining attention from parents who are uninterested in them because they are preoccupied with their own marital problems. The courts may become involved, not only when a couple seek divorce, but also when there are disputes after a divorce or separation about the husband's or wife's access to the children of the marriage. The courts and social workers may both become involved if a couple are physically violent to their children or to each other. It is usually assumed that it is the husband who is physically violent to his wife, but there may be physical violence from a wife to her husband. This latter issue is only just emerging in public discussion, no doubt because men find it difficult to admit to the police or social workers that their wives attack them. A 'real' man would not allow himself to be assaulted by a woman, especially not by his own wife. Another view of
masculinity may well include positive acceptance of the idea that a husband may beat his wife – it certainly did so in the not too distant past, and there is some evidence that it was to be found among some young males in the 1970s (Willis, 1977)

Throughout this unit various levels of what will be called patriarchal ideology will be mentioned. This will include some discussion, in Section 4, of traditionalist patriarchal ideology, which is articulated and maintained and has been revitalized by contemporary Roman Catholicism, the patriarchal ideology behind present-day British law as it affects marriage, divorce, the family and sexuality, and the informal patriarchal values found in many everyday family situations. Such an ideology has affected most, if not all, of us, as we grew up in cultures, or sub-cultures, which transmitted, articulated and modified patriarchal ideology.

The core values of this ideology may be defined as follows: women mother, men fight (Easlea, 1981). In patriarchal ideology it is presumed that women, not men, should look after babies and children. Men, not women, should be prepared to fight for their country, or for their football team. Boys are usually taught ‘to stick up for themselves’ in the school playground, on the street or, later on, at work. However, some recent developments do challenge patriarchal ideology both in theory and in social practices. Some of these developments will be discussed in Section 3.

2 'THE FAMILY' AS AN AREA OF MORAL DISPUTE

Debates and discussions in the social sciences, and particularly debates about applications of the social sciences to important social issues such as the family, consist of a complex blend of three types of proposition. You may be familiar with these at this stage of your Open University career. These are

1. propositions of a factual kind – 'facts',
2. theoretical, or conceptual, propositions,
3. value judgements

It is important in reading texts about the family to try to disentangle these three types of assertions. I will say something about each of them briefly to help you to identify what each type of proposition looks like.

Propositions of a factual kind. These are typically propositions of a quantitative type which claim to show how many people do, or think, something or other. These may be expressed as numbers for example, 'there are over 2.75 million females living in Great Britain', or they may be expressed as a percentage, or a proportion, e.g. '52% of the population is female', or 'just over half the British population is female' (see HMSO, 1981a and 1981b).

Theoretical, or conceptual, propositions. These are not always in the form of a hypothesis to be tested against data of a quantitative kind, but may be used rather to order and tabulate data into categories of analysis. These categories have to be derived from some way of looking at the world, or at society. This is necessary as a matter of logic. This means that it is not a fault in an analysis that the concepts used are derived from such wider, philosophical ways of construing the world, or society, because this is unavoidable. No one can do otherwise. Differences between
various social scientists may be seen in the degree to which the categories that are
used to look at the world are seen as being derived explicitly from a larger,
coherently organized theoretical perspective or paradigm. Some people speak or
write as if 'the facts speak for themselves' and therefore feel that they do not need a
wider theoretical perspective. This, however, is misleading, for the facts have to be
organized and related to a wider problem before they can 'speak' to anyone. The
categories used to organize such facts, or data, are derived from a theoretical
perspective of some kind, and this ought to be made explicit.

Value judgements. The third type of proposition to be found in much social scientific
discussion, and certainly in discussions about the family, concerns those propositions
which either explicitly or implicitly reflect the moral and political values of the
participants in the debate. It used to be held by many social scientists, as it still is
by some, that such value judgements have no place in the social sciences, including
applied areas such as social work and counselling. Many social workers think that
they should not seek to impose their moral values on their clients, yet they cannot
claim to be working in a value-free manner when they make interventions in families
and in other situations. Social work is not best described as the application of social
science in a value-free manner.

The relationship between social scientific, factually based analysis of social
institutions and moral values is raised in an important and acute form in the social
analysis of the family and personal sexual relationships. The standard view of this
relationship holds that the social sciences are concerned with establishing what is
the case - with 'social facts', as the French sociologist Emile Durkheim called them
- and that moral philosophy and/or moral theology is concerned with discussions
about values. The relationship between these two types of discourse has been seen
in the following way by many social scientists that nothing follows about how we
ought to act from a set of empirical propositions about what is in fact the case. So
the ways in which people do act are irrelevant to how people ought to act.

This view has been based upon the work of the Scots philosopher David Hume
(1711-76), who asserted in a quotation which became a classic position in British
empiricist philosophy that

In every system of morality, which I have hitherto met with, I have always remarked,
that the author proceeds for some time in the ordinary way of reasoning, and establishes
the being of a God, or makes observations concerning human affairs, when of a sudden
I am surprised to find, that instead of the usual copulations of propositions, is, and is
not, I meet with no proposition that is not connected with an ought, or an ought not.
This change is imperceptible, but it is, however, of the last consequence. For as this
ought, or ought not, expresses some new relation or affirmation, it is necessary that it
should be observed and explained, and at the same time that a reason should be given
for what seems altogether inconceivable, how this new relation can be a deduction from
others which are entirely different from it. But as authors do not commonly use this
precaution, I shall presume to recommend it to the readers and am persuaded, that this
small attention could subvert all the vulgar systems of morality, and let us see, that the
distinction of vice and virtue is founded not merely on the relations of objects, nor is
perceived by reason. (Hume, quoted in MacIntyre, 1967, pp 171-7)

This view of Hume has been held to support the claim that social scientists should
deal with the production and analysis of social facts, and should eschew making
value judgements on their findings. The activity of making moral judgements - that
is, producing propositions containing an ought or an ought not - is thought of as
being external to the social sciences themselves.

Such a view is less widespread today than it used to be in the past because many
more social scientists, including economists, social psychologists and sociologists,
acknowledge that their values do influence their work. The decision about which
topic, or problem area, a social scientist is to study, and how she or he studies it,
depends upon wider moral and political views - for example, whether to research
race relations, to work on market research for an advertising firm, to study issues surrounding the role of women, lesbians or gay men, or to develop selection procedures for officers in the armed services, such choices reflect wider moral values. These choices are not to be seen as fixed and permanent ones. A moment’s reflection illustrates this: think of the difference between social psychologists, for example, working upon the selection of officers in the armed forces between 1939 and 1945 and the same research task among the United States forces during the Vietnam war. The two situations are not morally, or politically, identical in that invasion by an enemy was a real threat to Britain in the Second World War, whereas the threat to the United States in Vietnam was a very indirect one.

Furthermore, some would hold that their choice of a basic theoretical perspective to study a problem is influenced by their values. This is because different theories highlight distinct areas for research. For example, there is very little theory about sexuality in Marx and nothing highly developed on economic class in Freud. Yet someone may want to work upon sexuality and gender, or on class, because they are concerned about sexual inequality between men and women, or about the social oppression of gay people, or about the exploited classes in the world.

All three types of proposition – factual statements, theoretical statements and moral values – will be found in the area of primary concern in this unit, namely the nuclear family and alternative domestic living arrangements. Much of the writing most people come across in their everyday reading will be the kind which mixes value judgements and ‘factual’ statements in newspapers in particular. Working ideologies about the family are continually being constructed and reconstructed, by politicians, teachers, journalists, parents, young people, and by moral theologians.

Feminist groups, both within political parties and outside them, have pressured for legislation and state intervention to help women gain full-time paid jobs outside the home and for women to be paid the same as men for the same work. Some of this kind of activity, and the research upon which it has been based, was presented in Unit 9 of this block, and therefore space will not be used here to add to that material. You should bear in mind, however, that political activity and organization has been necessary for women to achieve the right to vote, to be treated in law as having equal rights to those of men in regard to property, inheritance and marital rights, and to seek equal pay for equal work – something which has still not been attained.

Turning now to the wider social and cultural context in which policies towards the family are developed, you will recall from Unit 6 that there is no simple, social scientifically based definition of the family which is universally valid. No single definition of the family can be given which is useful across all historical periods in one society or culture zone, or which holds for all cultures, whether influenced by Christianity, Islam, Hinduism, Buddhism or Communism. However, there are other, non-social scientifically based conceptions of the family which do assume that a particular form of the family, the modern Western, nuclear, monogamous family, for instance, is or ought to be, universal. Each major world religion, and the various sects that have developed in Western countries in the nineteenth and twentieth centuries, offer a view of how the family ought to be socially organized (Wilson, 1970 and 1982). It is usually assumed that the family pattern which any particular religion sanctions should be universal, but some religions are more tolerant on this issue than others. Hinduism is fairly tolerant, as are some forms of liberal, Protestant Christianity, for example. The major world religions contain values and practices which are frequently encoded in laws and rituals about marriages. They include patterns about the choice of a marriage partner, about how children ought to be brought up and by whom, and about the care of the old and sick members of a family.

Moral values about the family vary from one time and place to another. In some monogamy is a major value, as in Western Catholicism, in others polyandry or polygamy is allowed, as in some versions of Islam. In some historical periods and
cultures marriage partners are chosen on the basis of romantic love, in other periods and cultures parents decide upon the marriage partner for their children soon after the children are born. There are contemporary religious pressure groups who treat this variety as a symptom of confusion, and they therefore seek to offer what they see as guidance and clarity amidst the plethora of values and ideologies. An example of this position will be studied in Section 4.1 below.

Some sociologists and social theorists have chosen to move outside the strict confines of descriptive social science, of social anthropological, social historical and sociological descriptions of what different cultural groups do, or have done, and have become involved in a more moral philosophical discourse. Unless this is done, such social scientists argue, their readers and students are confronted by a wide variety of practices and value positions, but have no means of assessing them. The only criterion some social scientists accept is a pragmatic one that certain practices seem to work for the particular group that adopts them. This criterion is less than satisfactory in pluralistic situations because different, but incompatible, values may ‘work’ for some people but not for others (see Fromm, 1962, and Marcuse, 1966).

People are faced now with a variety of practices and religiously grounded moral values in one society, as has been the case in Britain in the post-Second World War period. Such variety is accepted by some groups, others find it disturbing and seek a more secure moral position, either for themselves and their family, or one which they think everyone in their society ought to follow.

Social workers, doctors, nurses, teachers and counsellors need to be aware of the variety of sexualities, marriage and family practices to be found in modern Britain. They need to be able to stand back from their moral values in conducting professional work with clients or patients and to avoid the assumption that their own values are the norm against which other people with different values should be assessed. The different assumptions made by various generations in particular sub-cultural groups, and the conflicts of values even within one major group and its moral tradition, now need to be acknowledged by social workers if they are to be able to understand their clients. Such groups of practitioners, however, need to know their own minds about this variety and confusion of values and social practices. One purpose of this unit is to help you begin to do this.

The ways in which a ‘moral panic’ developed in 1986 about groups of people travelling around the country, called ‘hippies’ by many politicians and journalists, illustrated the lack of such clarity about values (for a discussion of ‘moral panics’ see Cohen, 1972). The confusion in public moral discourse, and in patterns of policing and legal practices, towards such groups of people who do not share many of the central values and their associated practices of the major, politically powerful groups in Britain, was expressed during this episode (see the newspaper report opposite from The Times). The ‘travellers’, as they called themselves, did not want to live in a permanent home with their spouse and their children, watching television as their major pastime in the evenings and at weekends, after working in a regular job, assuming that they could find one. In this period, the mid-1980s, there were between three and four million people unemployed, so that even if some of the travellers were motivated to try to find regular, paid employment they may not have been able to do so.

Some of the couples among the travellers lived and slept together with other families, in relatively large groups. Others were not in such permanent relationships, some children were cared for by couples who were not their biological parents. This way of life was based upon very different values from the modified traditional values which underlie the law and the ‘official’ view of marriage.
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Many new patterns of domestic living have emerged in Britain during the last three decades. Some, if not all, of these new forms have arisen in response to dissatisfaction with traditional values and from some people’s painful experiences in modern nuclear families and in marriages. Section 3.1 examines some research into people’s experience of marital breakdown, goes on to discuss some work on homosexual couples, and then considers the category, or label, of ‘lesbianism’, which is a more problematic category than many people, especially men, assume. Section 3.2 discusses some research on communal forms of living.

### 3.1 Couple relationships

There is a wide variety of couple relationships which do not involve the two people in marriage. Some of these relationships involve couples who live together and who may marry later on in their lives; some are between two people who ‘see a lot of each other’ but do not live together, some are between a couple where one or both partners has been, or still remains, legally married to someone else. Experience of one or more of these kinds of couple relationships helps to form a person’s values and outlook. Difficulties in such relationships, or in earlier married relationships, quite frequently come to affect how a person experiences later relationships and contribute to the development of their overall moral outlook.

Some Roman Catholics — clergy, members of religious orders, and laity — find that the moral theology of their Church on celibacy and on the indissolubility of marriage, causes them a great deal of pain, suffering and sorrow. Catholic couples may lose not only a husband or wife, a home, their children and financial security when their marriages break down, but also their faith when they discover what many come to see as the harshness of the Church towards their desire to re-marry. The Roman Catholic Church’s teachings about marriage and sexual morality will be considered in Section 4 of this unit.

However, it is not only people brought up as Roman Catholics who may experience anguish as a result of their own experiences of being married not matching up to their expectations, often implicitly held until something goes wrong. People who hold a Protestant, or secular humanist, view of marriage and human relationships may also experience difficulties in handling marital breakdown in their own lives. In research carried out by Nicky Hart during the 1970s among members of a club for divorced and separated people in a Midlands city, it was found that most, if not all, of the men and women she interviewed were unprepared for a marital breakdown in their own lives. All their expectations had been of successful and happy marriages of the kind they imagined everyone else experienced (Hart, 1978, pp 110–11)

The people interviewed in Hart’s research all experienced great personal distress when their marriages finally failed, some falling physically ill for some months, others having severe psychological problems such as depression, withdrawal and loss of purpose, loss of self-esteem and of personal identity (pp 132–3). At the time of her research Hart argued that 20 per cent of marriages would end in divorce, following the change in law made in the 1971 Act altering the grounds for divorce. Previously some misdeed on the part of a husband or wife had to be established in order to obtain a divorce. In the Divorce Reform Act of 1969, which became effective in 1971, the notion of a ‘matrimonial offence’ was removed from the statute book, and the ‘irretrievable breakdown of marriage’ became the sole ground for divorce, after two years of living apart and five years’ separation a divorce could be granted with the consent of only one spouse. In 1985 the law was changed to allow irretrievable breakdown of a marriage to be established by one partner admitting responsibility for the breakdown without the separation rule being invoked. The percentage of marriages ending in divorce reached over 30 per cent in the late 1970s and early 1980s.
At this point you should read the article by Nicky Hart, 'Mental breakdown as a personal crisis' (reproduced in the Block 2 Offprints Booklet), bearing the above points in mind. Note the categories she uses to distinguish various domestic settings she heard about in the interviews – categories such as 'wedlock', 'separation', and 'status passage'.

In the United States divorce has been more frequent for a longer period than in Britain. This has been partly because state laws about marriage and divorce have been less influenced by the Churches than the laws in Britain. In England the Churches, especially the Church of England, have had a strong influence on the legislation surrounding marriage, and this influence has made divorce more difficult than in the United States. The 'modern' culture of the United States has been more tolerant of divorce than that found until recently in most of Europe, although according to Goode (1956) some stigma attached in the past to divorced persons in America. In a culture of a more traditionalist type, as used to be found in Britain, stigma over divorce and divorced women and men persisted longer. Indeed, stigma still attaches to the divorced or separated in some areas of modern British society, even outside the sub-culturalism of Roman Catholicism.

Couple relationships, not necessarily involving religious or legal marriage, have probably been more frequent in the United States in the decades since the 1940s and 1950s than in Britain and Western European societies, at least until recently. 'Couple relationships' come in a variety of forms, but the term is used typically to mean relationships between men and women involving strong emotional attachment. Such a relationship may or may not include sexual relations between the couple, whether or not such relations occur is affected by a variety of factors such as age, health, the values of one or both partners, and opportunities. Not all couple relationships involve co-habitation, for example, but may be conducted while both partners retain a separate household, if they can afford to do so (see Weiss, 1978). Young people involved in a relationship may still live in the same household as their social or biological parents, which usually restricts their sexual activities. Not all couple relationships are founded upon the desire for sexual activities; relationships among older people, or among couples of any age, who enjoy being together and value the emotional attachment without sexuality being involved, are examples of such non-sexual coupling (Weiss, 1978, p 137).

Not all couple relationships involve both men and women. Some are between two men or two women, and again they may or may not involve sexual activities between the couple. There are economic, as well as social psychological, advantages to living with another person. It is often said that 'two can live more cheaply than one'. Many male homosexuals have long-lasting relationships in which sexuality may never have been involved, for example (Plummer, 1978). Women have maintained couple relationships involving emotional attachment, sometimes more easily in the past than in the present, given the more widespread awareness of the label 'lesbian' which may attach to such bonds between women. Less social stigma was attached to lesbianism than to male homosexuality in the past. This may have been due to the social invisibility of lesbianism as a social and legal category, whereas any practising male homosexual was subject to legal prosecution until the 1960s in Britain. Gay couples are probably more numerous in the 1980s within Western societies than in the past, although there is no reliable method of establishing how many such couples exist. This lack of accurate quantitative data exists partly because social stigma continues to be attached to homosexuality, and there is no easy and reliable method of sampling and reaching such couples for research purposes (Plummer, 1978).
In an overview of research conducted on male-male couples up to the late 1970s, Kenneth Plummer has argued that definitions of a ‘gay couple’ are not easy to arrive at, as can be seen in the following extracts from his paper, ‘Men in love observations of male homosexual couples’ (1978)

It is, perhaps, a sign of the times that a book on ‘The Couple’ should include a chapter on homosexual couples. While nothing seems more natural than to discuss heterosexuality in terms of relationships and couples, homosexuality has been thought of as a condition requiring special causal explanations and special devices for controlling it. Only recently in this culture has homosexuality come to be viewed increasingly as a legitimate alternative way of life, and as a relationship

WHAT IS A GAY COUPLE?
Two approaches to identifying ‘a couple’ are possible – the subjective and the conventional. The former suggests that a gay couple exists when a homosexual defines somebody as his partner. How an outsider defines the relationship is irrelevant, the important thing is the meanings that individuals attach to their own relationships. By this kind of definition, for example, a husband and wife living together in marital disharmony for thirty years and who do not see themselves as a couple, are not a couple, while two homosexuals who fall in love but part within weeks are a couple during the time they define their relationship in this way. Such an approach has difficulties, though it does direct attention towards what people themselves mean by couples.

The second kind of definition is more conventional and attempts to establish independent criteria by which any relationship can be assessed as a couple or not. Such criteria may include the emotional, social and sexual nature of the relationship, its duration, its exclusivity and whether or not the two people live together. By such criteria one definition of a ‘gay couple’ would be a fairly permanent, more or less exclusive relationship based upon a social, emotional and sexual foundation, between two people of the same sex who sometimes share a common home. This would be an ideal type from which many variations could be derived. The main feature of the definition is that it includes several criteria, any one of which, if taken alone, would not depict a couple. Men may have long-term emotional commitments to other men, they may set up house with other men, they may have permanent sexual relationships with each other – all these would not be couples. Outsiders often make mistaken assumptions about the relationships of others; they may assume that two homosexuals who demonstrate a close friendship are also lovers, but generally this is not true. Indeed, these Leznon and Westley (1967) observed in their study of a Canadian homosexual community, a kind of ‘incest taboo’ appears to exist amongst homosexuals, such that friends are prohibited as sexual partners. Many homosexuals call their close friends ‘sisters’, depicting a strong, non-sexual bond. Similarly, outsiders may assume a love affair when two homosexuals set up house together, but homosexuals often do this out of convenience, practical considerations being more important than romantic ones. In other words, a range of relationships does exist in the homosexual world, but only a few could be labelled ‘couples’ according to the above definition (Plummer, 1978, pp 173 – 4).

Plummer ends his chapter by quoting, with approval, a statement by the London Gay Liberation Front manifesto published in 1971

We do not deny that it is possible for gay couples as for some straight couples to live happily and constructively together. We question however as an ideal the finding and settling down eternally with one ‘right’ partner. This is a blueprint of the straight world which gay people have taken over. It is inevitably a parody, since they haven’t even the justification of straight couples – the need to provide a stable environment for their children (though in any case we believe that the suffocating small family unit is by no means the best atmosphere for bringing up children). (Plummer, 1978, p 199)

For some male homosexuals, therefore, the conventional couple relationship is perceived as being undesirable. However, there is some reason to suppose that this has now changed in Western countries since the arrival of AIDS (Acquired Immune Deficiency Syndrome). In the 1980s male homosexuals have been at risk from this syndrome, which may lead to death. Some homosexual and bisexual men have become less promiscuous sexually and more cautious in their actions.
The arrival of AIDS generated a ‘moral panic’ in the British newspapers and media in the early 1980s (see Weeks, 1986, pp 96 – 8) AIDS was called the ‘gay plague’ in some popular newspapers, thereby establishing gay men as the carriers of a plague – a term which created irrational responses among some people who feared contracting the syndrome by using objects such as beer mugs and glasses which had been used by gay men. Some religious groups saw AIDS as a punishment from God for the immorality of homosexuality. This view was denied by others, including the bishops in the Church of England, who emphasized the need for care of people with AIDS, not the social ostracism and moral gloating expressed by some fundamentalists. The moral panic about AIDS created high levels of anxiety among many gay men, which required counsellors to help such people cope with their fears about AIDS. As Ken Plummer points out in Unit 8, intravenous drug users also became a group at risk from AIDS, some of whom developed the disease.

Sociological research and other kinds of social scientific research into lesbianism has been much less developed than that into homosexuality among males.
'Lesbianism' is a problematic category in that it is not clear whether or not it necessarily involves sexual relations between two women in order to be applied, or whether it covers deep emotional ties between two or more women who do not relate to one another in terms of physical sexual acts. Male homosexuality has been defined both in the general culture of modern societies and in social science literature as explicitly involving sexual activities between males, where 'sexual' is defined as involving some actions involving the genitals of at least one of the males involved. This emphasis upon orgasm, genital touching and manipulation in definitions of male homosexuality is not directly transferable to lesbianism. Annabel Faraday (1981) argues that the label 'lesbian' is not a useful or helpful one as far as women's relationships with other women in patriarchal societies are concerned. One could say, although Faraday does not express it in this way herself, that the category of 'lesbian' has to be carefully located in the more general theoretical framework, or frameworks, from which it is derived. If this is done, it appears that the category is one which has been produced primarily by men about women. Faraday does say that the category, or label, 'lesbian' is not one of great meaning or usefulness for women themselves in understanding the character of their relationships with one another under patriarchal conditions where women are subjects in a culture and society defined in largely male terms. The emphasis upon sexuality, upon orgasms, upon genital contact is seen as a male definition of same-gender, or cross-gender, relationships. Women, or perhaps one should say some women, seek to challenge those kinds of emphases so that 'lesbianism' becomes a relatively less significant concept for understanding women's position in patriarchal society and cultural structures.

Faraday writes, for example:

What I wish to stress throughout this paper, however, is that while research on lesbians is less extensive, itself a reflection of the neglect or denial of women in the broader field of sociology, the task is not to 'address the balance' or to put lesbians 'on the map' alongside male homosexuals as if they could be discussed within the same conceptual frameworks. Emotional relationships between women, whether or not they have involved overt physical expression, have tended to remain invisible and insignificant to historians and sociologists alike. It is essential that notions of 'the lesbian' are reconceptualized within the context of her oppressed social position as woman and not as 'female homosexual.' Any discussion of lesbian women can do and does great harm and injustice to lesbians, indeed to all women, if it fails to examine the power differentials between the sexes, the implications of those power differentials for relationships between women and between male researchers and female research 'objects', or if it presents a definition of 'lesbian' in sexual terms without examining the socially constructed and male-defined nature of 'sexual' meanings (Faraday, 1981, pp 112–13).

Faraday argues that the perceived neglect of lesbianism in contrast to the larger amount of research on male homosexuality 'has tended to result in studies which claim to present definitive portraits of 'the lesbian', almost as some newly discovered species or sub-category of 'woman', and which are defined initially or centrally in terms of sexual behaviour' (p 114). She continues:

This is not to deny the validity or reality of lesbian identities as they are embraced by women themselves, this is neither desirable nor possible. What I do wish to suggest,
however, is that researchers who are genuinely concerned with the area of ‘lesbianism’ sensitize themselves to the power of naming and of category creation.

One of the earliest statements of lesbian-feminism was provided in 1970 by a group of women calling themselves the Radicalesbians, this still remains an invaluable starting point for conceptualization. In contrast to earlier, non-feminist writing linking lesbians with femininity, this statement presented the lesbian identity not only as a positive choice but also as a level of consciousness which challenges the essentially oppressive and restricting nature of male-defined and male-enforced ‘femininity’. Their statement encapsulated how the primarily sexual definition of ‘lesbian’ is continuous with the sexual definition of ‘woman’, both demonstrate contempt for women in general and give primacy to men and male sexuality. ‘A lesbian is not considered a “real woman”’. And yet in popular thinking, there is really only one essential difference between a lesbian and other women, that of sexual orientation’ [Radicalesbians, 1970, p. 173].

The Radicalesbians defined the lesbian not in terms of her ‘sexual’ behaviour, but in terms of her total identity – as a ‘woman-identified woman’, they went on to show the political significance of putting women first in society which demands that women structure their lives around men. The use of the label ‘lesbian’ has historically been a mechanism of control which radically affects all women, if lesbians are women who, via whatever initial experiences, come to reject not only the male servicing role but also images of themselves as sexual objects – self-images upon which patriarchy is built – they must be portrayed negatively. ‘“Lesbian” is one of the sexual categories by which men have divided up humanity’. Affixing the label lesbian not only to a woman who aspires to be a person but also to any situation of real love, real solidarity, real privacy among women is a primary form of divisiveness among women, it is the condition which keeps women within the confines of the feminine role, and it is the debunking scare term that keeps women from forming any primary attachments, groups or associations among ourselves’ [ibid p. 174].

Since that statement appeared, lesbian-feminism as a life style and as a political orientation has provided a springboard for analysing the control of women through the politics of sexuality under male supremacy. The perspective throws into question one of the main tenets of the ‘devancy’ approach – namely, the ‘taken for granted’ nature of labels and their stigmatizing effect – by focusing on the etymology of the words and the processes of ‘lesbian’ labels and definitions and by emphasizing the positive and political nature of lesbian identities (Paraday, 1981, pp. 127–8).

Some women, whether they see themselves as lesbian or not, whether they are defined in this way by others or not, do live together in domestic situations. Some see themselves as a ‘couple’, others do not define themselves as involved in a relationship which could be described as that of a couple – they are simply sharing things and helping one another out. Others have shared domestic living arrangements with more than one other woman, with or without children. These larger groupings may be termed ‘communes’ by the participants. Section 3.2 examines a piece of sociological research on communes.

3.2 Communes

There are some people who have lived for varying lengths of time, from a few months to most, if not all, of their lives, in a communal situation of one kind or another. Communes are defined here as having more than two members, as distinct from a couple. Communal living involves eating, talking, working and sleeping in the same social group, in a bounded physical space, marked out from non-members by these common activities. Property will be jointly owned by the commune members in the typical case.

Communes have been established most frequently in the past by religious groups. There have been celibate religious orders in the Roman Catholic, Orthodox and Anglican Churches. Other types of commune have been founded to realize a set of
A religious commune of Benedictine monks and nuns at Turvey, Bedfordshire (right), and an American secular commune photographed by Henri Cartier-Bresson (below).
values which were felt to be unrealizable in the secular world, as among Protestant Christians in the seventeenth century in Britain and the United States, and among the numerous religious sects and cults of various beliefs, some based in oriental religions, which have developed in this country (Wilson, 1970 and 1982)

More recently, secular communes have been founded in Western capitalist societies. These have nearly always held a strong ideology to motivate their members to set up and live in such communes (see Abrams and McCulloch, 1976). These secular communes were found to be seeking closer ties of friendship between members than was possible in conventional domestic living arrangements in contemporary capitalist society. Abrams and McCulloch (1976) argue that the type of friendship being sought by those living in communes was not as exclusive as that between a couple involved in a romantic love relationship, but deeper than the usual friendships found outside the nuclear, or extended, family and kinship networks in modern society, if and when such friendships could be established.

In the following extract from Abrams and McCulloch, note the continuity they suggest between pre-Christian notions of friendship in Aristotle and the modern, secular movement of communal living.
What do you think are the main factors which militate against 'deep Aristotelian friendships' between (a) two women, (b) two men, (c) a man and a woman, in contemporary Britain?

(Abrams and McCulloch, 1976, pp 26–9)
4 TRADITIONAL MORAL DISCOURSE ON MARRIAGE AND THE FAMILY

The developments in the 1960s and 1970s discussed in the preceding section, including new forms of domestic living, serial monogamy, increasing tolerance for male homosexuality, the positive evaluation of relationships between women, and the development of secular communes, have all been criticized in the 1980s. Traditional morality has been reasserted in some quarters, especially by Roman Catholic bishops, lay politicians and philosophers. The arrival of AIDS has added fuel to the fire for many upholders of traditional moral values about family, sexuality and gender.

In this section this reassertion of traditional morality about the family and marriage in particular is explored by considering a number of extracts. These extracts articulate the Western tradition of marriage and family found in Catholicism and in some European philosophy. First, a number of texts which illustrate traditional moral teachings of the Roman Catholic Church are presented, this is followed by a discussion of the work of a modern moral philosopher, Roger Scruton.

We have chosen the Roman Catholic Church in particular because it makes major social interventions in the area of the family and sexual politics. The first set of texts considered here present the modern moral theology of the Vatican, the other piece to be considered is a chapter from Roger Scruton’s book Sexual Desire (1986). This latter text has a complex relationship with the Catholic Church’s moral theology in that it tends to reach similar conclusions to those of the Vatican and the Pope, but by a more strictly philosophical route. Scruton would probably hold that any reasonable person could reach similar conclusions to his own without any reference to the magisterium of the Church (that is, the teaching authority of the Roman Catholic Church). Both of these kinds of text have to be treated seriously, as they are by various groups both inside and outside the Roman Catholic Church. The texts help to form and shape the opinions of some 800 million Roman Catholics in the world, including some legislators in Britain, Ireland and in other countries which contain politicians who are influenced by the Roman Church’s moral teachings on the family and marriage. For example, in 1986 the Irish people voted in a referendum to keep divorce outlawed. The Roman Catholic bishops and most clergy in Ireland had hinted that this was how a good Catholic ought to vote. This event illustrates a major point that the Roman Catholic Church is a social institution which intervenes actively, both at a national political level and at the personal level, in the law and morality about marriage and the family. To see how one newspaper described the events in Ireland in 1986 read the article opposite by Mary Holland from The Observer.

4.1 Sacred traditionalism

Traditional moral values about marriage, sexuality and family life are frequently surrounded by a special ‘aura’, that of the ‘sacred’. The sacred was distinguished from the profane by Emile Durkheim: the sacred is that which is set apart from the profane, the everyday, the utilitarian. The moral values of the Roman Catholic Church are a major example of traditional family and sexual values active in Western Europe, parts of Asia, Africa and the Americas. These traditional values are taught by sacred figures – the Pope, the bishops and priests – all of whom are set apart by celibacy from the profane sphere. The institution of life-long monogamous marriage is portrayed by the Roman Catholic Church as being a sacred one. This Church also included specific roles being made ‘sacred’ for women either that of being a wife and mother, or being a celibate member of a religious order, as you will see later on in the extract from a document by Pope John Paul II.

Documents called Papal Encyclicals carry the full weight of the teaching authority of the Church, are expressed through the Pope and may claim to be invariable moral teachings. In 1930, for example, an Encyclical called ‘Casti Connubii’ (‘On Christian Marriage’), written by Pope Pius XI during the period of fascist rule in Italy, stated...
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29 June 1986

But man finds his true identity only in his social milieu, where the family plays a fundamental role. The family’s influence may have been excessive, at some periods of history and in some places, when it was exercised to the detriment of the fundamental rights of the individual. The long-standing social frameworks, often too rigid and badly organized, existing in developing countries, are, nevertheless, still necessary for a time, yet progressively relaxing in their excessive hold on the population. But the natural family, monogamous and stable such as the divine plan conceived it and as Christinity sanctified it, must remain the place where ‘different generations live together, helping each other to acquire greater wisdom and to harmonize personal rights with other social needs’ (Pope Paul VI, 1967, p 19)

It is important to note in the above quotations an issue which was discussed in Block 1, namely the relations between the social and the natural. There is an assumption made in the quotations of a natural law which is God-given, and which makes the monogamous family a universal and ‘natural’ institution; ‘the natural family, monogamous and stable such as the divine plan conceived it’ in the above quotation, for example. This reflects an earlier assertion in the Pope Pius XI document ‘Matrimony was not instituted or re-established by men but by God, not men, but God, the Author of nature, and Christ our Lord, the restorer of nature, provided marriage with its laws’

Pope John Paul II has continued in this traditional way of thinking, partly because it is so difficult to change fundamentally any values in a system of beliefs about authority which makes earlier statements about morals sacrosanct. Traditional authority systems cannot easily allow changes to what are regarded as fundamental moral teachings. Hence the disappointment many Roman Catholics experienced when in 1968 Pope Paul VI issued his Encyclical ‘Humanae Vitae’ (‘On Human Life’), maintaining that artificial methods of birth control, used within marriage, were immoral.

Pope John Paul II has written about the Christian family in the modern world in ‘Familia Consorcio’ (1981). This document was called an ‘Apostolic Exhortation’, which is not regarded as an infallible pronouncement. Some extracts from this publication follow, which you might like to read in order to gain an idea of the type of discourse which still affects millions of Roman Catholics in the world, via the priests, nuns, teachers and counsellors who work within the Vatican’s teachings. Some Roman Catholic priests, teachers, social workers and doctors do question this position and encourage individuals to follow their own conscience in such matters. Now read the extracts which follow.
The situation of the family in the world today
6 The situation in which the family finds itself presents positive and negative aspects: the first are a sign of the salvation of Christ operating in the world, the second, a sign of the refusal that man gives to the love of God.

On the one hand, in fact, there is a more lively awareness of personal freedom and greater attention to the quality of interpersonal relationships in marriage, to promoting the dignity of women, to responsible procreation, to the education of children. There is also an awareness of the need for the development of interfamily relationships, for reciprocal spiritual and material assistance, the rediscovery of the ecclesial mission proper to the family and its responsibility for the building of a more just society. On the other hand, however, signs are not lacking of a disturbing degradation of some fundamental values: a mistaken theoretical and practical concept of the independence of the spouses in relation to each other, serious misconceptions regarding the relationship of authority between parents and children, the concrete difficulties that the family itself experiences in the transmission of values, the growing number of divorces, the scourge of abortion, the ever more frequent recourse to sterilization, the appearance of a truly contraceptive mentality.

At the root of these negative phenomena there frequently lies a corruption of the idea and the experience of freedom, conceived not as a capacity for realizing the truth of God's plan for marriage and the family, but as an autonomous power of self-affirmation, often against others, for one's own selfish well-being.

Worthy of our attention also is the fact that, in the countries of the so-called Third World, families often lack both the means necessary for survival, such as food, work, housing and medicine, and the most elementary freedoms. In the richer countries, on the contrary, excessive prosperity and the consumer mentality, paradoxically joined to a certain anguish and uncertainty about the future, deprive married couples of the generosity and courage needed for raising up new human life, thus life is often perceived not as a blessing, but as a danger from which to defend oneself.

The historical situation in which the family lives therefore appears as an interplay of light and darkness.

Man, the image of the God who is love
11 Christian revelation recognizes two specific ways of realizing the vocation of the human person, in its entirety, to love: marriage and virginity or celibacy. Either one is, in its own proper form, an actuation of the most profound truth of man, of his being 'created in the image of God'.

Consequently, sexuality, by means of which man and woman give themselves to one another through the acts which are proper and exclusive to spouses, is by no means something purely biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and a woman commit themselves totally to one another until death. The total physical self-giving would be a lie if it were not the sign and fruit of a total personal self-giving, in which the whole person, including the temporal dimension, is present if the person were to withhold something or reserve the possibility of deciding otherwise in the future, by this very fact he or she would not be giving totally.

This totality which is required by conjugal love also corresponds to the demands of responsible fertility. This fertility is directed to the generation of a human being, and so by its nature it surpasses the purely biological order and involves a whole series of personal values. For the harmonious growth of these values a persevering and unified contribution by both parents is necessary.

Marriage and virginity or celibacy
16 Virginity or celibacy, by liberating the human heart in a unique way, 'so as to make it burn with greater love for God and all humanity', bears witness that the Kingdom of God and his justice is that pearl of great price which is preferred to every other value no matter how great, and hence must be sought as the only definitive value. It is for this reason that the Church, throughout her history, has always defended the sanctity of this charism to that of marriage, by reason of the wholly singular link which it has with the Kingdom of God.

In spite of having renounced physical fecundity, the celibate person becomes spiritually fruitful, the father and mother of many, cooperating in the realization of the family according to God's plan.
You might reflect on the above extracts in terms of the following questions:

1. What is meant by the phrase ‘a truly contraceptive mentality’ (see para 6)?
2. How is the institution of marriage seen and constructed (see para. 11)?
3. How is celibacy seen and valued (see para 16)?
4. Why is the indissolubility of marriage seen as ‘good news’ (see para 20)?

The documents produced by the Popes are not always followed to the letter by the laity. Roman Catholics do get ‘divorced’, and may re-marry in the Western legal sense. Some married Catholics do practise artificial methods of birth control, especially in the advanced industrial countries of the West. Some priests and nuns leave the Roman Catholic Church in order to marry. Nevertheless, the formal teachings of the Papacy remain based on traditional Catholic moral theology and do exert real effects on people’s lives.

What do you consider are the main positive and negative effects of the traditional morality about marriage, divorce and the family? Make a brief note of these.

4.2 The revitalization of tradition

In the last two decades a number of modern British philosophers have tried to defend traditional moral theology on sexuality, marriage and the family. A recent example can be found in the work of Roger Scruton, a British philosopher whose book *Sexual Desire, A Philosophical Investigation* was first published in 1986. The book may be seen as an attempt at the revitalization of traditional moral teachings about lifelong monogamous marriage and sexuality as being primarily for reproduction, not pleasure. The notion of ‘revitalization in culture’, particularly in a religious movement, was used by an American anthropologist, Anthony Wallace, to connote a social movement which aims to reduce cultural confusion and to bring
organization into a rich but disorderly field by eliminating some of the materials (thus reducing the cultural repertoire to more manageable size) and combining what is left into a more orderly structure' (Wallace, 1966, p 211)

Roger Scruton's work can be seen as similar to an intellectual movement among some philosophers to try to defend at a rational level the Church's traditional moral theology on marriage, the family and sexuality. It derives some of its wider interest and, indeed, its vigour from being part of an attempt to revitalize sacred tradition. It is a position which remains a politically and socially active one. This constitutes a major reason for choosing to examine a part of it in some detail here. Another related reason for giving some attention to Roman Catholic moral values is because there are a number of doctors, both in hospitals and general practice, as well as nurses, politicians, social workers and teachers, who take a traditionalist moral position. This viewpoint may sometimes affect their work and may lead to problems in relations with non-Catholic colleagues, patients or clients.

Scruton reaches conclusions which are intended to be compatible with Roman Catholic moral theology about marriage and the family, and may be seen, therefore, as an attempt to defend rationally Roman Catholic moral theology in this area. This moral theology is considered both by some within the Roman Church and others outside it, believers and unbelievers alike, to be particularly obscurantist towards matters concerned with human sexual relationships. Scruton's arguments have been developed within the context of English philosophy, which was strongly influenced by the work of Ludwig Wittgenstein for two or three decades after the end of the Second World War.

Roger Scruton also uses some arguments from European philosophy, especially from the work of existentialists and phenomenologists who have stressed the importance of the personal, the ethical and the emotional levels in human life and experience. This emphasis has often lost any concern with material and historical issues. There is an absence of any systematic discussion drawing from the disciplines of sociology, social history and social anthropology in Scruton's text. This is true of other philosophers, too, not just of Roger Scruton. The level and nature of philosophical discourse is considered by most philosophers to be autonomous, or virtually autonomous, of social scientific discourse. Social scientific discourse is characterized either as being descriptive, rather than prescriptive, or as being confused and muddled when it attempts to produce a theoretical explanation of a social phenomenon. Social phenomena are held by Scruton, for example, to be properly the concern of philosophers, especially moral philosophers. (Note Scruton's criticism in the extract which you will be asked to read shortly in the Block 2 Offprints Booklet, of Fromm, Brown, Marcuse and Reich. In the extract Scruton mistakenly assumes that these writers advocated a return to 'natural' sexuality. This may have been true of Reich, but not Fromm in The Art of Loving, nor of Marcuse, who was critical of Reich's biologism. See Fromm, 1962, Marcuse, 1966, Reich, 1972.)

Scruton argues that sexual desire is not a biological given, arising purely from nature, but is socially constructed. 'It does not follow from this, however, that sexual desire is "merely conventional", or not a part of human "nature." For some artefacts are natural to human beings' (Scruton, 1986, p 348). He continues 'Sexual desire is as natural an artefact as the human person, the collective endeavour which paints our face on the blank of nature also generates desire, as one of the fundamental links between embodied persons'.

Here Scruton links the conception of the social construction of persons, or personhood, with the social construction of sexual desire. Neither personhood nor sexual desires are seen as given by biology, but as constructions of human social groups. For this reason the process of socialization is a moral activity, that is to say, it involves the realm of values, culture, or the Lebenswelt as it is called by phenomenologists, following the work of the philosopher Edmund Husserl (1859–1938), a term used by Roger Scruton in order to distinguish the realm of human meanings from the 'objective' world of natural science. Without being
introduced to a culture an infant cannot become a recognizable human person, nor, argue Scruton and others, for Scruton is not alone in this by any means, can a person come to experience sexual desires outside of culture, or society, or a 'social formation'. The central feature of a socio-cultural formation in this context is the family. The family is concerned with the formation of persons with sexual desires for other persons, not merely for 'bodies'.

Just as there is no meaning outside society, this argument claims, so there can be no liberation by returning to 'nature', to our 'natural' desires, for nature is seen as being impersonal and meaningless. This contrasts, it should be noted, with traditional Catholic philosophy, which assumed that as the natural world, including animals and *homo sapiens*, was created by God, it was neither fundamentally, unredeemably evil, nor was 'nature' seen as being meaningless. The handiwork of God could be found in it, indeed the early natural scientists thought they were exploring the mind of the Creator in discovering and writing about 'nature' (Weber, 1980, first published 1904–5).

The way in which 'the family' is discussed depends upon the fundamental philosophical presuppositions of the contributor to the debate, as the work of Roger Scruton illustrates. However, notice that the labels which tell us to which religious or political organization a speaker belongs, do not describe that contributor's philosophical approach. Some of Scruton’s arguments about the social construction of sexual desires, for example, echo those found on the secular left and in some feminist literature. Philosophy may be said, therefore, to have a degree of autonomy of both Church and party (religion and politics).

In discussions about 'the family' the philosophical starting point of the author is paramount, for this will affect, if not fully determine, the type of social theory that is used to describe and discuss 'the family'. Whether it is seen as a 'natural institution' as it was by Plato and Aristotle, for example, and by twentieth-century Popes, or as a socially constructed institution, will depend on wider philosophical assumptions. It is a great merit of Roger Scruton’s analysis in *Sexual Desire* that he makes his philosophical assumptions explicit. He also recognizes that debates about sexual morals are about social institutions such as marriage and the family, institutions which have been undergoing major changes in Western societies since the 1960s, and that a discussion about such social institutions is not narrowly 'moral' but more widely 'political'.
Scruton goes on to argue that the political includes ‘the sacred’. He writes ‘in the ideal polis religion has always had its place, and carried with it the lamp of the sacred’ (p 353). He continues ‘the “restoration of the sacred” may be a political hope, but it cannot be a political task to make it one is to risk the most violent cataclysm and the collapse of liberal political institutions’ (p 354).

The role of the state is to protect some social institutions of civil society, crucially the family, and to suppress others, such as the private army (p 355). The family, like the state, is not, and cannot be, founded upon liberal notions of a ‘social contract’. ‘Marriage is a public endorsement of the passion which separates lovers from their surroundings. It is an endorsement of their exclusive privacy’ (p 356). This is a historically and culturally specific view of marriage. In other non-Western cultures and other historical periods in the West, marriages have cemented material, economic and political links between families, they have been arranged by parents of the bride and groom when those to be married were babies or young children, and marriage is by no means always private. Indeed, the first act of sexual intercourse was once a publicly watched event (Aries, 1973).

There is a link between marriage, the family and private property, Scruton argues.

Does anything strike you as odd in this passage? Before reading any further in this unit look again at the passage and write down in a line or two any aspect of the quotation which struck you as being odd – if anything did.

You might have picked out the first sentence as being odd. Is it really a ‘small step’ from the institution of marriage to that of private property? Or you may wonder if it is the case that ‘only what is privately owned can be privately shared’. Is this true of electricity, or water, or of an allotment rented by a family from the local authority? Some things can be privately shared which are not privately owned. It would seem Or you might have noted down the next sentences as being odd. It asserts that ‘ownership of the home is ownership of a stake in the means of production’. The example of the household as a centre of a means of production for agriculture, for making carpets and clothes to be sold on the market presumably, might seem odd if you live in a typical flat or suburban house in a British town or city. (According to EEC and OECD estimates, in 1985 27 per cent of the British population were engaged in agricultural production as farm owners, tenants, and farm workers.) It has been true that some houses have been centres of production, but this is hardly true in modern Britain. This argument obscures the real means of production in the major factories of private companies. Some of these may be owned by a family, but many of the largest are owned by thousands of shareholders and, indirectly, by the millions who take out a pension or an insurance policy.
It is indeed true that 'no account of erotic love will be either politically innocent or politically neutral' (p.361) This has been well illustrated and argued in the chapter of Roger Scruton's book which we have been considering.

Roger Scruton's analysis is termed 'a philosophical investigation' into sexual desire. This approach has, to my mind, both strengths and weaknesses. The strengths lie in the rigour with which this work is written. Sexual Desire is a seriously argued book and engages with important philosophical and theoretical arguments about the social construction of human sexual desire. Scruton is, in this sense, anti-essentialist, that is, he does not assume that sexual desires are given biologically, as a part of human nature. In short, he is not a biological determinist. This is an advance over essentialist views of sexuality because it entails that all sexual desires can be seen as constructed and produced in people as a result of complex interactions in families and among children in a way which does not define some desires as being 'natural' and others as 'unnatural'. Is kissing natural? There is no clear answer to this question. Human cultures differ over whether kissing is part of sexuality or is primarily a form of greeting, or the expression of joy at some event, such as occurs when a football player has scored a goal.

Scruton's approach, by eschewing an essentialist view of sexual desire and emphasizing its constructed character, is an advance on traditional Catholic thinking, for instance, which has used the categories of 'natural' and 'unnatural'. Homosexuality and lesbianism are 'unnatural' in the traditionalist view and, therefore, not God-given, they are immoral forms of relationship, as Pope John Paul II reiterated in 1986.

One of the central weaknesses of Roger Scruton's case, in my view, lies in the lack of an adequate factual and sociological background to his claims about basing social institutions in the sacred. For instance, in his discussion of marriage there is no mention of the plurality of religious perspectives in complex societies such as those of North America or Western Europe. In these societies there are many traditions of the sacred represented within Christianity, from Roman Catholic to Protestant, various groups and sects from other world religions, especially Hinduism and Islam, and a variety of secular viewpoints. The historical epoch in which the sacred could encompass all, or most, of a population in a given political territory has passed.

Pluralism is now a social and cultural reality in societies such as Britain, and this includes moral pluralism too. There is a wide variety of views about sexuality and marriage and no way of arriving collectively at one single agreed moral and ritual basis for these views other than the liberal pluralism Scruton criticizes. The Roman Catholic Church finds pluralism difficult to accept, indeed, it refused to accept moral pluralism in its rejection of a change in the law to allow divorce for non-Catholics during Ireland's referendum on divorce in 1986, as mentioned earlier in this unit.
Scruton also has difficulty in adjusting to pluralism. Yet modern societies such as Britain are now beyond a period when one moral and religious sacred worldview could overarch all the major institutions of the society, unless this view is itself liberal and tolerant, bland and relatively accepting of differences – as some might say the official Church of England has become (see Bocock and Thompson, 1985, Chapter 15).

Scruton also virtually ignores the criticisms made of traditional forms of marriage by feminists. One might say that he fails, therefore, to be comprehensive. Women are seen as having no good reasons for being critical of the role assigned to them in traditional conceptions of marriage. They should find fulfilment in their roles as wife and mother in Scruton’s view, this value judgement is implicit in the piece you have read, and it is made more explicit in other parts of the book and in some of his other writings.

Women have not always been in the modern domestic roles of wife and mother preferred by Scruton, nor are they today. In agricultural societies, women have important tasks to perform apart from cleaning the house, cooking, washing and child care. Many women living on European and British farms do such extra tasks. They often grow the food in gardens near the house, look after chickens and collect eggs, and in some situations milk cows and nurse lambs who have no mother. Roger Scruton may not disapprove of this household-based, unpaid work by farmers’ wives. He does not discuss it explicitly.

The role of women changed too during the two world wars, when women worked in paid employment in ammunition factories, on the farms and in the armed services. As you may recall from Unit 9, many women work in paid jobs outside the home in Britain in the 1980s. The ideal wife-mother at home, content, blessed with children and a loving husband, which seems to be Roger Scruton’s desired role for women, is a very specific view of an idealized family life which few women have in fact led in the past, which some do not want to lead in the present, and which, in any case, has caused some women to suffer from neurotic illnesses. The lack of any serious discussion of these issues is a major weakness in Roger Scruton’s over-philosophical text. It is ‘over-philosophical’ in the sense that it is dealing not with purely theoretical or conceptual issues, with no empirical import, but with concepts such as sexual desire, gender and marriage, which do have empirical effects in the lives people lead. Many women find that the concepts of marriage and the family of the traditional type, which Roger Scruton supports, have had real effects on them – not all of them love-enhancing or life-enhancing.

Two feminist writers, Luise Eichenbaum and Susie Orbach, who have worked as therapists with women, have written about the experiences of women trying to cope with their role in the family in Britain as follows.
The voices of women are not heard by Roger Scruton, or if they are heard they are not discussed. The voices of women are not heard in the Roman Catholic Church's hierarchy either. It is men who formulate moral theology for women.
5 SUMMARY AND CONCLUSION

The problematic nature of the relationship between social facts and moral values is illustrated in a very acute form in the area of the family and marriage. New forms of domestic living arrangements, such as communal living, single people who may have an active sexual life, sheltered housing for the elderly, gay couples, single parents, all raise issues which challenge some of the basic values of traditionalism, especially the ideal of life-long monogamous marriage and the extended family, simply by existing.

The construction of social facts, including data in statistical tables, depends upon a conceptual framework derived from a theory. The choice of a theory itself reflects the more general moral, political and 'religious' philosophical position of the person, or group, conducting social scientific research or making social interventions in areas concerned with the family, marriage and new kinds of domestic living situations from gay couples to communes.

The problems caused by socialization into the British liberal Protestant, or secular humanist, cultural values and social practices were considered in Section 3. For example, the problems resulting from serial monogamy were considered in the research carried out by Nicky Hart outlined in Section 3.1. This research suggested that people were unprepared for their own marriages going wrong. They grew up expecting everything to fit the assumed normal pattern, at least in their case. They assumed that broken marriages happened to other people, not to themselves.

A wide variety of domestic living arrangements may be found in the late twentieth century both among British and North American groups, as new patterns and values have developed in these societies since the end of the Second World War. These new forms of domestic living include couples living together without a formal or legal marriage ritual, gay and lesbian couples, single parents of either gender bringing up one or more children, single people of all ages living alone who may be involved with one person emotionally or sexually, or with several, or with none, and various communal living situations from celibate religious orders, through religious sects which include married people in their communities, to new secular, ideologically based communes such as the ‘travellers’ mentioned in Section 2 of this unit. The work of Abrams and McCulloch was outlined in Section 3.2.

An example of an influential moral position was outlined in Section 4 – the case of the moral values of the Roman Catholic Church. The values of traditional morality about the family and marriage were found to be articulated and actively created in the moral theology coming from the Vatican during the twentieth century, as outlined in Section 4.1 of this unit. The recent philosophical work of Roger Scruton was taken as an important example of the intellectual and political revitalization of traditional morality about sexuality, marriage and the family, in Section 4.2 of this unit. Traditional Roman Catholic moral values are an active political force in the modern world. This was illustrated in the result of the referendum in Ireland in 1986 on whether to allow legal divorce and re-marriage after divorce, mentioned in Section 4. It produced a victory for the position taken by the Roman Catholic Church, namely to reject the proposed moves of the Irish government to legalize divorce and the re-marriage of divorcees in the Irish state.

The variety of domestic living arrangements to be found in a modern society such as Britain is the important point for you to gain and retain from reading this unit. This basic ‘social fact’, or socially constructed proposition, has implications for moral values; it means that some accommodation for the changes in domestic living arrangements which have occurred in modern societies has to be made in social and moral philosophy. These changes have implications for social policy. It is not really sufficient, and may cause unnecessary misery, unhappiness and suffering to people, to re-assert traditional morality given the deep changes which have developed in the ways people live domestically and in the expectations both men and women have about themselves and their relationships. To base the state’s social security system, taxation system, legal services and social work agencies upon these values will create problems. Such problems are clearly set out in Chapter 7 in the Course Reader by Carol Smart, which you studied in Unit 7 and which you might like to re-read now. These problems will be addressed later in the course.
REFERENCES


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Unit 11 THE BODY POLITIC: HEALTH, FAMILY AND SOCIETY

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STUDY OBJECTIVES

By the time you have read this unit you should be able to

1. assess the part that the British National Health Service plays in health care (Sections 2.1, 2.2 and 2.7),

2. discuss the implications of different kinds of critical analysis which may be brought to bear on it (Sections 2.3, 2.4 and 2.6),

3. use the concepts of ‘discourse’ and ‘biopolitics’ to discuss the relationship between ‘health’, ‘normality’ and ‘family’ (Section 3),

4. outline a history of health, health institutions and the development of the modern family which demonstrates relationships between concepts and social institutions and between the state and the private sphere (Section 3),

5. outline and discuss the origins and current role of the British health visiting service (Sections 2.5 and 3.4, and television programme),

6. distinguish and discuss the notions of the monitoring and surveillance of child health and development (Section 3 and television programme).

There are also two more general objectives, dealt with throughout the unit that you should be able to use and discuss the concepts of ‘critique’ and ‘reading’ history
Health, like child care, is a personal and private matter, but one with major public, political and moral implications, it is also a major part of the British public welfare system and a major area of state intervention and control. This unit, which is intended to be about one and a half weeks' work, starts by looking at the formal state institutions of the health service, the critiques that have been made of it, and what we can learn from them about the nature of professional medicine. We then go on to look at the wider social framework and set of socially constructed 'definitions' in which professional medicine is embedded. In the course of doing so we return very firmly to the 'family' theme of this block, for we find that the health services constitute only a small part of what we would normally understand as 'health care', and that most diagnosis and treatment occurs privately within the family. We find, moreover, that public welfare provision may be seen as an expression of a particular way of defining and constructing 'families' which is of comparatively recent origin. An aim of the unit, therefore, is to show how definitions of 'the private sphere' and its relation to public state activity underpin and are fundamental for the nature of social order.

Another major aim of the unit is to help you refine some of your social scientific skills specifically, skills of critical analysis and the sociological reading of history. The unit draws on a number of perspectives, for example feminism, Marxism and the perspective of the French philosopher Foucault, to illuminate aspects of health and welfare provision, and you will be helped and encouraged to work out what each of these perspectives can or cannot 'deliver' as a tool for understanding the socially constructed world. A major example used in the unit is the rise of the uniquely British health visiting service from its origins in Victorian charitable activity, and we shall be presenting two related but subtly different 'readings' of its history to demonstrate how a theoretical perspective shapes and underlies a reading of the past as it impinges on the present. A related television programme. TV Programme 6 'Health Visiting and the Family', looks at the current practice of health visitors and how the service's origins are still expressed in its practices, notes to accompany this are given at the end of Section 3.4.

While reading this unit you should bear in mind what the rest of the block has said about the diversity of people's lives and the nature of 'family ideology'. In one sense 'the family' is non-existent, a purely ideological construct. That is, at any one moment only a minority of people actually live in stereotypically ordered families, and the main force of the concept of family is normative, to declare how people should live. On the other hand, 'the family' is a real entity in another sense: the norms embedded in the concept are shared and experienced by most people, most people aspire towards family life, and 'the family' is a target of welfare and government intervention. The tension between how people actually live and what they take for granted as 'normal' will be a major theme in the later sections of the unit.

There is no set reading associated with this unit, except that we send you back at one point to remind yourself of ground covered by Susan Himmelweit in Unit 1.
2 THE HEALTH SERVICE

2.1 The public provision of medicine

The public provision of welfare, including public health provision, can be traced through the nineteenth century, and even further back to the voluntary hospitals of the eighteenth century like Westminster, St Thomas's and St Bartholomew's. But it is the period from the 1830s to just before the First World War which saw an increasing trend of state intervention into matters of health and sanitation which had once been regarded as private. Why the state intervened in order to deal with public health (an idea which emerged slowly throughout the nineteenth century) and the ways in which it did so are vital matters which can be 'read' historically from a number of perspectives. The orthodox perspective, and the one which you may well recall if you have read the history of Victorian reforms of the Poor Law, of local government, and of public health and sanitation, is the one which stresses the role of reformers like Simon and Chadwick, and of novelists such as Disraeli (in Sybil, or the Two Nations, 1845), Dickens (Oliver Twist, Hard Times, Little Dorrit) and others in revealing social conditions, and which focuses on the 'great landmarks' of parliamentary Acts.

History written from a pluralist perspective emphasizes the competition and conflict between interest groups. In Victorian England the course of reform can be traced in the clashes and debates between factory owners and philanthropically inclined reformers whose wealth came from land, between those like Edwin Chadwick, who saw the need for the state to regulate the conditions in which diseases such as cholera flourished, and those shopkeeping, commercial and middle-class groups who would pay through local rates for the proposed reforms, between those who feared political centralization in Britain and those who saw it as a necessity if greater evils were to be avoided.

The early Victorian period was dominated ideologically by the principle of non-intervention by the state in economic relationships (laissez faire). Most public health reforms of the early period challenged that principle directly, although in a limited way. The Factory Acts limited the hours and conditions of work of labourers, and particularly of women and children. The Royal Commission on the Health of Towns (1842) led to the Public Health Act of 1848, which allowed municipalities to fund public works such as water supply and sewage, thereby imposing costs on the rate-paying middle classes. This legislation was enabling rather than mandatory, for precisely the reason that the costs fell on local ratepayers, local authorities were empowered to carry out these works, but never required to do so.

What is usually referred to as the 'sanitary' movement continued into the mid-Victorian period and on into Edwardian England. The aims of the reformers (which included the Conservative Disraeli) rested on a 'discourse' (we shall discuss the meaning of discourse later in this unit, or ideology which evolved over this long period but which had certain continuing elements.

Firstly, the reformers made a connection between dirt and disease which has been part of our taken-for-granted common sense for many years now, but which was vehemently denied by many in early and mid-Victorian Britain. A germ theory of disease was not fully accepted until the 1860s, and the blunt assertions by Simon, Chadwick and early Medical Officers of Health that 'the filth track, the cholera track, and the fever track are identical' were still resisted, but the cholera epidemics (which first came to Britain in 1831/2 of 1848/9, 1853/4 and 1866 took many ratepayers to the grave as well as the insanitary poor.

The recognition that public health was indispensable was the second element of the sanitary discourse. The ideological implications of this recognition were important because it meant that the state could and should intervene in private lives and in independent local government. Laissez faire could not be allowed to run as far as imperilling the lives of the ratepayers. Lord Macaulay put the reluctant case for accepting sanitary reform (and its costs) in 1846.
I am as firmly attached as any gentleman in this house to the principle of free trade properly stated, and I should state that principle in these terms that it is not desirable that the state should interfere in the contracts of persons of ripe age and sound mind, touching matters purely commercial, but you would fall into error if you apply the principle of non-interference where the public health or the public morality is concerned.

The Public Good aspect of health – the view that society through the state should intervene to bring about services which the private market would not pay for – led to public provision of clean water, sewage, cemeteries, factory inspection, compulsory vaccination against smallpox, controls on house-building, and regulation of overcrowding. All these reforms occurred at different times in Victorian Britain, and all raised public expenditure and were resisted for this reason by the minority who paid local rates, despite the arguments of people like Chadwick who calculated that getting rid of avoidable disease would actually save money, principally by lessening demands on the Poor Law which was paid for and spent locally. Only from the 1870s did many of the health and sanitation reforms become matters which local government had to do rather than being permitted to do if they chose.

The public good cannot, even in a perspective which ‘reads’ the Victorian history of public health as the result of altruistic reformers, be seen simply as providing services to the poor which they could not afford to buy but which they wanted. Public health and sanitation measures also meant regulation and control of the poor. Controls on overcrowding, for example, raised rents in some areas and were resisted or avoided by the poor, who were unorganized and without a vote. Compulsory vaccination against smallpox dates from 1861, and no allowance was made for those who might object on conscientious grounds, certain diseases were made notifiable to the Medical Officer of Health, with fines or imprisonment for those who avoided doing so.

We are now so used to seeing the great Victorian reforms as bringing desirable improvements that it is easy to lose sight of the fact that many of them were regarded at the time as an invasion of privacy and an erosion of the rights of families and individuals to keep living arrangements and health private.

The Victorian reforms greatly expanded the power of the state – that is, both central and local government – to intervene in the personal and private matters of health and health-related issues. The intervention was not ideologically neutral (if such a thing were possible) but embodied values and social constructions which continued into later schemes for the public provision of health care into the Liberal government’s reforms of the National Insurance Act (1971) and into the National Health Service Act (1946), which is one of the foundation stones of the modern welfare state. ‘Reading’ or conducting a critique of the implicit ideology of public medicine is a way of revealing the ideologies which underlie the history and practice of public health in Britain, and it can be done from different perspectives, we shall offer three of them in this unit. Before discussing what we mean by ‘critique’ and how it is done, we shall show the connections between the Victorian reforms which we have just outlined, and the development of public health care in the twentieth century. But first we must draw an important distinction.

### 2.2 Public health and personal health

Richard Titmuss (1968) has distinguished two aspects of publicly funded health care. Public health is collectivist and preventative. It is collectivist because it cannot be supplied on an individual basis. Many of the Victorian public health reforms were collectivist. Clean water supplies and efficient sewage disposal (which between them eradicated epidemics like cholera) cannot be supplied only to some people without leaving the risk that those who do not get them will infect those who do. Thus everyone has to have clean water if the ‘cure’ is to be effective, it is no good leaving pockets of backwardness among those who cannot or will not pay for the new
services, because they might infect their neighbours. Everyone, according to the
collectivist, has an interest in seeing that minimum standards of clean water and
sewage disposal are enjoyed by all and, if necessary, imposing (through the state)
the requirement that all conform to water and sewage regulations. Public goods like
clean water have the potential disadvantage that some will not pay for them if they
do not care or if they expect their neighbours to pay for them because it is in the
neighbours' interest. So it is difficult to finance services like these on the basis of
pay-as-you-consume. That is why there is strong pressure to finance public services
from taxation everyone pays for them to some extent or other, and everyone enjoys
the benefits. This argument - for state intervention in a limited way - was
accepted in Britain by the 1870s when Disraeli's Conservative government passed a
number of Acts in public health and sanitation which extended or strengthened the
reforms of the early Victorian period.

Personal health is individual health, the complaints which we take now to our family
doctor or which see us admitted to hospital. Clearly, public and personal merge into
one another because, for example, if individuals catch an infectious disease because
of lack of public sanitation it will also be a personal problem which the individual
will want to be cured. But the distinction can be maintained in health complaints
which owe, or seem to owe, nothing to general conditions but are accidental, of
unknown origin (heart disease, for example), or arise because of personal neglect.
The patterning of individual health problems is not random, as we shall see, but
follows divisions of social class and region. This patterning makes it increasingly
difficult to maintain a clear distinction between personal and public health, but we
are concerned at the moment with how the Victorians and Edwardians saw the
connection and how the 'health debate' evolved then, rather than with how modern
medical knowledge has changed our perception of the connections between diet and
housing (to take the two main examples) and health.

The connections between poverty and disease were graphically illustrated by a
number of reports in the early and mid-Victorian period. The consequences of
poverty in the rapidly expanding cities of industrializing Britain were seen as
overcrowding, damp and insanitary housing, poor diet, and defective public services
such as water and sewage. Those effects brought the further consequence of chronic
ill-health and shortened life expectancy, and particularly high infant mortality. The
Victorian public health and planning reforms were aimed at some of these
consequences but in themselves did nothing to deal with poverty as such, simply
with some of its consequences which had public health implications.

However, arguments that the personal health of the poor also required treatment
were advanced as early as the Royal Commission on the Health of Towns, which
itself was fundamentally arguing for solutions to collective problems rather than to
individual ones. Personal health treatment for the poor was a patchwork of Poor Law
infirmaries, of higher status voluntary hospitals (which increasingly became more
interested in acute and 'interesting' diseases than in chronic conditions) and of
charitable efforts by doctors and medical missionaries, particularly in the later
Victorian period. In short, the poor received preventative health measures but
curative care was uncertain in the extreme and readily available only to the skilled
working class and tradesmen who voluntarily insured with Provident and Friendly
Societies and with the craft trade unions. The middle and lower middle classes
could buy personal health care according to their means. The amount of personal
health care which the individual received depended on the ability to pay or, for the
better-off working class, on their membership of a voluntary insurance scheme. For
the poor these were means-tested charity hospitals (which until the twentieth
century took only patients unable to pay for medical care). These were not spread
evenly throughout the country, however, took only acute as opposed to chronic
cases, and even then were selective in the cases they took. Apart from these, the
poor in casual, unskilled jobs or in no jobs at all were thrown entirely on to the Poor
Law, and the popular identification of Poor Law hospitals with workhouses was often
made
Personal health measures came much later than those related to public health and were the result of bringing together several different strands in the Victorian debate between non-interferers and interventionists. The main debate was about the causes of poverty and, by extension, the causes of individual ill health. Edwin Chadwick, although a noted sanitary reformer in public health, was an equally strong supporter of the new Poor Law (he was secretary to the Poor Law Commissioners) whose principle of less eligibility was aimed directly at forcing the poor into employment. Poverty was a personal moral defect brought about by unwillingness to work, and the option of work had been made less attractive by the laxity of the old Poor Law hence the tougher spirit of the new Poor Law of 1834.

The same moral defects of the poor which made them poor also showed themselves in lack of hygiene, in poor parenting, in drunkenness, and in poor household management— all defects which led to poor personal health as well as posing public health risks where the poor were crowded into slum housing— as reported in Leeds (1842), Sheffield (1849), and London and Newcastle (1885). Housing remained in short supply throughout the nineteenth century in all the expanding cities as the population grew rapidly, and so overcrowding continued to increase.

The social work of the later Victorian period was aimed at the remoralization of the poor as a cure for their poverty. The Charity Organization Society (which will be discussed at length in Unit 13) was the originator of the idea of ‘case-work’, in which direct intervention was made by a case-worker into individual families to remould them in exchange for charitable payments. Thrift, temperance, and habits of industriousness were what the poor needed. The spirit of charitable social work—the spirit of personal moral change—ruled in health matters, too, particularly in hygiene and the removal of the squalor and filth which social workers and missionarines to the poor saw in the slum dwellers they visited.

It was the mothers who were the first target for change as the guardians of the home and of infants. The Manchester Ladies’ Sanitary Reform Society (founded in 1861 and an offshoot of the Health of Towns Movement), which employed working-class women to visit mothers at home and instruct them in the need for cleanliness and good diet, is often said to be the first organized hygiene movement (but see Section 3.4 below). Its example spread widely in Britain in the later nineteenth century, and most cities possessed charitable societies with the same purposes.

By late Victorian times the poor were viewed as a health problem in a wider sense than the public health threat of the early and mid-Victorian periods. The ‘private’ sickness of many of the poor was now seen as a problem demanding public intervention—at first charitable, but increasingly with demands for state intervention. The principle of non-interference was eroded further by the enormous outcry after the Boer War (1899–1901), when high proportions of recruits were rejected by the army as physically unfit. The Inspector General of Recruiting feared ‘the gradual deterioration of the physique of the working classes from whom the bulk of the recruits must always be drawn’ (Bruce, 1961). The debate on ‘national efficiency’, as it was called, was the immediate background to the Liberal government’s health and welfare reforms in the Edwardian period—reforms which are widely acknowledged to be the beginnings of the British welfare state. The state’s interest in children as a national resource dates from the shock which followed the revelations about recruits to the Boer War. But it intermeshed with a more general debate on national efficiency and eugenics, a fear that Britain’s racial stock was declining and that Britain was losing out to its trading competitors (the USA and Germany) and to potential enemies (particularly Germany). For the first time, the working class were seen as a national resource, and the health and physique of children required state intervention. The first responses were free school meals in 1906, the medical inspection of school children, introduced in 1907, and the Notification of Births Act 1907. (This last measure, made mandatory in 1915, was to enable health visitors to visit the homes of all new-born babies and give advice on hygiene and child care.) More generally, there was a commitment to improving the quality of ‘mothering’ Concentrate on the mother. What the mother is the children
are. Let us glorify, dignify and purify motherhood by every means in our power', said John Burns, once a trade union agitator and later President of the Local Government Board, at a conference in 1906 on infant mortality.

The poor still relied on charitable medical care, although the number of hospitals offering free care to acute cases expanded slowly but steadily in the Edwardian period, when local authorities took over many Poor Law infirmaries and built new ones. The greatest change in personal health care came with the Liberals' National Insurance Act of 1911. This was partly copied from Bismarck's reforms in Germany. Lloyd George appealed both to the self-interest of employers in supporting reform and to the National Hygiene movement's fears of race decline when he spoke for the new Act. The Act aroused opposition from employers, who had to pay contributions towards sickness absence by their employees, and from the British Medical Association, whose members, the general practitioners, would take panel patients and be paid for them by the state. The middle classes were excluded from the scheme, partly because the doctors feared losing their private patients and partly because the Liberals insisted that the scheme would be funded entirely from contributions. Only working people were in the scheme, non-employed wives and children were excluded, and if they could not afford the fees for private treatment they had to resort to the local authority hospitals (the old Poor Law hospitals) or rely on charitable medical treatment, which was in general available only for acute illness.

The 1911 Act was the forerunner of the 1946 National Health Service Act, which extended the insurance principle of medical care to women and children and to the middle classes. The Liberal reforms and the slow extension of local authority hospitals left a patchy and cumbersome system of personal health care in Britain in the interwar period. Pressure for reform came from the Labour movement and from middle-class fears of medical costs. The organized medical profession resisted further reform as it had resisted the 1911 scheme on the grounds that what was being advocated was a system of state-salaried doctors. Though the British Medical Association opposed the wartime proposals for a National Health Service and the Labour government's Bill, it was accepted after a lengthy opposition but on terms which were much more favourable to the British Medical Association's position than the Labour Party had wanted.

The architect of the National Health Service, Aneurin Bevan, had to accept a scheme about which he had doubts concerning independent contractors (the general practitioners) and the freedom of patients to choose the doctor they wanted, and also the continuation of private practice. The need to extend health services to the dependants (primarily women and children) of the insured contributors (mainly men), however, and the need to provide hospital care and general practitioner care in those parts of the country (predominantly the poorer parts) where it had been very thin, overrode the Labour movement's doubts. This is the Health Service which we largely have today: a commitment to health care based on need rather than on the ability to pay, and a service which was available throughout the whole country and in poor areas as well as affluent ones. The NHS has come under strain as successive governments of the 1970s and 1980s have made control (or cutbacks) of public expenditure a main priority for policy. Critics have pointed to the original aims of the NHS and argued that its purpose of achieving equality of health does not stand up to the continued differences between social classes in illness and life expectancy, nor have the regional inequalities in health care provision disappeared. Inequality in health is something we shall examine in Section 2.3, when we subject the history of the state's intervention into health to the first of our three critiques.

A theme of this unit will be the way that it is possible to understand the present in a number of ways through the reading of history, depending on the theoretical stance from which one starts to construct a 'reading'. The pluralist reading above lays stress on the role of individual reformers, on pressure groups, and on intellectual currents which shape the terms in which the national debate was conducted at differing times. The health service in Britain now, in this reading, is the result of the
evolution of concern originally for the poor, then for the working class as a whole, then finally to everyone irrespective of social class or gender.

Other readings of history, and specifically of the history of health care, are possible, and we shall be presenting some in later sections. Our first reading gives the picture of a long struggle for reform which finally succeeded. This is not the whole picture, however, and we can make the beginnings of a critical analysis by looking at aspects of the history of the health services which our account does not bring out as important or which it does not mention at all. Critique begins with revealing the incompleteness of an accepted account of events and suggesting an alternative perspective which promises wider coverage. Alternative perspectives will interpret the same event with a different significance, and focus on evidence which is thought insignificant (and perhaps ignored) in another perspective.

The three critiques we shall use are (a) the feminist critique, (b) a Marxist critique, and (c) a more subtle critique of the ‘discourse’ or ideology – the supposedly factual (value-free) propositions implicit in medical practice.

This latter critique, of the discourse of medicine, will be looked at in Section 2.6.

Q. Can you identify the seeds or starting points of a feminist critique and a Marxist critique in the history of public health provision?

A feminist critique could start from the Burns quotation and its ‘gionification’ of motherhood linked to the concerns of the National Hygiene movement. Women are seen, implicitly, as the producers of a fit labour force and potential soldiers, and as located in the home. Their role as paid workers or as individuals is ignored or submerged in their primary role as mothers. The account also says nothing about the chief medical experience of women – giving birth – and the issues raised in Unit 1 by Sue Himmelweit. A Marxist critique could take Lloyd George’s arguments to employers in which he advocated National Insurance as a means to fight socialism, which would threaten the bourgeoisie, but would ask who pays the insurance and who benefits from it, this would provide an analysis which focuses on structured inequalities in capitalist society. An analysis of inequalities (not in itself Marxist) will inform such an analysis. Marxists would examine and attempt to explain why the inequalities in health which the National Health Service promised to do away with have not in fact been eliminated. They would also focus on the power of the medical profession, as members of the bourgeoisie, to determine the form and operation of the NHS.

These are only starting points, the sections which follow will discuss more aspects of the critiques that can be made in the area of state intervention in health, starting with the Marxist one.

The concept of ‘critique’

‘Critique’ (or ‘critical analysis’) is not the same thing as ‘criticism’. The word ‘criticism’ has come to mean ‘negative appraisal’. ‘Critique’ does not necessarily imply appraisal of an account, whether negative or positive – though this may often be present – but analysis of what may be seen as underlying the account. Critical analysis is the basic stance of the social scientist, who asks not just ‘Is this account true or false?’, but ‘What assumptions underlie it and what other possible accounts does it conceal or rule out?’ Each of the units of this course has offered a critique of a fundamental shared set of constructs – around pregnancy and childbirth, for example, or childhood, youth, old age, or the role of women as mothers. In each case the author has tried.
to tease out what we commonly believe to be true (or take for granted, without anything as ratiocinative as 'belief') and to offer alternative accounts which are at least no less true and afford the possibility of questioning these assumptions.

The basic tool of critical analysis is the comparative method, in two varieties: cross-cultural comparison and historical comparison. In Helen Lentell’s Unit 6, which opened this block, you were given the opportunity to question current preconceptions about ‘the family’ and its inevitable and quasi-biological nature through a brief analysis of other cultures where ‘private life’ is organized differently. In the current unit we shall draw more on historical comparison, trying to show that the present state of affairs is neither inevitable nor beyond critical analysis, because at other times things have been different. In both cases the aim is to illuminate our current conceptions or ‘constructions’ by showing that they are questionable: other people, at other times or in other places, have understood the social world differently.

Another basic tool is the adoption of a different ‘standpoint’. In Section 2.2 we analysed the health services in their own terms, as well-meaning providers of a public good (though at the end we began to doubt the evenness of that provision, and these doubts are expanded in Section 2.3). We shall go on in Section 2.4 to adopt the standpoint of wage-labourers, using a Marxist perspective, and ask whether the form of current provision and its inequalities is ‘in their interests’ and whether a clearer pattern can be seen if we ask this question. In Section 2.6 we shall take the standpoint of someone un convinced that professional medicine is a valuable provision and show, we hope, that there are severe difficulties in convincing a sceptic who does not share the medical profession’s basic assumptions. Going further, we shall adopt a woman’s standpoint on obstetric medicine, to show that the conceptualization of current medical practices as in women’s interests is far from beyond dispute. Each change of perspective will involve questioning what is taken for granted as factual and/or as of value in the popularly accepted account and seeing if better — more comprehensive — sense can be made using different premises.

A final point (for the time being) on the concept of ‘critique’. A critique is often advanced by one who is critical (in the common-language sense) of current ways of thought: laying preconceptions bare with the intent of overturning them. There is no necessary connection between critical analysis and criticism, however. It is just as much critical analysis to identify values and norms underlying practice and to argue for their retention (see, for example, the extract by Roger Scruton discussed in Robert Bocock’s Unit 10 of this block).

### 2.3 Inequalities in health provision

The welfare state measures, and the developments in welfare and medicine which preceded them, are generally seen as having resulted in considerable improvements in health. We think of ourselves as being healthier than, say, our grandparents’ generation, and in many ways we are. Indicators of health such as infant mortality have shown steady improvement over the last one hundred years. At a common-sense level we are very strongly inclined to regard health interventions as ‘a good thing’. To quote Ehrenreich and Ehrenreich (1975)

The question most frequently addressed to angry groups of service consumers in the sixties was ‘What do you people really want?’ The initial answers could be condensed to one word: more – more educational opportunities, more health and mental health services, more welfare and social services
Whether it be medicine, therapy, the monitoring of child development, food and drug regulations, or the more basic 'conditions of civilization' such as pure water and the hygienic disposal of sewage, we have tended to think that 'they' (the providers of services) have our interests at heart and are working for us. Our current health provision is the outcome of long struggles to build a country fit for ordinary people to live in.

There are demonstrable inequalities in the provision, however, and these are not random but conform to patterns which suggest another perspective on the purposes of health provision. There is very good evidence, for example, that the health service does not succeed in procuring an equal state of good health across the socio-economic classes. Men and women in unskilled jobs have a two-and-a-half times greater chance of dying before reaching retirement age than their counterparts in professional occupations. Deaths at birth or during the first month of life are twice as likely in families where the father is an unskilled manual worker than in professional families (see Unit 1). (Cause of death is immaterial: whether the cause be accident, infectious disease, cancer, heart disease or respiratory complaints, the class gradient is equally marked.) Incidence of chronic bronchitis varies, as a percentage of all cases between the ages of forty and sixty-four, from 6 per cent in the professional class to 26 per cent among unskilled workers (see Townsend and Davidson, 1982, as the source of these and preceding statistics). Unskilled males are 50 per cent more likely to be suffering from acute illness than professional males, and 80 per cent more likely to have a chronic illness of long standing, the differences are larger still for women, though the comparison is confused by the fact that married women's class is generally measured by husband's rather than own occupation (see Abbott and Sapsford, 1967a). On average women live longer than men, but within each gender the working class have a shorter expectation of life than the middle class (as you may remember from Unit 4).

Regional inequalities are equally marked. As the Black Report commented, 'the healthiest part of Britain appears to be the southern belt below a line drawn across the country from the Wash to the Bristol Channel' (Townsend and Davidson, 1982, pp. 57–8). Geographical and class differences come together in the appalling health figures for dwellers in Britain's inner cities.

All the environmental sources of illness are stronger in poorer areas, and even more so in the inner city. Smoking is more prevalent, diets contain more sugar, starch and fats because foods higher in protein, minerals and vitamins are more expensive, damp and cold give rise to chest complaints and rheumatism, nervous tensions, air pollution, mould from damp, all contribute to allergies. Low birth weights are common because of poor maternal diet and smoking during pregnancy. There are more accidents in the home and on the street. There are health risks arising from poor refuse-disposal systems, shared toilets, ducted air heating, exhaustion from overwork and the effort of coping with stress leads to reduced resistance to other diseases. Recession intensifies all the factors precipitating illness. Personal health is one of the most telling and tragic indicators of the degree of inequality in Britain (Harrison, 1985).

Health inequalities by class are in part mediated by straightforward economic factors. The poor tend to work in more dangerous, polluted circumstances and to eat less well than the rich. Class inequalities may be further compounded by gender inequalities. Working-class wives tend on the whole also to eat less well than their husbands, Graham (1984, pp. 130–1) argues that women's 'duty' to see the family fed may often lead to their neglecting their own diet in impoverishment and, particularly, one-parent families, and he cites a number of empirical studies to make her point. Partly the inequalities may arise because those in lower socio-economic positions do not find doctors as 'accessible' as people in middle-class occupations. One can well see that a middle-class doctor is more approachable by and intelligible to a middle-class than a working-class patient. The published figures tend to show that working-class people visit doctors less often, even when sick, than do middle-class ones, have briefer consultations when they do go, obtain less information from their doctors, make less use of family planning, ante-natal and immunization.
services, and receive less and inferior help in old age. Coupled with this 'felt inaccessibility' may be a large degree of real inaccessibility for mothers on low incomes, and particularly for mothers bringing up children alone.

Many of the journeys women make are to secure resources for health. Many of these journeys, too, are made with, and on behalf of, children. The cost of public transport, and the problems it presents for travellers with children, lead many women to prefer to walk. However, the tendency to concentrate food retailing outlets and medical services in fewer, larger centres serves to distance the carers from the resources they need. This centralization of family services means that the delivery of care to families increasingly occurs in a symbolic sense only. Parents must travel and collect the supplies of food and medical care that they need for their families. In such circumstances, the costs and benefits of securing these supplies are often finely balanced. For poorer families in particular, a rational decision may be one that rejects professional care (Graham, 1984, p. 145).

2.4 A Marxist critique of health provision

None of what we have said about health inequalities so far is in any way Marxist, but is rather the 'factual' material commonly taught to nurses and doctors about the service in which they work. The unequal distribution of ill-health, and of health resources, is common ground shared by social scientists of many different theoretical persuasions, and is amenable to individualistic as well as structural explanations. Even when it can be observed that health and illness are closely connected to class, or socio-economic, positions, we are still some way from a Marxist analysis. 'Class' is not an exclusively Marxist concept, but is widely used in the social sciences as a way of classifying the distribution of occupational and other rewards between different groups. It is a measure of 'socio-economic position', and is often used as an indicator of 'life chances' (for example, access to income, wealth, education, job mobility, housing — and health, where 'life chances' has a more literal meaning).

So what would distinguish a Marxist analysis of health and health care from what we have discussed so far? We would suggest that there are three main issues which differentiate a Marxist approach to the study of health:

1. The central idea of classes as essential to the understanding of the whole of a capitalist society, such that classes — and the conflict of interests between them — are the main driving force of social development. At the centre of this conflict are the two major classes — the bourgeoisie (or capitalist class), the owners of productive wealth, and the proletariat (or working class), those who must sell their labour to live. The 'middle classes', of managers and professionals, tend to play a supporting role to the interests of the ruling, capitalist, class.

2. The conflict of interests between classes affects the whole of the social organization of the society, including politics and the state, through which class interests are organized and fought over at a national level. Which interests prevail in this conflict will shape the sorts of policies pursued by the state.

3. The organization of production in a capitalist society (and the central class conflict) affects all other aspects of the society (from the family through to health care). All aspects are shaped by the demands and consequences of the system of production such that, for Marxist analysis:

   state interventions in the health field are bound everywhere in the capitalist world by real constraints that are deeply rooted in the capitalist mode of production and that are largely above the volition of individual health care workers, public officials, and the citizenry alike. Capitalist industrial growth produces health needs that are treated by medicine in capitalist societies in such a way as to make the solutions to these needs compatible with the capitalist organization of the economy (Renaud, 1975).

With these comments in mind, let us look back at the brief history of health care in Britain presented in Sections 2.1 and 2.2 and see how it would be different when viewed from a Marxist perspective.
One central difference concerns how to explain the origins of public health care. Where the account given in Sections 2.1 and 2.2 stressed the causes of social concern about the poor, and the role played by social reformers such as Chadwick, a Marxist analysis would stress the class forces and interests that were at work in nineteenth-century Britain. For example, the sorts of ‘health needs’ that emerged were themselves the consequences of how capitalist industrialization took shape in Britain: the overcrowded, ill-housed and insanitary conditions into which the new urban working class were placed, the destructive effects of both intensive factory work and unemployment on the health of the working classes, and so on. In Renaut’s words, the pattern of ‘capitalist industrial growth produces health needs’

Equally significant, however, is the way in which those health needs were defined and responded to. Marxists would see the question of class interests as central to the creation of public health provision in a number of ways. It is significant that the first form of public (as opposed to private or charitable) health care was provided through the Poor Law, an institution whose main function was to deal with the unemployed and unemployable (the population of ‘surplus labour’). The health of labour (or the ‘labouring classes’, as the working class was often referred to) was the frame of reference through which capitalist interests viewed health care in the nineteenth century. The increasing commitment to state-organized health provision through the nineteenth century expressed a capitalist concern about the condition of the labouring classes which had three rather different aspects.

First, it marked a growing concern with the reproduction of labour. Ill-health and physical degeneration meant a decline in ‘national efficiency’, a loss of economic (and military) competitiveness in the period when Britain’s world dominance was being subjected to increasing challenges from other nations. State intervention, then, was justified as a way of improving the efficiency of the labour force which British capitalism needed to maintain its competitiveness.

Second, it expressed a fear about contamination and contagion through the density and insanitary conditions of urban living. The physical degeneration of the ‘labouring classes’ was not only a source of concern because of its economic consequences, but also because it represented a potential source of infection for other social classes. Typhoid and cholera might breed in the working-class slums, but the density of the new towns and cities encouraged their rapid spread to the middle and upper classes.

Third, state intervention in health also expressed a concern about the political instability of the working class. The nineteenth century was marked by periods of disturbance and upheaval ranging from noting to extensive trade union and political agitation among the working class, and these challenges to the social order which the dominant classes wished to maintain provided a recurrent source of anxiety and fear. In the development of health care through the nineteenth century, it is possible to identify different types of strategy being used by the dominant classes to contain and control the ‘dangerousness’ of the working class. In the early part of the century, the Poor Law (and its main institution, the workhouse) was used to discipline and contain the ‘surplus labour’ which might otherwise be dangerous (ranging from criminality through begging to ‘infecting’ the labouring classes with disease and dangerous ideas). By the mid-century, however, the state was being used to intervene in the social conditions of the working class, the sanitary movement being the most obvious example. Here, health-care interventions aimed simultaneously at improving the health of the working class and at stabilizing and regularizing the conditions in which they lived, opening up the slums and rookeries to a more orderly way of life – one which was more suitable to the demands of capitalist production and its view of social order. Here, too, a Marxist analysis would draw attention to the interests that lay behind the growth of state intervention around the health and development of children (school meals and medical inspections, for example), through which the state took a hand in trying to secure the reproduction of future generations of labour.
By the early twentieth century, we can see health care playing a different political role. With the development of organized labour (both in trade unions and political parties), health care became—in Marxist terms—a bargaining counter in a politics of concession and compromise, aimed at offering the working class (or sections of it, at least) a stake in the future development of capitalism. The concession of political rights (the vote) and social rights (to a limited range of health and welfare services) aimed to prevent the growth of ‘socialism’, and to counteract the danger that the political rise of the working class posed to the continuity of British capitalism.

From a Marxist viewpoint, health care in Britain was shaped primarily by class interests and conflicts. It emerged from the economic and political interests of the dominant classes and was determined by their concerns about how to create a social order which would support the further development of capitalism (and how to fit the working class into that social order). But it also became an arena of political conflict and bargaining between class interests as the working class emerged as an organized political force at the end of the nineteenth century. From this standpoint, state health care in Britain is the outcome of conflicting interests: capitalist interests in the health of the working class, and working-class interests in protecting themselves from the worst effects of ‘pure’ capitalism.

The result of these conflicts was the creation of a health care system in Britain which, while it met some working-class interests, did not represent an ‘overthrow’ of capitalism and capitalist interests. The National Health Service was certainly influenced by demands from an organized working class (for universal provision, and for ‘free’ treatment), but it also involved ways of defining and meeting health needs which were accommodated within the constraints of British capitalism. For example, the class inequalities in the distribution of ill-health have continued in spite of the NHS, and illness has continued to be treated as a ‘personal’ matter despite evidence about the occupational and social conditions that create it. Equally, the model of health which has dominated the NHS has focused on ‘acute’ rather than ‘chronic’ conditions, and on ‘reactive’ rather than ‘preventive’ medicine. Marxist analysts have argued that these orientations to health embody capitalist (rather than socialist) imperatives. The attention to ‘acute’ conditions of illness involves a stress on getting individuals back to a ‘productive’ life quickly, whereas ‘chronic’ conditions interrupt working lives less dramatically. Similarly, ‘preventive’ approaches might interfere with working conditions, patterns of life and patterns of consumption (e.g. alcohol and tobacco) which are seen as necessary and profitable.

The NHS, then, can be seen as being subjected to contradictory pressures and demands—the pressure to promote health being limited by the pressure not to disrupt the ‘normal’ workings of the wider society (e.g. by not costing too much, or by not pressing for changes in profitable conditions of living and working). In recent years, too, the NHS has been subjected increasingly to the pressures of ‘market forces’, where health care is treated as a commodity like any other, to be purchased by the individual consumer. Health, and health care, is a significant field of capitalist enterprise, ranging from private hospitals and services through to the pharmaceutical industry, and this field of enterprise can also play a major role in shaping what are seen as health needs, as well as what the ‘solutions’ to them should be.

For a Marxist analysis, therefore, health is not a separate area, detached from the main economic, social and political structures of capitalism. On the contrary, it is shaped in all its aspects, by the conditions and constraints of a capitalist economy. The distribution of health and illness, the definition of health needs, and the solutions available are structured by the economic and political interests which dominate in a capitalist society. Even where conflicting political and social interests have changed the definition of health and the provision of health care, these have taken place within the confines of capitalism. One central issue for Marxist analysis, and the propositions which it develops, is the importance of a comparative approach.
to the differences between capitalist and non-capitalist societies. Thus it is the way
in which health care is shaped by and integrated into the structures of a capitalist
economy in Britain that has been the major focus here.

In this section we have not presented a Marxist history of health care in Britain.
Rather, we have highlighted the issues and concepts which a Marxist interpretation
(or 'reading') of history would put in the foreground. Thus, classes, class interests,
class conflict and the role of the state are the central concepts through which a
Marxist analysis looks at the history of capitalist societies, while the earlier frame of
reference (of social concern, interest groups, reformers, etc.) has receded into the
background. A Marxist perspective provides a different way of 'reading' social
concerns and reforms, by looking for the class interests which they express.

**On 'reading' history (1)**

The social scientist's use of history is typically rather different from that
of the historian, concerned not so much with establishing what things
were like in the past as with trying to elaborate our understanding of
the present. Thus the brief and crude 'readings' of the history of
welfare offered above (we shall offer readings of increasing complexity
in later sections) begins to explain present health provision as the
outcome of class conflict and class interests.

Note that such 'readings' are selective. From the complex pattern of
events we have emphasized a 'story line' which explains state
involvement in health as an apparently necessary process undertaken
by the state in the interests of maintaining capitalism. Alternative
readings would emphasize different 'story lines' by 'reading' history
through a different frame of reference, and using different organizing
concepts. Note, therefore, the role of theory in constructing a reading of
history: we are not talking about 'uncovering truth' — there can no
more be one single true account of the past than there can of the
present — but of testing and illustrating theory by seeing if a plausible
sequence of historical events can be perceived with its aid.

Note also, however, that all accounts of history are 'readings': they all
embody theories about what is important. 'Great man' history
emphasizes the importance of individual thought and action and of key
events such as reforming innovations and the passing of legislation.
The now more fashionable 'economic' history often emphasizes the
impact of technology on people's lives: the automation of factory work,
the effects of modern transport and communications, the effects of key
industrial inventions at the start of the industrial revolution, or the
earlier effects of switching from arable to sheep farming on the need for
agricultural labour. These accounts are just as selective, however, and
just as dominated by theory as the 'critical' accounts stressing the
pursuit of sectional interests which are given in this unit.

Before you proceed, re-read briefly the 'Marxist' history in Section 2.4
and the apparently more discursive account in Sections 2.1 and 2.2.
Note the selection of events out of which the reading of history is made
up, the kinds of explanation given for the events, the norms (taken-for-
granted suppositions) and values explicitly avowed in the accounts. See
where the accounts are similar and where they differ, and decide what
is to be concluded from the similarities and differences.
2.5 **Health visiting: a Marxist interpretation of history**

In the Marxist analysis, the form of social relations under capitalism, including the scope and activity of the state, is seen as shaped by a fundamental conflict of interests and the ways in which it is ‘managed’ – the interests of capitalists are in potential or often actual conflict with the interests of those who ‘possess’ only their labour as an asset. Social relations are structured both formally and informally in the interests of the capitalist class – towards the preservation of private property, the opportunity for accumulation of capital, and the orderly management of labour. This is not a slur on current regimes, but a description of what it means to be a capitalist society. If things were different, it would not be capitalism. Thus the history of the welfare state’s foundation which we gave in Section 2.1 can be reshaped by pointing out that one more or less explicit reason why reforms came about at the time they did – indeed, one given by the participants themselves – was anxiety that the English working classes might not otherwise take on the burden and sacrifices of war. Many of the great reforms of the nineteenth and early twentieth centuries – the introduction of efficient sanitation and clean water, for instance – were started by industrial philanthropists with the explicit intent of improving the quality of the workforce on the one hand and forestalling insurrection on the other.

In what follows we are going to examine the development of one particular aspect of health provision, using a Marxist interpretation or reading. We have already established the sorts of issues that a Marxist perspective would emphasize, and we will now see how they can be used to provide a historical reading.

Health visiting is a service unique to Britain, other countries do employ public health nurses, but none performs the same range of functions and services as are provided by the British health visitor. Health visitors are Registered General Nurses with obstetrics training and a specialized qualification in health visiting. Health visiting became a statutory and fully state-controlled service under the National Health Act 1946 (subsequently modified by the Health Services and Public Health Act 1968). It was envisaged that health visitors would perform a wide range of duties with all age groups, specifically concentrating on health education, but with a major focus on mothers and their children.

*It shall be the duty of every local health authority to make provision for the visiting of persons in their homes by visitors, to be called ‘health visitors’, for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection* (National Health Service Act 1946, para. 24 (1))

With the growth of attachment to general practitioners (as opposed to ‘working a patch’), health visitors do get referrals to work with other age groups, and in recent years there has been some attempt to get health visitors to undertake routine visiting of elderly people. However, in practice health visitors still spend most of their time with children under five years old and their mothers, and it is still the most important aspect of their work, although they have no statutory right of entry, they are the one group who routinely visit all families with children under the age of five.

The origins of health visiting in the nineteenth century can be seen from a Marxist perspective as the imposition of ‘sensible’ behaviours on one class by another – middle-class ladies inculcating ‘good practice’ in working-class mothers. It was later taken up by the state to deliver ‘services’ which regularize the process of reproduction and child rearing. (A similar history can be traced in many areas of social service provision – in the development of the probation and aftercare service from court missionaries, for instance, or of modern social work practice from the various charity organizations. This will be discussed further in Unit 13.) It is fairly easy to ‘read’ health and social work interventions in a crudely Marxist way, as practices designed to ensure a healthy workforce reproduced into the next generation, and/or as the imposition of bourgeois norms (patterns of life) on the
proletariat in bourgeois interests. Health visiting expressed a concern about the 'failure' of working-class families to organize and run their household 'properly', and involved efforts to teach working-class mothers about standards and practices of hygiene, child care and household economy which had become the normal – and 'taken-for-granted' – pattern of middle-class households. The working-class family was seen as in need of education (by example, if necessary) to bring it up to the civilized standards of the middle class. Health visiting was not a service started by the state and staffed by qualified personnel, but one that grew out of the nineteenth-century health discourse and the philanthropic endeavours of the new middle class. It was only gradually during the course of the twentieth century that it became a service organized by the state and staffed by qualified workers.

The origins of health visiting are generally traced to the work of the Manchester Ladies' Sanitary Reform Society, which was founded in 1861 and which in 1862 began to employ working-class women to visit the homes of the poor to teach them about hygiene and to assist them wherever possible (see, for example, Dingwall, 1979). The Society found that such messages were received with far less suspicion if presented by a paid working-class, rather than a philanthropic middle-class, visitor. (This type of endeavour spread to other areas of the country during the latter part of the nineteenth century.) These paid women were supervised by lady volunteers and they worked from rules supplied to them.

They must visit from house to house, irrespective of circumstance, in such localities as their superintendent directs. They must carry with them carbolic powder, explain its use, and leave it when it is accepted, direct the attention of those they visit to the evils of bad smells, want of fresh air, impurities of all kinds, give tracts to mothers on feeding and clothing their children, when they find sickness, assist in promoting the comfort of the invalid by personal help, and report such cases to their superintendent. They must urge the importance of cleanliness, thrift and temperance on all possible occasions. They are to get as many as possible to join the mothers' meeting of their district, to use all their influence to induce those they visit to attend regularly at their respective places of worship and to send the children to school (quoted by McCleary, 1993, pp. 85–6).

These health visitors, then, carried out a variety of duties including health education and nursing, as well as ensuring religious observance in working-class homes. It is important to recognize here that 'health' is bound up with a variety of other social and cultural norms. The carbolic powder is accompanied by instruction on how to rear children as well as advice on thrift, temperance and religious observance. The 'health education' presented touched on the whole way of life of the working-class family. However, by the early twentieth century a change in emphasis began to occur. Health visitors began to be seen as 'well baby' nurses, and this role was assisted and emphasized by changes in legislation that first enabled local authorities to require the notification of all births (Notification of Births Act 1907) and finally made it compulsory (in 1915). The major reason given for this legislation was that it would enable health visitors to visit all new births during this period milk kitchens (to provide
purer milk for mothers who could not breastfeed their infants), infant consultation clinics and schools for mothers began to develop. All of these employed female home visitors and may be seen as the beginnings of the infant clinics that health visitors provide today for mothers with young babies. Such developments meant that working-class children (and patterns of working-class child rearing) came under greater public scrutiny, being subject to checks, investigations and advice about how children should be properly cared for.

Two other major changes occurred in this period. One was that health visiting gradually began to be taken over by the state local authorities started to pay the salaries of some visitors employed by voluntary organizations, and their numbers increased rapidly. The other was the move away from volunteers and paid, but unqualified, working-class women, to a paid, professional workforce. It is worth remembering that in earlier sections we have identified this period as one in which the state was taking a greater role in health care, not least because of the concern about 'national efficiency' and the physical condition of the working class. In the nineteenth century, the voluntary organizations had recognized the need to provide some training for their employees, but the first examined course was run by North Buckinghamshire County Council in 1897. In 1907 Bedford College for Women and Battersea Polytechnic began to provide training courses for health visitors – a two-year course for educated women and a six-month course for nurses. In 1908 the Royal Sanitary Institute, which was the examining body for sanitary inspectors, also set examinations for health visitors. (This continued to be the examining body for health visitors until the establishment of the Council for Education and Training in Health Visiting in 1965.) Also in that year Manchester Corporation took over full responsibility for health visiting and required that all new appointees should be nurses. By 1925 the Ministry of Health was requiring all those taking health visiting courses to have midwifery training. In 1928 the Ministry required that all future appointees should hold the health visiting certificate.

The foundations of the modern health visiting service had now been laid down. There have been changes in the content of the syllabus for health visitor training, in the length of training (from six to twelve months), in the exact nature of the duties carried out by health visitors, and the change from working 'a patch' to attachment to a general practitioner. The basic role of the health visitor has not changed, however.

Thus the origins of health visiting, and to some extent its development, can be traced to middle-class values and middle-class fears. In nineteenth-century Britain no one was totally immune to the infectious diseases (see Wohl, 1983, for surprising accounts of Victorian conditions). In seeking the cause of these diseases medical men blamed the sanitary conditions of the poor, and part of the response to this was the employment of working-class female sanitary missionaries to visit from house to house in poor areas giving out tracts on hygiene and where possible giving instruction. By the end of the century, with the decline in the death rate, concern switched to the infant mortality rate (which was not declining) There was also a general concern about the health and fitness of the working class, with a moral panic developing at the time of the Boer War when so many potential recruits were found to be unfit. From a Marxist perspective, then, health visiting can be seen as developing from a voluntary endeavour by the middle class as part of a strategy to protect themselves from the spread of infectious diseases and contamination by water and sewage, to a state activity when a more general concern developed about the health and 'efficiency' of the working class.

What is important in this analysis is not an argument that health visiting brought about no 'improvements' in health, but that those improvements were both motivated and shaped by particular class interests. The conception of health, health problems and sanitation involved a class ideology which saw working-class ignorance and 'bad practice' as the problem which needed to be overcome.
2.6 Cultural critiques of medicine

In the late 1960s and the 1970s a range of doubts about health service provision grew up which are of a more radical cast – doubts about the validity of the form the provision takes and the relevance of professional and doctor-centred medicine. These have come to be grouped together loosely under the title 'cultural critique of medicine', but in fact there are three separate but related lines of criticism involved: criticism of the professionalization of medicine and the 'expert role' of doctors, doubts about the ability of scientific medicine to live up to its claims, and feminist critiques of the patriarchal assumptions built into modern medicine and its aptness as a tool of social control over women.

The first of these lines of attack questions the fundamental basis of medicine as currently practised and administered in the West; the claim to 'expert status' for doctors. Some writers on health issues have become increasingly suspicious of a medicine which treated as bodily ills, located in the person, what could more realistically be seen as aspects of inner-city living, for example (continuing the community health and sanitary tradition in Britain outlined in Section 2.1). They ask themselves whose interests are served by this individualization of collective problems: the patient's or the profession's? It is argued, to put it crudely, that medical provision takes the form it does in order to maintain doctors in employment.

Doctors argue that lengthy training is necessary for the effective practice of medicine, and that the length of this training and the expertise thereby gained justifies the very high financial rewards of the profession. They also monitor their own profession and exercise effective control over who may practise medicine, in the interests of maintaining standards. The effect of the latter, however, is to ensure the former: another explanation of doctors' high salaries is that there are very few doctors, a fact ensured by control over the size of intake to medical schools. Doctors played an important part in shaping the welfare state's health provision by fighting for clinical autonomy and the right to continue in private practice alongside public work rather than becoming salaried state employees, so that the eventual form of the NHS was a compromise between what doctors wanted and what had originally been envisaged, but a compromise which left ultimate control largely in the hands of the doctors and their official bodies. A net result is a health service which specializes in the 'cure' of individual problems on an individual basis.

This kind of critique gains force from the second criticism: the realization that scientific medicine might not after all be as effective as is often supposed in curing disease. The dramatic reduction in infant mortality and ill-health generally in England in the late nineteenth and early twentieth centuries is demonstrably not due to medical interventions, such as the intervention of doctors in individual 'cases of disease', but rather to improved sanitation and the provision of relatively unpolluted water, coupled with an improved standard of living which entailed better diet and housing (Trotman, 1968; McKeeson, 1976 and elsewhere), charting the rise in life-expectancy and the fall in deaths from infectious diseases since the nineteenth century, demonstrates that in almost all cases the greater part of the improvement had been effected before inoculation and the use of drugs became common (see Figure 1 on the previous page). Deaths from tuberculosis in England and Wales, for instance, fell from nearly 3000 in 1850 to about 500 in 1940, deaths from whooping cough fell from about 1400 in 1850 to about 200 in 1940, and deaths from measles fell from
over 1100 in 1850 to about 100 in 1940. In none of these cases did immunization become generally available till the 1950s, and in the case of measles it did not become generally available till the late 1960s, by which time the death rate was approaching zero (See also Jane Lewis, 1960, for a comparable account of the decline of infant and maternal mortality in the early twentieth century)

Illich (1976) goes much further in his criticism of modern medicine than just calling it ineffective, he is inclined to regard it as a source of death and disease in its own right.

Every twenty-four to thirty-six hours, from 50 to 80 per cent of adults in the United States and the United Kingdom swallow a medically prescribed chemical. Some take the wrong drug, others get an old or contaminated batch, and others a counterfeit, others take several drugs in dangerous combinations, and still others receive injections with improperly sterilised syringes. Some drugs are addictive, others mutating, and others
mutagenic, although perhaps only in combination with food colouring or insecticides.

Other drugs contribute to the breeding of drug-resistant strains of bacteria.

Unnecessary surgery is a standard procedure.

These two kinds of cultural critique – of professionalization and of the validity of the ‘knowledge base’ – are brought together in feminist critiques of how medicine intervenes in the life of women, such as you have already met in Unit 1. Feminists have taken issue with the entrenched sexism of the medical profession – the assumptions that are made about what women’s lives are and should be, which amount to a form of social control, with the competence of the medical profession to deal with ‘women’s problems’, and with the conceptualization of normal female life-events as medical problems in the first place. Organized women’s movements are attempting to take back control of the technology so that it can be used by women for women – or not used at all, if that seems more appropriate.

It is noticeable that in doctors’ eyes women become serviceable machines for the production of babies, and that the welfare of the baby tends to be an overriding concern. Mothers are held personally responsible for all the illnesses and upsets of their children, irrespective of actual origin. This link between medicine and the protection of children will be discussed at length in later sections of the unit.

However, let us note now, in passing, that the ‘duty’ of mothers to bear children for the state is an aspect of gender ideology which regularly surfaces at times of war or political crisis – in Nazi Germany with the slogan ‘Kinder, Kirche und Kuche’. For example, or more recently, in South America. Gloria Bonder (1983), an Argentinian sociologist, cites a content analysis of 104 speeches made by General Pinochet of Chile in the period 1973–76 and concludes that in such rhetoric women are given the timeless, ahistorical role of producing children and sacrificing them by donating them to the army, as if this were their great and generous gift to the world of men. She points to similar elements in political speeches of the Argentinian military government at the time of what in this country we call the Falklands War – upbraiding of mothers for raising inadequate sons, and exhortation of them to give their children to the war effort. English rhetoric ran along very similar lines at the time of the Boer War and in the First World War (Davin, 1978).

Doctors’ competence to advise, even in ‘medical’ aspects of women’s lives, has frequently been questioned by women writers in recent years. It has become evident that despite many years of training, male middle-aged doctors are, on the whole, not well-informed on the biology of pregnancy, childbirth, breastfeeding, menstruation, vaginal infections, menopause or the dangers of hormones (as in the example of birth control pills). The analysis of gynaecological textbooks carried out by Scully and Bart (1978) also demonstrates graphically and with sick humour that medicine knows little or nothing about female sexuality but rather perpetuates a very extensive body of myth as ‘knowledge’. Scientific medicine is particularly criticized for its technologizing of pregnancy and childbirth, as we saw in Unit 1.

Now quickly reread Section 3 of Unit 1, up to the end of Section 3.3, for examples of this kind of critique.

Thus we find that women themselves have initiated a far-reaching critique of the medical profession’s claim to competence, knowledge and authority, at least in so far as reproduction and female health are concerned, and they argue that the way in which the medical profession has become established amounts to an attempt at hegemony – at domination through a set of authority relations which rest on the power to dispense services and the general belief in superior knowledge and
competence. However, analyses of the rise to ‘power’ of the medical profession do
support the contention that the authority of doctors rests as much on codified social
relations as on ‘real’ knowledge and competence – see, for example, Furedson (1970)
and Parry and Parry (1976). Analyses such as those of McKeown and Illich do
suggest that medicine is not as competent as might be supposed, nor as scientific or
successful.

2.7 Realities of health care

So far we have considered two major kinds of critical analysis of public health
provision in Britain. The first, the Marxist, accepts the value in principle of what is
provided but points to structured inequalities in practice and deduces from the form
in which the service is provided that it reflects the wider socio-economic structure of
our society. The second, the cultural critique, tends again to accept the value of a
medical service but questions the competence and disinterested nature of our
medical service. (The feminists go beyond this, in some cases, to question the values
of doctors – specifically, the value placed on children’s well-being at the expense of
the lives of their mothers. This is a line of argument which will be taken up again in
Section 3.) However, we suggested that the discussion so far has been curiously
limited, or even blinkered. Try the activities below, and see if you agree with us.

1. Stop to consider your own health
   (a) Are you often ill?
   (b) Do you get headaches?
   (c) Do you suffer much from colds?
   (d) Do you suffer from hay fever?
   (e) Do you sometimes suffer from aching back or joints?
   (f) Do you sometimes have difficulty getting to sleep?
   (g) Do you often go to the doctor?
   (h) Do you suffer from a condition akin to haemorrhage at regular
       intervals?
   (i) Have you ever experienced sudden weight gain over a period of some
       months, coupled with occasional nausea, back pains, etc?

Most people would answer ‘no’ to questions (a) and (g) – they often have
’symptoms’ but do not often define themselves as ill, and they seldom visit
the doctor – but ‘yes’ to at least one of questions (b) to (i). The apparent
paradox is generally resolved by regarding these very common physical
experiences as ‘not really illness’ but the temporary result of accident or
excess, or just ‘something that happens to everybody occasionally’, or else
(as in the case of the common cold) as essentially incurable and inescapable
experiences, and in that sense ‘normal’

Questions (h) and (i) are interesting, because men who answered ‘yes’ to
them would be confined to hospital immediately, but question (h) is the
normal monthly experience of very nearly all women aged between about 12
and 50, and question (i) has been experienced at least once by all mothers.

What does this say about our concepts of ‘health’ and ‘illness’?

2. Now look back over Section 2 and consider the problems with the kind of
account we have been building so far. To what extent could an account
such as this be satisfactory as an account of health, rather than just of the
health service?
Our discussion so far has covered state provision of medical care, but this is only one aspect of the broader question of health – the daily concern and practice of ordinary people with their own bodily state and that of their children, the health care which is neither bought nor provided ‘free’ by the state, but carried out routinely as part of our ordinary daily lives. Health is in a very real sense a private matter. Most of the health decisions that are made, and most of the health care that is undertaken, is either done by people for themselves or provided within families without any call on outside agencies of any sort. As we have seen, and as we shall argue from another perspective in a later section, the health of the body has provided a major channel of social intervention within the comparatively recent history of our society. In this section, however, we want first to look at what people do in their ordinary lives and how health decisions are generally managed.

Many things ‘go wrong with the body’, but most of them we construe as fairly minor and deal with as our own responsibility. Not infrequently we just ‘shrug them off’ and wait for them to ‘get better’. For example, most people, when they catch a cold, just carry on with their normal routine, though in some discomfort. The decision to ignore the ailment or to do something about it is crucially conditioned by what we have to do in the next few days and what demands this will make on our bodies. Sometimes the sufferer will prescribe his or her own treatment, in the form of a rest, or an early night, or a meal, or perhaps one of the range of ‘home medicines’ such as an aspirin or a germicide. Illnesses are often familiar to their sufferers, so that their habitual course is ‘understood’ and a ‘best’ treatment discovered to work.

With children, parents take both legal and personal responsibility for their health and welfare, and the state’s provision is more often used. Children are always hurting themselves, however, and always developing symptoms, so a majority of possible visits to the doctor still never happen, with home treatment or a ‘wait and see’ policy being substituted instead. Kathryn Backett’s book, Mothers and Fathers (1982), which is an interview study of parents with young children, has some illuminating and sometimes quite amusing examples of the ways in which parents struggle to make acceptable sense of their children’s current state of health – as ‘just a phase’ or ‘something he’ll grow out of’, or ‘nothing very serious’, or ‘a bit worrying, but we can cope with it’. Only in the last resort is it regarded as something to be taken to the doctor, though the health visitor, a female relative – most frequently ‘Mum’ – or a knowledgeable friend might be quizzed informally, to see if a wrong decision might have been taken. Much depends, again, on the known history of the child and his or her health. Family members – mostly mothers – take responsibility for diagnosing the existence of a complaint (as opposed, for example, to ‘just a bit off colour’ or ‘a bit tired’ or ‘not quite himself today’), and in the process of assessing its severity they apply a concept of ‘normal disorders’, distinguishing those which are explicable and not worrying, such as colds or chicken-pox, from unexplained sicknesses which are more likely to be a cause for real concern. They also draw the line between ‘real’ illness and malingerings or ‘just putting it on’, for illness is a ‘moral’ category in families. Someone has to be the arbiter of whether the person concerned is to be seen as ill, merits special treatment and an investment of family time and worry, or as complaining about something that either has no real existence or that they will ‘just have to live through’.

Most initial decisions about illness – whether the person is to be seen as ‘really’ ill, whether the complaint is normal and explicable or unrecognized and worrying, and what is to be done about it – are made not by ‘professionals’ but within families, generally by the mother. Most treatment, nursing and general sick care is also performed by women within families. Often very little help is available to them. Many people do not live in highly supportive communities or tightly organized kin-groups, and even for those who do live near their kin and know their neighbours well the amount of support that is received may be grossly overrated (see, for example, Cornwell, 1984, Locker, 1981, Abbott and Sapsford, 1987b). A great deal of the responsibility for care – particularly of children – falls directly on women.
within families, without alleviation. Even where support is on offer, it is generally provided by other women in the community, and most volunteers who provide informal care are also women. This ‘natural affinity’ of women and child care is something we shall discuss in Section 3

2.8 Summary

So far we have discussed the health services in Britain as ‘construed’ from a number of perspectives:

1. A pluralist model (deliberately cast at a ‘simple-minded’ or ‘common-sense’ level and not representative of any particular pluralistic thinker). This would present the current state provision as the outcome of influences on governments by a wide range of pressure groups, plus the ‘imputed influence’ of the need to please or satisfy various sectors of the electorate at various times. This account is undoubtedly a true one, but many critics have argued that it is not a sufficient one.

2. We outlined patterns of inequality in current provision and gave a Marxist interpretation of them and of the precise form that health provision takes (again a composite, true to no particular Marxist thinker).

3. The cultural critiques which we considered in Section 2.6 may have some overlaps with a Marxist analysis but can also stand alone (Illich, for instance, is far from Marxist in his approach.) They go beyond the Marxist analysis by asking not just whose interests are served by the way things are but also whether the provision we receive is as good as it claims to be. Cultural critiques have disputed medicine’s claim to have reduced the incidence of disease and suggested that the form which medicine takes might have more to do with protecting the professional status of practitioners than with serving the interests of patients.

4. Within the cultural critiques, feminists have expressed these points very strongly, seeing the medical profession as a form of domination of men over women through, for example, the technological control of the childbirth process, even though male doctors’ knowledge of female reproductive anatomy and physiology can all too easily be overrated.

5. Some feminists have gone further, to question the values which ‘doctoring’ expresses with regard to women. Obstetric medicine is geared to the preservation of child life, and doctors’ subsequent advice is geared to children’s well-being. Little account appears to be taken of the dignity, freedom or well-being of the women who happen to be mothers.

Thus a health service emerges which can be seen as an expression of interests — class interests, gender interests and, more locally, professional interests. Its ability to deliver in reality the services on which it bases its reputation has also been questioned. We must ask, therefore, why it holds the central and in practice unchallenged place in our lives that it does. The question becomes more pressing still when we realize that ‘the health services’ in fact constitute only a small and arbitrary part of the full spectrum of health care and health decisions. Most of these are carried out not by state institutions but by private persons in their everyday lives. To answer the question of why medicine holds the power that it does, and particularly why the care and preservation of children is seen as so important, will involve us in a fundamental re-analysis of many of the ways in which we understand our social world. This is the subject-matter of Section 3 below.
In this section we take up another form of critique and another way of ‘reading’ history, based on the work of the French social philosopher Michel Foucault. Our explicit aim is to present a more comprehensive account of the way that health care and the concept of health function in our culture. Underlying this, however, is the broader aim of the unit as a whole, to relate the way that people live, think and act to the forms of state welfare provision and social control. We hope to show (a) just how constructed a social world is the apparently ‘natural’ or ‘normal’ state of things into which state or private welfare intervention is made, and (b) how the nature of ‘the state’ and ‘the family’ have developed together during the last two hundred years.

In Section 3.1 we have necessarily to take a slight detour in the main argument, laying some groundwork for the understanding of Foucault’s ideas, this may seem dry and abstract, but we hope it will come alive in its application in later sections. Section 3.2 outlines the basic argument and the crucial notions of health discourse and biopolitics, and Section 3.3 applies these notions to trace the development of the family and the child, as we currently understand them, as the intersection of this health discourse with a rhetoric about the proper role of the state. The ideas are illustrated in more detail in Section 3.4 through a reworking of the history of health visiting. Finally, Section 3.5 expands on the implications of ‘norms’ and ‘normality’ as a form and exercise of power.

### 3.1 Foucault, ‘ideology’ and ‘discourse’

As we have seen, the Marxist account presents a plausible history of health services but not a comprehensive one of health. The structural explanations we have looked at so far account neither for the way we think about health – ‘common sense’ and most of the cultural or Marxist critiques tend to take the concept of health as ‘natural’ or ‘given’ or at least ‘unproblematic’ – nor for the vast amount of health care which lies outside the formal health services (as well as the gender asymmetries within the delivery of that care).

Marxist perspectives are not, of course, without concepts for the analysis of experience. Traditionally, at this point in a Marxist exposition, one would turn to the concept of ideology – the superstructure of ideas which help to preserve current social order and the way they are embedded within current social institutions and social practices. Instead, however, we propose to draw on the work of Michel Foucault, who has produced a very promising theorization of the role and development of health concepts in recent history and the way in which they interact as both cause and effect with social policies, social institutions, social practices and the lives and beliefs of ordinary people. The merit of the account put forward by Foucault, in our eyes, is that it is able to produce a better (more realistic and comprehensive) theorization of the flow of power within social relations than orthodox Marxists, one not so much constrained to demonstrate a ‘top-down’ imposition of control (i.e. by the bourgeoisie over the working class).

Foucault presents a reading of history in the sense discussed earlier, that is, he selects certain events as significant and ignores others. You will see as you read on in this section that he tends to give little attention to economic, social, political and industrial changes which would feature largely in other readings, or to the impact these had on families – especially the growing separation of home and work and the gradual exclusion of women from the workplace. Nor does he tease out the economic correlates of the growing ideology which accompanied these changes – the belief that a woman’s place was in the home, caring for her husband and children. What Foucault adds to the more directly materialist accounts, in our opinion, is an emphasis on the ways in which medical and philanthropic discourses, interacting with a liberal _laissez faire_ political policy, shaped the ‘idea’ of the modern family and more specifically created the role of wife and the role of mother as we currently understand them.
A key concept for Foucault is 'discourse' — the broad set of 'ideas' or 'meanings' or 'possible statements' about a topic which are dominant at particular times among particular sets of people: the ideology, if you like, but without the presumption of necessary power inequality which generally accompanies the use of that term, for those who shape the discourse are nonetheless seen as also being subject to it. A discourse is made up of 'factual' statements — statements about causation or about statistical frequency — and 'norms' in the sense of statements about what _should_ be the case. These two kinds of statement are difficult to distinguish in practice, however — not all the 'factual' statements of modern medicine have a demonstrable base in 'fact' — and all of them carry a 'value' in the sense of being advanced (or potentially advanceable) as reasons why people should do this or refrain from that.

What we feel we need to justify or excuse or do with deliberation, as opposed to what 'comes naturally' or 'stands to reason' or is 'done without thinking', is defined by the discourse. Thus social control is not just something that others do to us, we do it to ourselves through our concepts of 'normal behaviour' and by the ideas which we accept as natural. The interesting thing, however, is that many of them are of recent origin. It can be fascinating to trace the way they have grown up, as Foucault does, and to see how they became embedded in social institutions. In the process, as human life is ultimately an indivisible whole, we find ourselves looking at the origins not just of modern conceptions of health, but at the birth of the modern family and the modern stereotype of motherhood as a woman's duty.

'Ideology' is a much-used term in the social sciences, and one used in a multiplicity of senses. A minimum use of the term would signify the ideas and values which underlie current practices, for example the notions of training and trainability which underlie the institution of the school, and the value given to these notions. Almost always, in the Marxist accounts from which the term derives, these ideas and values are related back to the class whose interests they serve and by whom they are seen as having been created. Schooling, for instance, is seen as instilling a work ethic, a set of disciplined habits and a competitive, individualistic cast of mind such as are needed for the continuation of the capitalist endeavour. In more sophisticated versions of the concept, as in its use by the French philosopher Althusser, the 'ideas' are not necessarily seen as verbalized propositions 'in the head', but as the results of learning by experience. School teaches that 'hard work and competition pay off', for instance, because school life visibly revolves around competition, and hard work visibly helps children to 'win', although 'personal ability', another ideological concept, may often be seen to help more. 'Ideology' also generally conveys the sense that a 'truth' is concealed by the ideological propositions, and another interpretation of events more favourable to the current mode of socio-economic organization is fostered on people in its place. We call 'personal ability' an ideological concept in this sense, for instance, because it suggests that some people 'are just better at school work than others', beyond the power of 'hard work' to overcome the difference. This is (probably) a true proposition, but the concealed truth is that middle-class children tend to do better at school than working-class ones, suggesting an effect of social environment rather than an innate and irremediable superenity.

The concept of 'discourse', which we prefer to 'ideology', also conveys the minimum notion of ideas underlying practices and, like the more sophisticated use of ideology, it does not require that these ideas be verbalized propositions actually held by some person. Rather, the discourse is the logic underlying social institutions — for example the 'truths of medicine' which must be assumed before medical practices 'make sense' — and while these 'truths' may be explicitly held by some people at some times, one can detect the same logic underlying events even when no one is stating it in words.

One way in which discourse differs from ideology, however, is in the notion that there is a 'truth' which an ideology is used to conceal. On the contrary, a discourse defines its own truth, it defines what it is possible to say on a topic — what counts
as a logical argument, and what counts as an acceptable premise in such an argument. For example, in the widely accepted proposition that ‘women should have their babies in hospital because it is safer for the baby’, we find an element of medical discourse (hospital is a safer place for babies to be born) and an element of a family discourse which defines values (the safety of the baby is more important than the comfort or dignity of the mother). These propositions are not true or false in any absolute sense, they are true, false or meaningless depending on whether we accept the discourses on which they are based. (Indeed, one may even reject these discourses and still find one’s behaviour coerced by them, because the world in which we live is one in which they dominate. For example, women who want to have their babies at home will find it difficult or even impossible to arrange this.)

Another important difference between Foucault’s concept of discourse and the more conventional analysis in terms of ideology is in its use of the notion of power. Conventionally one speaks of power as that by which persons or classes impose their will on others to prevent or repress what the others would like to do. Foucault argues against this kind of reductionism. He argues that there is not ‘power’, but rather ‘powers’ — that there are many ways in which one person or class may influence the behaviour of another. He distinguishes between repressive power (coercion) and creative or enabling power, and between the legal power of the state and power which is based on the possession and control of knowledge. In The History of Sexuality (1979) he concentrates on ‘creative’ powers — the power of the norm (i.e. that which is defined as ‘normal’) and power based on knowledge of the new scientific discourses (medicine, philanthropy and economics, the emerging social sciences). He is, in fact, well aware of the existence of repressive legal powers and of their concentration in a central state apparatus, but he tends to take these for granted, what interests him is the idea of the power of knowledge and the power of the norm, and the way that power/knowledge may in fact be widely dispersed through all levels of society rather than concentrated as a state or class monopoly.

A key idea in Foucault’s later work is the concept of resistance to the imposition of discourses. He would argue that, at all levels of society, resistance is always possible because there are always alternative discourses on which the subject may draw. It is possible to reject the implications of a discourse or, more important as a tactic, to ‘reframe’ a situation as a case of a different discourse. As an example, in Volume 1 of The History of Sexuality Foucault points to how medical, psychiatric, welfare/philanthropic and legal discourses come together to construct (among other things) the modern homosexual as a ‘type of person’ whose sexuality is ‘characteristic’ of him. In the search for scientific ‘truth’ (knowledge) about sexuality, the activities of medical men, moral reformers and ultimately legislators created a new category of sexuality. Men had buggered men before the Victorian era — the behaviour was not new — but the picture of the ‘homosexual personality’ as a disordered/sick/perverted individual with a distinct and deviant sexuality inhering in him is a creation of the new discourses. Homosexuals became identified, labelled, excluded from normal social interaction. Two kinds of ‘resistance’ are clearly possible. The more straightforward is simply to deny the reality of the new categories — to say that there is no such thing as ‘the homosexual’, that one’s sexual behaviour is not an indication of a ‘type of personality’. This is a tactic unlikely to succeed in a world increasingly dominated by a scientific discourse in which people are classified, measured and assigned a place according to abilities and deviations which are seen as inherent in them. The more successful tactic which is actually employed is to accept the label ‘homosexual’ but dispute its medical implications — to assert homosexuality as a valid form of sexual expression and to seek the power and right to form stable and socially recognized homosexual ‘families’. Thus the discourse of the family may be used as the basis of resistance to the discourse of medicine.
3.2 Biopolitics and the health discourse

Foucault has used the term ‘biopolitics’, for example in Volume 1 of The History of Sexuality, to refer to the development of ‘official’ and ‘popular’ concern about the health of individuals and the population. Simply, biopolitics refers to policies which started to appear in European societies in the late eighteenth century and which were concerned with the body — that is, the human species as a species and the bio-processes that support it. As examples we might take the then quite new concern with population growth, the birth rate, the death rate, the general state of health of the population, etc. — policies which directly impinged on individual physical bodies and the space of personal existence. It is of France that Foucault is writing. However, as we shall see, similar processes and stages of development can be traced in the history of England.

Foucault is concerned with the ‘conditions of possibility’ — that is, the way that things become thinkable and implementable. In the late eighteenth century a new political anatomy developed: the body became seen as an object, a target of power, and it could be seen as docile and therefore could be worked on, used, transformed and improved. It could, in a word, be ‘normalized’. Thus in Discipline and Punish: The Birth of the Prison (1977) Foucault describes the horrendous death of Damon the Regicide on 2 March 1757, who was torn to pieces by the agents of justice, and contrasts it with the use of ‘reformatories’ eighty years later. During this brief period the emphasis in penology had switched from deterrence by exemplary physical punishment to normalization and the surveillance of bodies, and the reform of the criminal. In other words, the possibility of the moral reform of persons, their rearrangement to suit a ‘social norm’, had been ‘discovered’ and embedded within a set of institutions and social practices in a brief eighty-year period. Biopolitics was concerned with the management of life rather than the threat of death. Summarizing Foucault’s contribution, Hewitt (1983) writes:

Foucault and his co-workers explore several aspects of the rise and establishment of capitalism. These aspects are seen as constituting a new domain of political life — the politics of the body, or biopolitics. They are, with reference to Foucault’s work, the investment of the body with properties making it pliable to new technologies of control, the emergence of normalization, the divestment of power from an absolute sovereign to a multitude of regulative agencies located throughout the social body, and the advent of the empirical human sciences making possible these new technologies of control.

Foucault argues that the body is not only involved in the political field — that is, in power relations — but also in the economic field, it is because the body is productive that it becomes imbued with or involved in relations of power and domination, but it is only useful as labour power if it is subjected. This subjection can be obtained in a number of ways by force, violence, ideology, knowledge. The last of these is seen as in many ways the most far-reaching and important. The discourse is knowledge, for ‘knowledge’ is the power to define what shall count as a ‘fact’ and to set norms.

This ‘knowledge’ of the body Foucault sometimes refers to as the ‘political technology of the body’. This technology is diffuse and is not localized in a particular type of institution or state apparatus. Thus Foucault’s emphasis is on the dispersal and diffusion of power through institutional techniques and the human sciences. The body at the same time became an object of knowledge for experts. Discourses,
'regimes of truth', developed which simultaneously constituted rules/procedures for doing things and legitimated control through the provision of reasons and principles. Thus power based on knowledge (e.g. of what the discourse defines as true) shapes and constrains, but its action occurs through enablement rather than prohibition. It works by defining an end as desirable and then showing a means to achieve it, in the process, the knowledge of the means gives power to the 'expert' who has it to dispense. However, the influence is not unilateral, because the ends have to be accepted before the knowledge of means grants power, and to each attempt to define ends Foucault would expect resistance on the basis of alternative discourses. The competition is not, in a sense, between the powerful and the powerless, but between alternative discourses which would grant power in different ways to different groups, by prescribing different ends as valued.

During the course of the seventeenth century there was a change from 'sovereignty' (personal rule based on prohibition) to 'government' (rule by administrative procedures aimed at encouraging 'desirable' behaviours). This change heralded a concern with the population, of which the family was one aspect. The family was displaced as a model of government and became adopted as a privileged instrument for the regulation or management of the population, a principal source of information and a target for population campaigns (We shall look at these changes in more detail below.) The concern was with the condition, the health, of the population. As the population became simultaneously subject and object – a subject with needs and aspirations and an object of government – there emerged a range of new tactics and techniques of power, concerned with the health and well-being of the people. There was simultaneously a large increase in the number of agents of pastoral power in both the public and private structures and institutions, for example, police, social workers, philanthropic organizations, etc., which mixed care and control.

In other words, social control switches, over the period of industrialization in England and Europe, from a rule of law and custom to a rule of knowledge and normality – from the prevention of undesired actions to the enablement and fostering of desired ones (but in a controlled way). The growing health discourse was a central factor in that change, and current forms of social control are nowhere more clearly expressed than in our current attitudes and practices with regard to the health of children and the behaviour of their mothers. The change was an all-embracing one, however, and included changes in the internal organization of families, their role vis-à-vis the state, and their place in popular understanding. This change and its current implications are discussed in the next section.

3.3 The health discourse and the modern family

As was argued in Unit 6, there is in one sense no such thing as 'the family', but rather a diversity of ways in which people live together in relation to each other and their children. 'The family' is a normative concept; it describes not so much what is as what is seen as the prevailing form of organization, what people aspire to and what they are supposed to aspire to. Moreover, the current norm of the nuclear family is a comparatively recent invention. In earlier times, the richer households were larger than our current ones, containing (as of right) relatives, servants, even permanent guests and 'clients' as well as the current 'core' of parents and children. The 'head of household' was a 'head' in a much more real and responsible sense than is now the norm: he was responsible to the state for his family's behaviour, but also responsible for its internal control, with far fewer restrictions and outside interventions than is now the case. The poorer households were in a sense smaller than at present – not less numerous in their membership, but provided with far less private space, so that a major part of most people's lives would have been spent on the streets and in the community rather than in the home.) The paradox is that modern intervention in family life was brought about by, and in the name of, laissez faire, non-interventionist state policies. It is the growth and ramification of the discourse of health and normality which underlies and explains this paradox.
In this section we shall trace the intermingling of three historical trends which have helped to define the relationship of people to each other and to the state

1. the growth of ‘scientific’ and ‘moral’ wrong and social pressure around the notion of the preservation and improvement of the nation (positive social engineering through the protection and preservation of children),

2. the increased realization of the dangers that paupersm (chronic poverty) presented to the state, both by taking men out of the workforce and by creating the conditions for insurrection,

3. at the same time the status of the state itself was much in dispute, as a necessary source of welfare support but also as something to be feared for its potential encroachment on the liberal ideal of individual freedom

We hope to show how these three trends or tendencies became woven together in their development to produce both radical changes in social institutions and a radically different way for individuals to understand the social world through these structures

We can start our argument with a notional turning point during the late eighteenth century, when medical and moral literature began for the first time to turn its attention systematically to questions of infant mortality and the nature of child rearing. In particular, there began to be criticism of mothers who left the care of their infants in the hands of others the use of wet-nurses and other nurses to take on the total care of children began to be a particular target of moral condemnation. The economic need to work experienced by poorer women in towns forced them to board children out with nurses whose competence and even honesty often appear to have been inadequate. The wealthy could afford the private and exclusive services of a nurse, but her ability and goodwill could not be guaranteed, and doctors began to blame nurses’ behaviour for what they perceived as the poor physical and moral development of children. The category of ‘the neglectful mother’, now widely accepted, was effectively invented during this period – there was little discussion of the use of surrogate child-rearers as a variety of neglect before this period – and from this category grew a two-pronged attack on family life which was to have very profound social and psychological consequences.

Both prongs of the attack had as their target the protection and preservation of children, and their ‘better’ (both healthier and more moral) upbringing. A link was forged between middle-class mothers and the doctor/moralist, increasing the mother’s influence and status within the home through this ‘knowledge’ at the expense of her husband’s previously unquestioned patriarchal control. (Note, however, that in this same period middle-class women were being forced out of productive employment.) The role of ‘housewife and mother’ was, again, virtually invented in this period, as a proper ‘life-project’ for women, as something to be sought in marriage partners by men, and eventually as the norm in marriage. (This points up how the liberties of one age can be the fetters of another: the private sphere and the role of ‘housewife and mother’, now to be seen as traps for women, originally gave them a greater authority and expertise within the family and thus could arguably be said to have acted as emancipatory.) At the same time, as families (in the person of mothers) were being encouraged to take greater responsibility for children, a redefinition of the ‘boundary of privacy’ was taking place, with the hitherto predominantly private matter of child rearing becoming an area of public concern and public policy.

Thus new image was then promoted among working-class people, as a way of regulating their behaviour, and its consequence was effectively to invent a new kind of family, foreign to working-class norms of the time. As working-class life began to centre more and more on wife and children rather than on the street and the extended kin-group, so the change worked to safeguard children on the one hand and to render the working man dependent and disciplined rather than autonomous and unruly on the other.
As Jacques Donzelot comments about similar developments in France,

the works of Jules Simon began to spread the work of this great discovery: woman, the	housewife and attentive mother, was man’s salvation, the privileged instrument for
civilising the working class. It sufficed merely to shape her to this use, to furnish her
with the necessary instruction, to instil in her the elements of a tactics of devotion, in
order for her to stamp out the spirit of independence in the working man. (Donzelot,
1980, p. 36)

By the end of the eighteenth century, the ‘discourse of motherhood’ was well enough
established in England that the feminist writer Mary Wollstonecraft (1792) took for
granted the requirement of women to be ‘good mothers’, and attacked the
negligence of many mothers of her time in terms reminiscent of the French medical
moralists: ‘many children are absolutely murdered by the ignorance of women’ (1982
edn, p. 209). The rhetoric of ‘woman as housewife’ seemed equally reasonable and
natural to John Stuart Mill seventy years later, when, even while denouncing the
subjugation of women, he considered that women who chose to marry would
‘naturally’ give up all other occupations inconsistent with the management of a
household. This position would have been acceptable to a majority of middle-class
nineteenth-century feminists (see Lewis, 1986), who pressed for equality in the
workplace and political and legal equality for all women but fully expected to have
to choose between marriage and motherhood on the one hand and a career on the
other.

Thus the ground was prepared for the growth in biopolitical concern over the state
of the ‘national stock’ — infant mortality and the health of children. Concern with
the physical health of the population was fuelled, as we have seen, by the dearth of
suitable recruits for the Boer War army. Concern with mental and moral adequacy
amounted to something of a ‘moral panic’ over the physical decline in the working
class and the apparent insidious growth of mental handicap in the population. The fear of racial ‘degeneration’ was firmly established as a ‘problem’ by the introduction of universal schooling in the late nineteenth century. The state had taken the responsibility of taking children – the potential workforce of the future – out of the factories and off the streets and giving them training which would instil ‘habits of industry’. This in turn led to a responsibility for dealing with the numbers who appeared unable to cope with such training, numbers unknown until the schools were established. (For more detail of this history, see Abbott and Sapsford, 1987b.)

The concern with the physical survival and the physical and mental well-being of children started with infant mortality and infant development as the major target around the turn of the century. ‘Quality of mothering’ was seen, from the start, as of crucial importance ‘Our voices thrill as we speak of “the mothers of great men”.’ [But] Who, in the name of all common sense, raises our huge and growing crop of idiots, imbeciles, cripples, defectives and degenerates?’, wrote Charlotte Gilman in 1903. ‘The need to educate mothers for motherhood was equally quickly established.

Given a healthy mother we are on the high road to securing a healthy infant, from healthy infancy we may expect healthy childhood, upon healthy childhood may be laid the foundations of a nation’s health. [But] Many women have had no instruction at all in infant care before their children were born. It is certain that infant mortality and suffering would be materially reduced if all women could have some training in the management of infants (Board of Education, 1915, p. 25).

Concern with maternal as well as infant death began to grow in the 1920s, with the realization that since 1900 the infant mortality rate had been halved while the maternal death rate stayed about constant. This acted as a spur for pre-natal medical monitoring by a growing body of ‘professional’ obstetricians.

**Note that we have used the term ‘surveillance’ for policing in the interests of others, as when philanthropists inspect the behaviour of households to whom grants have been given in order to ensure that the money is spent for the purpose for which it is given. Inspection in one’s own interests – health check-ups, for instance – we have called ‘monitoring’. Note also, however, that the latter blurs into the former. Ante-natal monitoring, for instance, alerts the mother to health problems, but it also makes possible state intervention to secure the health of the unborn child.**

We can also see a process of ‘pathologization’ in attitudes to childbirth and child rearing from about the last third of the nineteenth century that is, they become seen as ‘problems’ needing medical intervention. For example, the possibility of ‘mental illness’ (depression following childbirth) begins to be recognized as a successful legal defence where a mother kills her own child soon after birth. This recognition grows to the point where mothers are told in official publications of the 1970s to expect derangement after giving birth (see, for example, DHSS, 1977). After the Second World War (though the seeds may be detected in the psychiatric literature of the 1930s) the two lines come together in the work of Winnicott and Bowlby on the natural tendency of mothers and infants to ‘bond’, to form close attachments necessary to the mental health of both – work which reinforced the rhetoric of motherhood and directly attacked the tendency of married women to take full-time paid employment, which had necessarily increased in wartime. Bowlby’s work on disruption of bonding (e.g. in rigid and impersonal orphanages and children’s homes) and its consequences for the mental health and behaviour of children, was particularly well publicized and became a dominant orthodoxy of the
1940s and 1950s, the persistence of which is still evident today in 'learned' writing about mothering and family life. Conclusions were drawn from Bowlby's work which his evidence could in no way support — for instance the necessity, for sound mental development, of bonding with a single female, the biological mother — and these have persisted despite a great deal of contrary evidence.

A second, related strand of discourse which developed in the nineteenth century was that of 'philanthropy'. It was argued that pauperism had to be alleviated if the social fabric were to survive, those who have nothing are npe for revolution. However, outright financial support of the poor, either by the state or by indiscriminate charity, was seen as counter-productive because it made men dependent and took them out of the productive economy. A part of the answer to the twin problems of proper child care and pauperism arose in the form of philanthropy — assistance conceived not as a right which the impoverished man could demand from the state, not as a free gift of a charitable person to one in need, but more in the form of an investment made to improve the 'national stock'. The task was to limit aid to cases where it was absolutely necessary, and to give it in such a form that it enabled men not to need aid in the future. Aid was to be coupled with advice, and education for self-sufficiency was always to be preferred to financial aid (for moral reasons, as well as being substantially cheaper). Surveillance to assure the correct use of aid (and advice) was also entailed. The proper role of the state was not to interfere in the private lives of individuals, if this was necessary, it was better carried out by private charities. State intervention was encouraged only in the last resort, but commonly matters of health and child safety came to be seen as 'last resort' issues, under the health discourse's influence.

Under the influence of philanthropic aid, coupled with the alliances mentioned above which were being formed between medical moralists and wives, families became open to surveillance, a proper target for advice, while the exclusive authority of husbands was greatly weakened by the intrusion of expert knowledge. At the same time the modern idea or norm of the family as bounded and private was being given institutional expression. The medics and moralists, as we have seen, created the category of 'wife and mother' as the central nucleus of such a unit, the philanthropists created the space for it to operate, in the form of the modern family house. Affordable housing began to be designed and built for the poor which was structured, as is nearly all housing today, to afford a maximum of surveillance of children with a minimum of surveillance by children of their parents 'in their own intimate play' (Donzelot, 1980, p. 42) — housing centred around a mental bedroom which is not on the whole available to children, containing rooms for children which are easily surveyed, and containing enough space that there was no need to go out into the streets and the surrounding community. This new housing enforced a new set of domestic relations, with husband and wife more constantly and intimately involved in, and thus responsible for, each other's behaviour, and turned in upon each other in mutual surveillance. It comes as something of a shock to realize that this necessary precondition of modern nuclear family life was invented less than two hundred years ago.
Matters of medicine and hygiene formed a second aspect of this educative and moral side to philanthropic endeavour, and here compulsion was positively advocated for the protection of society as a whole. The preservation of children, and the ability of women to mother them, are to be seen as at the heart of this endeavour. An example would be Factory Act legislation to curb the employment of women and children while it was to the short-term advantage of families that all family members should bring in a wage, it was seen as to the long-term advantage of society that women and children should not be ‘wasted’ in this way.

The result of the change of discourse is to render the family both a supposedly self-sufficient entity which society is to protect at all costs, and a prime target for social intervention. The force of the discourse was to control ‘from inside’, without labelling the state or the bourgeoisie as the agents of this control. In the process, a new kind of family is created, a new norm – the modern, bounded nuclear family. The efforts to secure the lives of children and their ‘proper’ upbringing, to overcome problems of pauperism, and at the same time not to give the impression of total state control, come together to build a family which centres round a ‘wife and mother’ who is seen as exercising some kind of professional skill. This family is housed in conditions which foster a growing closeness between family members at the expense of ties with the outside world, and at the same time put each family member under the eyes of others in a way not previously possible. The control of poverty on the one hand and of unruly or neglected children on the other brings the state into the family as advisor, policeman and (only in the last resort) provider of assistance, but much of the advice is directed at the mother, bypassing the father’s previous traditional authority. The final result is a different way of looking at life, a different set of norms and expectations, which are what we now take for granted and generally fail to recognize as a comparatively recent historical invention.

Thus a ‘philanthropic’ discourse about the ‘supervision and remoralization’ of the poor and a ‘health’ discourse about the importance to the nation of its children come together to build a family centred on the ‘wife and mother’ Housing, similarly, was created to serve this family, and acted in its turn to promote it (see Sophie Watson’s article in the Course Reader). This mother became both ally and prey of a growing army of specialists – first obstetricians and then child psychologists and psychiatrists – and the family became a socially controlled institution and a primary site of intervention. Foucault’s emphasis on the emergence of discourses and practices which both produce and regulate objects of knowledge has enabled us to see the important role that philanthropists, legal institutions, medical and social workers have played in shaping the modern family.

On ‘reading’ history (2)
Again we invite you to note the way in which this history is used to illuminate the present, reaching backwards from current ways of thought and the social institutions which give them substance, looking for a time when things were different, then tracing events forward again to establish the breadth of implication of the changes that have been noted. We have reached back to the time before the state concerned itself as intimately with the well-being of children as it does today, and before the ‘natural’ role of women as mothers and help – meets was fully established. Tracing the impact of ‘biopolitical discourse’ in creating these two roles, we find evidence of a laissez faire discourse of self-help backed only in the last resort by state intervention, and we note strong similarities with the concept of ‘philanthropy’ which was growing up to replace the ‘charitable’ support of paupers. The two together lead forward into such diverse areas as modern psychological theories about childhood socialization and even
the nature of the modern family – diverse areas all illuminated by a common ‘sense’ when viewed from this perspective. We would be the first to agree that this is not a complete history of the period, but it is a useful one for our present purposes.

Note that its purpose is to cast light on the meaning which underlies current practices. In Foucault’s terms, it is genealogy, not archaeology – a history of the present, not a reconstruction of the past. In studying history we are not looking for causes of the present or why things have to be as they are, but only for antecedents which help to explain the precise shape of current practices. History always provides at best weak evidence of causality; that one event precedes another is no evidence of a causal link between them. By tracing a common logic from complex current institutions to their often simpler antecedent forms, however, we both supply evidence that the logic is sound and can sometimes modify it to make better and more comprehensive sense.

3.4 Health visiting: a Foucauldian history

Using this framework, we can now ‘re-read’ the history of health visiting given in Section 2.5. Health visitors can readily be seen as one set of agents of the pastoral power which Foucault described as growing out of the new health discourse, and their origins, the conditions for their existence, can be located in biopolitics and the medical and hygiene discourses that developed in nineteenth-century Britain.

In the early nineteenth century, the conditions brought about by industrialization became a cause for considerable concern. The Poor Law Amendment Act 1934 can be seen as one outcome of this, a measure to ‘persuade’ the poor to work rather than seek relief, one that blamed the causes of poverty on the poor themselves (This is a net effect of the new discourse as described by Foucault. Health and economic efficiency are both represented as ultimately properties of individuals, so the management of health and poverty tends to focus on the management of individuals. This tendency is exacerbated when poverty and disease are both concentrated in the one class.) Thus we find the beginnings of a new way of defining what came to be called ‘the social question’, a new technique for characterizing and regulating the population. The conditions in which the poor lived were seen as a potential source of contagious diseases and also of social and moral corruption. Reformers, to counteract this, suggested a programme for social hygiene, hygienic reform, improving welfare, and obtaining detailed information about the lives of the poor. This was aimed not only at disease, but also at the chain of conditions which were seen as linking susceptibility to contagion with criminality, moral and physical depravity and political sedition. The family is seen as a prime target for intervention; the working-class child is seen as endangered by disease and corruption and therefore a potential danger to society. Jacques Donzelot (1980) referred to this surveillance strategy as ‘the policing of the family’. That is, the use of political power to investigate the details of the population’s everyday life and to secure its well-being and happiness – its fitness for work, its morality and discipline, the quality of its health, and so on.

The early Victorians thought that poverty was inextricably linked with health, and this led to a concern with the health of the poor. The Inquiry into the Sanitary Conditions of the Poor headed by Edwin Chadwick, which reported in 1842, documented a close correlation between insanitary housing, overcrowding, lack of sewers, etc. and the death rate. One of the responses to this report was the formation of the Health of Towns Association (1844) which developed a propaganda campaign for the implementation of sanitary legislation. The (all male) membership of this association comprised leading men including doctors and lawyers. Local sanitary associations were also founded in a number of cities.
The chief object of the sanitary associations was to diffuse among the inhabitants of the district the valuable information elicited by recent inquiries and the advancement of science as to the physical and moral evils that result from the present defective sanitary conditions of these towns, and to impress upon the working class, in particular, by every available means, a conviction of the injurious influence exerted upon their health and moral conditions by inattention to ventilation and to the cleanliness of their persons and houses. (quoted by Dowling, 1963)

These associations also utilized male visitors drawn from the professional classes to visit the poor districts and to advise the poor on matters of sanitation and general cleanliness in their own homes. (In Newcastle the association also used working-class men.) It was this aspect of the work that was later taken up and developed by the Ladies’ Sanitary Reform Association.

This latter Association can be seen as the outcome of the growing feminism in Victorian Britain (see Banks, 1981) and of class-conscious philanthropy associated with the evangelical revival. Philanthropic good works were an outlet for upper middle-class Victorian women who were denied a role in production, no longer satisfied with their roles as wives and mothers, but continued to share Victorian middle-class attitudes to women. It is important to clarify the distinction between charity and philanthropy. By charity we mean outright support of paupers by individuals or, more often, by state agencies. As we have pointed out above, philanthropy in the nineteenth century was a private intervention in the problem of pauperism. It was carried out in the form of personal conduct and morality. Philanthropy was provided in two ways: (a) assistance and aid, and (b) the diffusion of medical and hygienic norms. It aimed to correct and reform by the giving of advice. It was based on an ideology of self-reliance and self-help.

The Ladies’ National Association for the Reform of Sanitary Conditions was a philanthropic organization established to educate the poor (and the middle classes) with specific reference to hygiene and cleanliness. The Association was founded in London and Brighton in 1857 under the auspices of the National Association for the Promotion of Social Science, which had been founded earlier in the year and had permitted women to be members on the same terms as men. The Association argued that the mother was the key person in health education and that the instruction of mothers, especially working-class ones, in hygiene was essential. Its priorities were the provision of courses for female teachers, who could then educate their own pupils, and of tracts that could be distributed to the poor. The main aim of this work was the preservation of child life — to reduce the mortality rate among children under five — and the major target was the mother. Home visiting was not part of the original plan, but many of the lady members already visited the poor on behalf of the parish, the Bible Society, etc., and they started to take sanitary tracts with them as well as religious ones. Conflicts developed between the working class and the middle classes, the message was not always taken kindly. In London, Mrs Raynor, a founding member of the Ladies National Association, felt that lady visitors would not gain admission to the houses of the poor. She therefore began to use working-class women to visit the poor, as female sanitary missionaries. From this beginning they began to be employed in other parts of the country as local branches of the Ladies’ Sanitary Reform Association were established. Surveillance of the living conditions of the poor had begun. The aim was to educate and to help, and not to form judgements, but nonetheless the major concern was the health of the individual and of the population, i.e. biopolitics.

Another aspect of biopolitics that developed in the nineteenth century was the monitoring and counting of the population. The gathering of population statistics, starting with the 1801 census, this enabled the health of the population to be measured more effectively. Morbidity and mortality statistics could be collected and compared over the years. Weeks has argued that concern with the population question began in early nineteenth-century Britain with the work of Malthus, and
surfaced again in the 1870s with the debate over contraception and the declining middle-class birth rate. At the same time as the birth rate was declining, the infant mortality rate was actually increasing. While the general mortality rate had declined in the second half of the nineteenth century, the infant mortality rate had remained high and even increased during the 1890s. There were large regional and class differences; for instance, the infant mortality rate was highest among the working class and lowest among professional and managerial workers. (As we have seen, these differences have persisted to the present day.)
This general concern over population growth erupted into a moral panic at the time of the Boer War. As part of the reaction to the depression of the 1870s, an imperialist discourse had developed, replacing the reluctant interventionist one, and with it there grew a concern for the future of the race and its ability to survive in competition with other races. However, at the time of the Boer War, three out of five working-class army recruits were rejected as unfit. This was said to be due to chronic ill-health, which was blamed on aspects of degenerate and shiftless lifestyle such as early marriage and the ignorance of mothers. There was also the growing discourse of eugenics, concerned with racial fitness and the breeding out of the unfit.

This politics of population was concerned, then, with a perennial threat – national decline – and in the debate that ensued there developed an increasing belief that health, hygiene and the fitness of the population were keys to progress and power. Despite the fact that the 1904 Interdepartmental Committee made fifty-three recommendations, which mainly concerned the importance of physical conditions, diet, etc., what was taken up and developed was a new stress on the role of motherhood as the key to a healthy population. One aspect of this was the emphasis placed on full-time mothering, working mothers were seen as particularly neglectful.

The problem of infant mortality is not one of sanitation alone, or housing, or indeed of poverty as such, but is mainly a question of motherhood – death in infancy is probably more due to such ignorance and negligence than to almost any other cause, as becomes evident when we remember that epidemic diarrhoea, convulsive debility and atrophy are brought about in large measure owing to improper feeding or ill-timed weaning; bronchitis and pneumonia are due not infrequently to careless exposure and death from measles and whooping cough is largely caused by mismanagement of nursing – three measures are needed to be carried out. (a) instruction of mothers. (b) the appointment of lady health visitors and (c) the education of girls in domestic hygiene (Newman, 1906, pp. 257 and 262)

The health visitor was a key agent in this new discourse. The 1904 Interdepartmental Committee took evidence from the Manchester Association and heard reports from a number of expert witnesses. They recommended the increased employment of health visitors to visit the poor in their homes. Rowan (1985) has suggested that this form of intervention was preferred to more direct methods of tackling poverty because of the continuing influence of laissez faire. However, as Wright (1986) and Weeks (1986) have pointed out, in addition to this one should note that in the debates surrounding the high infant mortality rate, one particular cause, infantile diarrhoea, was selected as the target for major concern. The cause of infantile diarrhoea was not seen primarily as poverty, but rather poor hygiene among the poor and specifically poor maternal training. (The statistics suggested that bottle-fed babies were especially likely to die.) Thus mothers, rather than poverty or poor housing, were assigned the blame for the high rate of infant mortality, and educating mothers in their ‘duties’ was seen as the answer to the problem.

In this period, then, child rearing ceased to be seen as an individual moral duty and became a national duty. Mothers raised their children for the nation. In this context a service provided by unofficial voluntary bodies was no longer seen as adequate, the state became involved, both employing health visitors and laying down the necessary qualifications for performing their duties. However, underlying this intervention and control was a continuing belief that infant care should remain the province of individual mothers and that the poor could best be reformed by direct contact with their betters. Thus, the alliance with mothers against paternal control and the use of the mother as a tool and agent of social intervention developed in England. Health visiting was established as a state service to educate mothers in matters relating to the care of children, and specifically in matters of hygiene.

The emphasis on the mother as having a ‘duty of care’ has continued to the present day, so that we now see women as ‘natural’ carers, and those that ‘fail’ to fulfil this duty are seen as inadequate in an almost biological as well as social sense.
Mothering is not seen as an inborn skill, however, but as one in which many women continue to need instruction and advice, and health visitors continue to provide this education. Their role has also developed into the monitoring of child development, and in this role they are a source of advice and reassurance on which mothers have come to rely. This advisory role, however, is still backed by the historical values which led to the foundation of the health visiting service. Monitoring progress for mothers serves also as surveillance of child and family fitness, ultimately on behalf of the state.

What this enables us to see is that conscious intervention to instil appropriate maternal behaviour was not repressive but creative in its effects. It created mothering and motherhood in the modern sense—a new norm of behaviour for women in families. We are also made aware of how discourses have both their 'conditions of existence' (the conditions which make it possible for them to become established) and their effects in concrete historical, social, economic, and ideological situations. The intervention we have described became possible because of social, economic, and ideological changes. 'Mothering' became 'thinkable' in the real sense that the possibility arose of the thought being translated into actions. That is, a particular mode of production does not demand a particular form of family in any simple way, as crude Marxists tend to argue, but it provides the basic preconditions and the limits within which families are organized and reorganized.
Central to what we have been discussing is the idea of values as embedded in practice. We have argued that health visiting, originating historically in a particular kind of discourse, will display the traces of that history in its current practices and express the values of that discourse. This programme was made to illustrate the point by examining health visitors at work and listening to them talk about what they do. We also hear from two ‘academics’

Pamela Abbott, Senior Lecturer in Sociology and Social Policy at Plymouth Polytechnic and one of the authors of this unit, who planned and co-ordinated the programme. In it she draws on her own current research, interviewing health visitors in the South West and going out with them on their rounds.

Jean Orr, Lecturer in Health Visiting at the University of Manchester and herself a qualified health visitor.

One statement in the programme is factually inaccurate. Since the programme was made we have checked back over the relevant Acts of Parliament, and we find that the statement at health visitors have a statutory duty to visit the homes of all new-born babies, though widely believed by health visitors, does not in fact act have a basis in the statutes. The National Health Service Act 1946 puts a duty on local authorities to provide home visitors, largely concerned with matters of maternity and child care, but it does not require that all new-born babies be visited; this requirement dates from an earlier departmental circular instruction which does not have the force of law. (The Health Services and Public Health Act 1968 (clause 11) in fact empowers local authorities to have this visiting carried out elsewhere than in the home.)

Before the programme, read through your notes on Sections 2.2, 2.3, 2.5 and 3.4 and remind yourself of the main arguments (or, if you are watching the programme before reading the unit, at least skim through these sections quickly and try to take in the main points made).

During the programme, note the main points raised by the academic speakers and look for evidence of them in what the two health visitors say. Note anything else of interest which might widen the account. Useful headings for your notes, we suggest, might be the extent to which ‘health’ dominates the discussion, the importance of ‘mothering’, mothering as a teachable skill, class values, patriarchal values. Note also the extent and nature of the ‘monitoring’ or ‘surveillance’ which health visitors perform.

After the programme, draw your notes together into an account of the values and presumptions which appear to underlie health visiting practice as portrayed in this programme. Ask yourself (a) what is to be done about these values, and (b) what values are held by the academics who participated in the programme. You should also form an opinion on the extent to which health visitors ‘monitor’ child health and development on behalf of mothers or undertake ‘surveillance’ on behalf of the state. You can compare your answers with ours, at the end of the unit.
3.5 The concept of normality

We have seen that well-known institutions such as health visiting and well-known visible things such as the modern family house can be seen as making coherent sense in terms of the development of a discourse on family and motherhood, which stemmed originally from a concern for the health of the population. There is more to it than this, however. Through the way that the discourse builds the ‘taken-for-granted’ of day-to-day life, it can be seen as explaining not only how the social (and physical) world is, but how we and those who shape it are to an extent constrained to see it. The discourse has become internalized as norms, and we police ourselves and each other by our assent to these norms. Both state and welfare agencies can then effectively step back and leave the system to us in its day-to-day aspects, the battle for primacy of discourse is now won, and the norms are set.

Not least among this set of new and controlling norms is the concept of health. The force of the new familial/medical discourse whose development Foucault describes is that poverty, dissatisfaction, childhood misbehaviour and what the normalists consider the inadequate care of children, together eventually with marital instability and basic sexual preferences, become social ‘illnesses’ to be dealt with by medical or quasi-medical means. Meanwhile, mechanisms of surveillance grow up which make the ‘treatment’ a realistic possibility.

Thus over and above any obvious institutionalized mechanisms of control, there are ‘core constructs’ which define social and personal reality in almost a grammatical sense. The philosopher’s use of the term ‘definition’ they specify the ‘right’, ‘normal’, ‘natural’ terms in which discussion may be conducted, conversely, they partially exclude other modes of construing by rendering them problematic and in need of justification. There are very many ‘core constructs’ which function in this way to focus and circumscribe the discourse of the personal in the social. Health is one of them, with its associated conception of the body. The concept of ‘family’ as currently conceived is another, drawing attention to the procreation and rearing of children and at the same time making it ‘natural’ that children should be seen as of central and overriding importance. Couples who both work, for example, are required to express guilt at their consequence: ‘neglect’ of their children or to explain why they do not feel it (More accurately, working women are required to deal with this guilt, the family discourse is asymmetric with regard to gender.) ‘Gender’ itself is a core defining construct as currently used, implying different needs, different capabilities and different modes of thought in people who differ objectively and at birth only in genital formation. Similarly, ‘time’, ‘possession’ and ‘value/worth’ are core defining constructs as currently employed, importing the values and modes of conceptual organization appropriate to capitalist industrial organization (that is, factory work and the sale of factory-produced goods) into every sphere of our personal and interpersonal lives.

The point is particularly well made by the notion of ‘unemployment’ we may argue as to what counts as being unemployed, and the rules for such argument are laid down within the work discourse — whether, for instance, those who have no interest in working are to count as ‘genuinely unemployed’ or as ‘maliciously idle’. That the world can at root be divided into two or three classes — those who sell their labour, those who could sell it but have in some way been rendered unable to do so, and those who could sell it but choose not to — is very difficult to question within current discourse. The notion of self-sufficiency, for instance — having land and growing or raising sufficient for one’s needs, but nothing for the market — has on the whole been ‘dragooned’ into one of these three categories, but the difficulty we find in doing so is a sure indication that it actually belongs outside the economic/work discourse. Similar remarks could be made of the working-class people who work only long enough to accumulate funds on which to live without working, or the African factory workers whose hours worked halve when wages are doubled. In all these cases the behaviour tends to make little sense to us except under the category ‘idleness’, because this is the only category available for such behaviour.
within this very powerful discourse. Precisely the same can be said for mothers staying at home to care for their children: our labour-dominated discourse has no sensible category to which to assign them – we tend to hesitate between a sick role (women ‘afflicted’ with children and therefore unable to work) and voluntary unemployment. (That the ‘family’ discourse is even stronger, however, is illustrated by the difficulty we have in imagining a father staying at home to look after his children!)

Even the concept of ‘self’, as currently employed, defines a discourse and expresses a world theory, rather than being a basic ‘fact’ that is necessarily true of all times and places. To be a ‘self’ of a particular sort involves holding a theory about what a ‘self’ is and can be, and acting on that theory. As Rom Harré has argued:

> Though personal beings are real, they are the product of theoretical activity. They are not, for instance, the result of biological maturation. To realise that one is a person is to learn a way of thinking about and managing oneself. It is not to make some kind of empirical discovery. (Harré, 1983, pp. 21–2)

And again:

> For cultures like ours the key question must be what kind of people-making work is facilitated [in socialisation] by the kind of self-knowledge common to the culture. For us, it facilitates self-knowledge, and self-mastery, or at least the idea of these activities as projects. (p. 258)

We are who we are and can do what we can do at least in part because we believe ourselves to be particular sorts of being with particular sorts of powers, and this belief is rooted in the ‘discourse of humanity’ current in our society.

4 CONCLUSIONS

In this unit we started with a brief analysis of the origins of the health services in Britain, ‘read’ as an outcome of pressure for desired change. From considering the actual inequalities in a supposedly egalitarian provision we moved on to consider a Marxist reading of the health services as reflecting the structural inequalities necessarily entailed in the capitalist mode of organization. Going further, we began to question – with the ‘cultural critique of medicine’ – whether what was provided was indeed quite what it purported to be. Whether the content and the organizational form of modern medicine were either as natural and inevitable or as unambiguously ‘scientific’ as we are given to believe. Finally in Section 2 we looked more widely at the whole range of the use of ‘health’ in ordinary discourse, and we came to the conclusion that ‘the health services’ are a small and fairly arbitrarily chosen subset of our normal health concerns.
From this base we went on in Section 3 to ask how one subset of 'health' procedures becomes an expert arena while the remainder is the private province of individuals and families. Using conceptual tools developed by Michel Foucault, we went further to look at the particular importance accorded in our culture to concepts of health – particularly the health of children and their mothers’ responsibility for it – and also at the nature of 'the family' in which the health and well-being of children is safeguarded and fostered. We found that attention to recent history was repaid by greater understanding of how things are now that our current conceptions are of comparatively recent origin and clearly reflect a perceived need for control on the part of a growing state organization whose basic 'rules of operation' for bad direct intervention. We found also that the process of resolving this paradox was intimately involved in the building of a whole range of our current normative conceptions – of health, 'the family', and the role of the state with regard to either

Thus we have seen that the taken-for-granted world may be described as expressing through its institutions, practices and common beliefs a complex network of 'propositions' which hang together to make a coherent 'discourse'. Discourses such as 'the health discourse' or 'the family discourse' are recognizable and coherent nodes in this network. Discourses determine what is easy to believe, what is seen as natural, but also what is to count as knowledge and legitimate power, thus paving the way for social control. Discourses are embedded in institutions, which are what give them force and stability. We think of social intervention as a tool of social control, but an examination of the health discourse and what stems from it makes it all too evident that the 'prior state' into which a given social intervention is made is itself far from passive or neutral, but rather expresses a pattern of previous social controls perhaps at variance with what the intervener proposes, but nonetheless comprehensive for all that.

A final point, however, to analyse a 'problem' by exposing the discourse which underlies it is still not to solve it, because social control and social definition are not escapable ills but logically necessary aspects of social living. One cannot do away with social controls, because social controls are logically inseparable from social relationships. One cannot do away with socially defined norms, because we have to have a picture of 'what the world is like' in order to operate in it at all, and we have largely to share this picture with others if, again, social relationship is to be possible – two basic and very obvious propositions of George Kelly's (1955) personal construct psychology. We may validly question taken-for-granted values and institutions, uncover the ideological bases behind social interventions, and hope to reshape them more in the interests of those currently subjected to them. We should not think, however, that by questioning their values we often, if ever, solve the problems for which they came into being. As Sue Wise writes of her own attempts to integrate her feminism with her social work practice,

I came to believe that I had set myself the wrong problem and that feminist social work was a fantasy based on a fundamental misunderstanding. That is, I see 'social work' now as the policing of minimum standards of care for, and the protection of the rights of, the most vulnerable members of our society. My starting point is thus social work as about social control and especially the protection of children and other 'vulnerables' – and this is a morally proper function (Wise, 1988, pp 2 and 71).

With suitable modification, this would seem to us a tenable position for most forms of social intervention.
APPENDIX: THE AUTHORS' COMMENTS ON TELEVISION PROGRAMME 6

Values of health visitors
Necessarily, 'health' dominates the discussion, thus, after all, is what health visiting is about, and the health visitors are all qualified nurses. That it does dominate, however, reinforces the importance of the health discourse in the construction of the health visiting service, for there are many other problems which people experience – housing, education, finance – which might merit home advice, but it is health advice which is actually purveyed in home visits. We note that this is not exclusively true and that the health discourse does not dominate to the exclusion of all else. For instance, housing problems were also discussed in one interview, but even where other problems are salient they tend to be 'framed' as issues related to mothering and the health of mothers and children.

The importance of mothering and the central duty of mothers to care for children are so much taken for granted by all participants that they are seldom discussed in the programme. That women desire to mother is similarly taken for granted. That they are able to do so without training is by no means taken for granted, however, one central role of health visitors, as expressed in the programme, is as 'experts in mothering' able to advise the inexpert.

Another role of health visitors that is brought out clearly in the programme is as 'monitors' of child development, again offering expert advice to parents on even slight deviations from 'normality', and also as 'surveillers' of the child's well-being, concerned to look for any evidence of mistreatment. (We note that the health visitors saw this latter role as of growing importance, not as an unchanging imperative. It is quite possible, however, that health visitors twenty years ago would have said much the same.)

Jean Orr raises the notion that the values and expectations within which health visitors work reflect society's middle-class and patriarchal domination. The 'middle class' point was raised in relation to developmental tests, where she suggests that some of the tests used require skills easily developed in middle-class households but less easily in working-class ones, because of the different sorts of toys available and the time that mothers typically spend playing with the children. We would not agree that this is necessarily true of, for example, the use of building blocks, one of our own children, who as it happened had never played with them before, learned to pile them up in one trial. Differential availability of books, however, and differential experience of parents using them, could well have its effects on tests for older children. (See below, however, for another slant.)

The 'patriarchal' point referred not to anything the health visitors said, but to the general medical model within which they work. This view has been discussed elsewhere in the unit.

What is to be done
As we saw earlier, critique is not necessarily criticism, and to talk about practice as reflecting values is not necessarily to say that the values are wrong or bad. Some kind of values, after all, must underlie practice, it is logically impossible to undertake a goal-directed activity without valuing some outcomes more than others, and for some reason. The 'middle-class' elements which Jean Orr detected in developmental tests might be seen as reflecting what will be expected of successful children at school, and so their use might be seen as conveying valuable warnings to parents on behalf of the children. The stress on good mothering and the protection of children may be excessive, and perhaps delivered at the expense of women's interests, but on the other hand children do need protection. Critical analysis does not prescribe easy 'solutions' nor even necessarily uncover 'problems'.

Monitoring and surveillance
The unit has outlined a history of health visiting in which monitoring and surveillance – advice as a service to mothers and inspection/instruction to protect the nation's children – are intertwined right from the start. We detect both elements still intermingled in current practice as portrayed in the programme. A part
of the health visitors' job, as they describe it, is to 'discuss' progress with mothers, to offer 'reassurance', to respond to a felt need. This is illustrated negatively when one of the health visitors says of mothers of older babies that 'they do not generally need to talk to us so frequently'. A regular part of the job, however, is checking for fine-scale developmental abnormalities, through set 'developmental checks' as well as more casual inspection, and this could be seen as both monitoring and surveillance. Health visitors advise mothers, but they are also the first stage of a selection process which could lead, for example, to special schooling for mentally handicapped children. Surveillance in purer form is evident, of course, in inspection for signs of child abuse. It is also more evidently present in the surveillance of quality of mothering expressed by varying the frequency of visits, 'depending on how mums are coping', and in the expressed power to supply the services of a 'family aide' who can show mothers how to talk to and play with children 'where the mothering skills are not there', all the nation's children are to receive at least 'good enough' mothering of a certain minimum competence.

The values of the academics

All participants in this programme were in fact agreed that health visiting is a service to be fostered. Within that broad approval each found points to criticize, and as academics tend to overemphasize the negative they may sometimes come across as hostile, but the critiques offered were felt and meant as constructive. The programme was intended to explore some of the arguments which have been presented in this unit and it should be viewed as an illustration of these perspectives. Television programmes are also 'accounts' or 'readings' and are in addition filtered through a series of approval mechanisms which may subtly or blatantly alter their character, so even more care and thought than normal is required in their use and interpretation.
FURTHER READING

If you want to follow up any of the ideas discussed in this unit (perhaps in a later year), the following booklist will get you started.

Origins of the British health service
DWORK, D (1987) War is Good for Babies and Other Young Children, London, Tavistock
NAVARRO, V (1980) Class Struggle, the State and Medicine, London, Robertson
WALTERS, V (1980) Class Inequality and Health Care, London, Croom Helm

General books on the sociology of health and illness
PATRICK, D and SCUMBLER, G (eds) (1986) Sociology as Applied to Medicine, London, Balliere Tindall

Marxist critiques
MITCHELL, J (1984) What is to be Done about Health and Illness, Harmondsworth, Penguin
NAVARRO, V (1986) Crisis, Health and Medicine, London, Tavistock

Cultural critiques
ENGLISH, D (1979) For Her Own Good, London, Pluto
ILlich, I (1976) Limits to Medicine, Harmondsworth, Penguin
WEBB, L (1986) Feminist Practice in Women's Health Care, Chichester, Wiley

Foucault and Discourse
SMART, B (1986) Michel Foucault, London, Tavistock
REFERENCES


BOARD OF EDUCATION (1915) *Annual Report for 1914 of the Chief Medical Officer of the Board of Education*, London, HMSO


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