WELFARE AND HEALTH: SYSTEMS IN TENSION

by

Catherine Ann Kennedy MN

A thesis for the degree of Doctor of Philosophy

submitted to

The Faculty of Arts

University of Glasgow

March 1998

ACKNOWLEDGEMENTS

I wish to thank my supervisor, professor Robin Downie for his unstinting support, kindness and encouragement during the writing of this thesis. The insights gained as a result of our discussions have greatly enhanced my ability to focus more clearly on the concepts analysed.

The following agencies have assisted me in researching particular topics and I am grateful to all of them. They are: the library staff at the National Institutes of Health, Bethesda, Maryland; the staff at the Reference Centre of the American Embassy in London; and Greater Glasgow Health Council.

I am particularly indebted to Brian Courtney at the Department of Health in London. On several occasions he has advised me in the pursuit of particular information and has selflessly shared insights from his own research in Oregon.

I am also grateful to Robert Whelan from the Institute of Economic Affairs for his discussions on the University Settlement.

Finally, I wish to thank my husband Peter for unfailing support throughout the entire period, and Mrs Marie McColl for editing the final draft.

ABSTRACT

This thesis argues the case for active citizenship in the context of two systems of welfare and health. The argument evolves via an analysis of three philosophical models of citizenship. Detailed analysis and discussion of the three models leads to the conclusion that one of the models is the most appropriate for the practice of modern citizenship. The preferred model is Neighbour-Centred and based on a communitarian philosophy. It embodies a pluralistic view of the state which attributes equal functional significance to the state, the market, and the many groups which fall within the remit of voluntarism. Within the three models, various tensions are identified which manifest themselves in the operation of two systems of welfare and health.

Analyses of the two contrasting systems of welfare and health (American and British) lead to the conclusion that neither system is satisfactory, based as they are on opposing political ideologies. The shortcomings within the systems lead to tensions which derive from the systems themselves and from the models previously described.

Critiques of the two systems by Illich and Marx further highlight the observed tensions. It is argued that the presence of these tensions is inevitable. To the extent that they are potential facilitators of change then they may have a positive effect. When they result in disequilibrium in the systems they may be destructive.

TABLE OF CONTENTS Page

CHAPTER ONE : INTRODUCTION.

1.1 A Synoptic Overview of the Four Parts of the Thesis.

'Defects', 'conflicts' and 'contradictions' are words which have been used in association with welfare states since their inception. The perceived shortcomings have received attention from both right and left ideological stances at various times. But whereas contradictions invalidate a theoretical system of logic or mathematics, an actual political system can in practice survive contradictions in its official ideology. What can be shown to be a contradiction in a theoretical system manifests itself in practical political life as a set of tensions or strains in the practice of citizenship or political debate about citizenship; and tensions or strains, provided they are not too acute, can be invigorating rather than destructive. Consequently, in this thesis I shall not pursue the negative path of seeking out 'defects' or 'contradictions' in systems of health and welfare but shall pursue the more positive path of discussing what I shall call 'tensions' in the systems, tensions deriving from different conceptions of citizenship. This view allows for a wider appreciation of the various ideologies and government strategies which influence health and welfare systems.

The contemporary concept of citizenship derives from various historical antecedents. More specifically it is possible to uncover three 'models' buried in ordinary discourse. A 'model' is an abstraction from a total structure. The aim of the thesis is to analyse the models, to dissect them, and from them to derive a fleshed out system which might serve as an acceptable theory of citizenship in terms of which health and welfare could be delivered. The three models, in so far as they are abstractions, can be in tension with each other as well as having specific internal tensions. My aim will be to show how these tensions are manifested when the models are at work in actual political systems, and to arrive at a decision as to how the resulting disequilibrium can be accommodated within the systems.

The concepts of health and welfare are vital components of the whole notion of citizenship. But they too are concepts with their own internal tensions and complexities in their relationship to citizenship. They therefore require analysis.

The models of citizenship and differing concepts of health and welfare will be shown to exert pressures as they operate in two contrasted actual systems of health and welfare. A predominantly individualist or laissez-faire system will produce a system with little state intervention, and the emphasis will be on individual responsibility and self-reliance (Telfer 1976). A more collectivist approach, on the other hand, will involve a strongly interventionist state, with an emphasis on collective provision of services and entitlement to such services. Each type will have positive and negative aspects, and from each will spring tensions. The two systems which I shall analyse i.e. the American and the British welfare systems, reflect the individualist and collectivist ideologies respectively, and within them one can see at work different models of citizenship.

1.2 Method and Terminology.

It is commonplace in technical papers to offer definitions of technical terms. It is less easy to produce definitions of terms in a philosophical work. The reasons for this are of some interest. The first reason is that philosophical terms often refer to concepts of a fundamental nature and the attempt to break them down into more basic elements is therefore bound to fail because there are no more basic elements.

The second reason why definitions are problematic is that definitions are strictly concerned with word usage, but philosophy is concerned with the concepts which underlie word usage. This is why recourse to a dictionary settles nothing since dictionaries simply record usage and provide synonyms which do not lead us to any more fundamental ideas. Nevertheless, dictionaries can sometimes provide clues to understanding concepts.

In philosophy the concern is therefore not mainly with definitions but with the analysis of concepts, and the conclusions of such analysis appear at the end of the investigation rather than at the beginning. This is particularly true of moral philosophy, because in moral philosophy the attempt is to propose ideals. In other words, moral philosophy is concerned with shaping concepts rather than with simply recording usage, and the shape of the concept cannot be appreciated until the supporting arguments are in place.

An example of this is the much criticised WHO 1946 definition of health. 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity' (WHO 1946). This is not a dictionary definition of health because it is certainly not a report of how the word 'health' is used. It might be said to be an analysis of the components within the concept (as distinct from the word) of health. But it is actually more than simply an analysis. It is recommending an ideal or a way in which we should understand health in the future.

In view of the complexities involved in dealing with the concepts with which moral philosophy is concerned, philosophers have developed their own methods. In this thesis I shall use mainly two methods: the method of models and the method of map work. Where there exists something which is very complex, it can be an aid to understanding if we look at the complexities in terms of one or more simple models. For example, the complexities of planetary and solar systems can be more easily understood in terms of a simple model of the kind found in the Planetarium. In this thesis I shall employ simplified models of citizenship as a fundamental method of understanding a complex concept.

In devising a model we are selecting certain elements as being important and putting them into a given perspective. This is where the method of map work becomes relevant. Maps record the relationship between places and natural phenomena, but they do so from a given perspective. They are not neutral (Ryle 1949). Thus, a concept like 'community' can be fully understood only if it is mapped beside related concepts like 'society', but the mapping will involve placing the concepts in a chosen order. Whether we are using models or map work we are involved in recommending norms or ideals.

With these very general ideas in mind, I shall list the basic concepts with which this thesis is concerned. These are: community, citizen, health, welfare and tension. In all cases what I now say is preliminary and the entire thesis is required for the fuller amplification of the concepts. Turning now to the concepts listed above, I shall attempt to provide an analysis and stipulate a way in which these words can best be regarded.

If we take first the concept of 'community', clearly the dictionary definition of the word will not do. This defines community as 'a group of people living in the same locality or having same religion, race, profession, interests etc.' (Oxford Dictionary 1978). Even in ordinary discourse this is inadequate since most people attribute some emotional feeling to the term community, or assume that some form of 'good' is implicit within it. Politicians and professionals draw on the benign connotations which are usually associated with 'community'. Thus we speak of 'care in the community'.

The wide variety of meanings which have been attributed to the term 'community' illustrate the difficulty in deciding on a satisfactory definition. Alternatively, one could say that there are so many *senses* in which 'community' is used that the context of use is vital. Any definition of community must therefore be stipulative or be mapped from a given perspective. The concepts which underlie the term community are those elements which together combine to convey both the sense of community as a feeling, and the idea of an association. The adjective 'common' is important here; it denotes 'sharing'. These underlying concepts are: a common location or territory, shared values, working together towards the good of the community and a sense of fraternity which I shall re-label neighbourly solidarity (Ch.3, p49). There are several variations of these elements available, but I suggest that these are the defining elements of the concept of community.

The concept of community must also be seen in relationship to other associations and institutions. Thus, on a map, it is physically placed in close proximity to 'the state' and 'society'. The relationship to the state is crucial to citizenship since the type of state i.e. democratic or totalitarian, will be instrumental in defining the way in which citizenship is practised.

The concept of 'citizen' presents problems of definition largely because it is constantly evolving and therefore it is specific aspects of citizenship which tend to be discussed rather than the concept as a whole. Unlike 'community' there appear to have been relatively few attempts to provide a fixed definition of 'citizen' or 'citizenship'. One of the very earliest definitions appears in the Greek Polis -'citizens are all who share in the civic life of ruling and being ruled in turn' (Aristotle). At certain periods it has taken on an emotional appeal.

An example of this is seen in the use of '*citoyen*' at the time of the French Revolution when it embodied elements such as liberty, equality and fraternity (Heater 1990).

The dictionary definition of citizenship confines its meaning to 'inhabitant of the state'. But there are many elements which contribute to the whole concept of citizenship. These include status, identity, nationality. Citizenship also implies various rights held by the citizen against the state. These can be identified as civil or legal rights, political rights and social rights. Yet another dimension is the idea of local versus global citizenship. All of these elements underlie the concept of citizenship, and hence any definition would necessarily have to encompass these. This would be cumbersome to say the least. Perhaps there is a case for saying that with regard to 'citizen' and 'citizenship,' no operational definition can be attached to concepts which are as complex as these. The complexity is due to the fact that in the concept of citizenship moral, political and metaphysical ideas are linked and any attempt at definition will tend to exclude an important element.

The definition of health which is most frequently cited is the definition which I have already referred to (p3). Given the complexity of the term 'health' it is not surprising that it does not lend itself to a short and simple meaning. Yet if we are discussing systems of health care clearly some attempt must be made to say what health entails. It is interesting to note that of the various definitions of health none have been more satisfactory than the WHO statement in 1946 (p80). Although it has been criticised for being too idealistic, it is nevertheless useful in the sense that a) it focuses on more than one aspect of health i.e. social, physical and mental health and b) it distinguishes between positive and negative health. Criticism of the idea of 'complete' well-being in all three areas is perhaps justified. It is difficult to imagine such a situation all of the time. Health must also be seen as relative and factors such as lifestyle, stress as well as a number of environmental elements and even age will contribute to a particular individual's overall state of health.

There continues to be more emphasis on the negative aspect i.e. disease than on positive aspects. Recently the main focus has been on the so-called lifestyle diseases. Rather than promoting positive health and so aiming to prevent these diseases, there is a pre-occupation with victim blaming after the event.

The term 'welfare', in the context of this thesis is concerned mainly with welfare systems and welfare states. This distinction is important because other perceptions of welfare, the economic view, for example, see welfare in terms of satisfaction of preferences only. The term 'welfare' itself as defined in dictionaries simply means 'faring well' or 'doing well'. This tells us very little about 'welfare' and nothing about the underlying components. We must therefore turn to the many social and political contexts in which the term 'welfare' is used in order to piece together its components. What then are the components of welfare? These could be identified as physical, emotional and material welfare. Physical welfare refers to general physical health, emotional welfare to mental or spiritual health and material welfare to economic factors such as standard of living. While none of these provide an actual definition of welfare they are aspects which underlie the concept of welfare and can be measured objectively (Rescher 1972).

The term 'welfare state' emerged in the early post-war period In many ways it has been an unfortunate label since there has never been any general agreement as to its boundaries or limits. Titmuss noted that the term was used with vagueness (Titmuss 1963). It was frequently used to draw a distinction between past and present, to show that the inadequacies of nineteenth century laissez-faire capitalism would be remedied by various social services provided by the state. Beveridge's original intention was to combat the five giants: want, ignorance, disease, squalor and idleness and the services provided aimed to fulfill this promise. In Britain the services provided by the state since the war have largely been related to the areas of housing, social security, health and education. In the United States on the other hand, the term welfare state is confined to welfare benefits and in that sense there is a certain stigma associated with its use.

The term 'tension' is used in this thesis to denote strain or disequilibrium in specific systems of health and welfare. One of the definitions of tension found in dictionaries describes it as 'forces pulling against each other'. To the extent that this thesis is concerned with imbalances between systems the dictionary definition is applicable. However this needs to be taken further. Using the method of map work the term 'tension' is located in relationship to concepts such as 'contradiction'.

In an attempt to clarify the specific use of 'tension' I shall refer to the law of Laplace found in physics. This can be exemplified in the pressure of blood in blood vessels. If we take a long tube of a particular radius, carrying blood at a particular pressure it is possible to calculate the tension in the wall of the vessel using the law of Laplace (Cameron & Skofronick 1978). According to this law the tension T is equal to the radius R multiplied by the pressure in the wall P i.e. T=RxP. If the tube is artificially divided in half, then in a state of equilibrium there is a balance between the tension at each edge of the tube that holds the top half of the tube to the bottom half (Cameron & Skofronick 1978). As long as the two tension forces are the same then a state of equilibrium exists maintaining stability and the status quo. However if there is an inequality in the two tension forces, in either direction, then a state of disequilibrium will exist which leads to a relative instability in the system under observation. In the first state it is clear that tension is maintaining stability in the system. In the other state, however, the non-equivalence of the two opposing tensions predisposes to instability.

This explanation can be extended to particular societies, although in the latter it is evident that the number of tensions will be much greater than two; thus human societies are intrinsically more complex than the physical system described above. The analogy can be further extended to different societies as well as tensions in particular societies. For example, in the United States there exists an imbalance in the system due to excessive pull in the direction of consumerism which causes a state of relative tension. By contrast, the British system displays excessive pull in the opposite direction, so to speak, as a result of its perceived 'nanny state' mentality.

The thesis is divided into four parts. Because of the division into distinct philosophical areas it has not been appropriate to follow the traditional path of providing a general review of the literature at the commencement. Because of the diversity of the concepts covered, each part incorporates its own discussion of relevant literature.

In order to make clear the complexities of the following chapters I shall begin with a synoptic view of the whole argument. This is intended to bring out the logical relationships of the parts of the thesis and their conceptual components.

1.3 Three Models of Citizenship.

Part One is concerned with an analysis of three philosophical models of citizenship. These are The Consumer-Centred Model, The Neighbour-Centred Model and The Client-Centred Model. The individual qua citizen is central to each of these models. So, for example, the Consumerist Model considers the citizen as a consumer, a user of services. The Neighbour-Centred Model, on the other hand, is concerned with the relationship between the citizen and his community and the communitarian view of the importance of community for individual development. The idea of the citizen as client is the theme of the Client-Centred Model. Given that an individual can be involved in all three of these roles at any one time, it is clear that there will be tensions between them. Let us look more closely at the three models.

1.3.1 The Consumer-Centred Model.

Although the label 'consumer' has a relatively modern connotation, the elements which it embodies are not new. The strands identified within the Consumer-Centred Model, are in fact deeply rooted in history. The five strands are - individualism, natural rights, property, laissez-faire-capitalism and consumerism.

The first strand, individualism, stresses the idea of the abstract individual, pursuing his own ends and isolated to the extent that he does not see himself as part of a community. This aspect is in direct opposition to the communitarian view of 'situatedness', that is the perceived importance for the individual of the particular community in which he finds himself.

The issue of rights in general is crucial to health and welfare debates. This is the second strand of the Consumer Centred Model. It is the early theory of natural rights which was part of seventeenth century individualism that is relevant here. A discussion of natural rights theory also provides the basis for a future analysis of welfare rights.

The third strand involves the concept of property. It relates to the period of the seventeenth century when the idea of property was still regarded as a condition of citizenship. This has been identified as possessive individualism and is closely linked with the philosophy of John Locke (MacPherson 1964). Locke referred not only to the ownership of property in terms of acquisition of goods, but he also spoke of property in ones own person, by which he meant that an individual's labour and the result of that labour were the property of the individual. It was the investment of personal energy and personality into the production of goods which made the end product the personal property of the individual. Therefore he had an indisputable right to such property. The emphasis in Locke's philosophy on property is that the right to property is not something created by government, but is a right which each individual brings with him into society in the state of nature. Locke held a specific view of the state of nature, in that he assumed individuals to be virtuous without the need for laws and government rules. The main function of government was, in fact, to protect individuals property (Locke 1690).

The influence of Locke's philosophy was particularly important in America where the Constitution reflects the importance of personal property rights. An analysis of Locke on property is therefore particularly relevant.

The doctrine of laissez-faire capitalism, the fourth strand, owes its origin to natural law and natural rights theory. This became an integral part of nineteenth century Liberalism in Europe. It began with the physiocrats in France and Adam Smith in Scotland and Thomas Paine and Thomas Jefferson in America (Fine 1956). In America in particular, there evolved a concept of the self-reliant, free individual which became the hallmark of American individualism. In England it was later associated with similar Victorian values. Laissez-faire assumes the existence of a free market economy in which self-interested, competitive individuals are engaged in the buying and selling of goods. Inevitably such a system, in which the government has a mainly protective and limited role, has some defects in so far as there is potential for exploitation of vulnerable groups in society.

A popular justification for the creation of the Welfare State was that it could overcome the defects of laissez-faire systems. There is certainly evidence to suggest that from the early eighteen hundreds there was pressure upon the state to adopt a more interventionist role, and

the idea of the negative state was being replaced by a recognition of the need for public welfare (Pinker 1979). In the light of the recent introduction of market forces into state welfare in Britain, inadequacies similar to those in the early nineteenth century have re-emerged, but in a new light. These inadequacies must now be considered against a background of a collectivist-style delivery of services over several decades. Since this has also proved to be less than ideal in various respects, there is therefore the possibility that a combination of both mechanisms may be an acceptable alternative. (Ch.11).

The fifth strand of the Consumer-Centred Model is 'consumerism' itself. I have called the model 'A Consumerist- Centred Model' because this strand is the most important in that it incorporates elements from the other four strands. The introduction of consumerism into health and welfare service delivery in Britain appeared initially to silence market-orientated critics of the Welfare State by emphasising consumer choice and consumer rights. The idea of patients and recipients of welfare benefits being able to accept or reject certain treatments or services was attractive. It was seen as a welcome improvement on the bureaucratic, paternalistic state-run system of service delivery. Competition and citizen empowerment are also key elements of consumerism. Again, these were initially seen as positive steps in achieving consumer rights. In reality however the proposed changes, as portrayed in the various charters, have proved to be superficial. Critics of the new consumerism maintain that what have been hailed as benefits are in fact weaknesses since citizens are now in competition with each other for limited resources.

Consumerism is relatively new in the British system of health and welfare. In America such services have always been part of private enterprise, although there is also an element of state capitalism whereby the government assumes responsibility for some public services. The individualism inherent in American culture precludes any possibility of entirely state-run provision of welfare services. The deficiencies within a predominantly market system are blatantly obvious in American society. This individualism appears to originate from the time of the earliest settlers, and was reinforced by political leaders. Consumerism seems to fit neatly into a system in which competition and success are embedded in the culture. However this has led to a winner/loser mentality with little or no state assistance for the unsuccessful. Thus, the American system, in particular, suggests a lack of balance, where there is too much pull in the direction of consumerism. In other words there is tension

between the economic system of capitalism and citizenship. The British system in relationship to consumerism may be moving towards a similar situation, although the potential for achieving a balance is greater given the history of welfare provision. In fact, one of the criticisms of the Welfare State has been that there was too much pull in the opposite direction and that with its nanny-state mentality it actually helped create a dependency society.

1.3.2 The Neighbour-Centred Model of Citizenship.

The second model of citizenship, a Neighbour-Centred model, has three strands. These are: community and communitarianism, the concept of fraternity, and the general will. This model is concerned with the importance to the individual of the concept of community. Indeed, whereas the first model regards the self as an abstracted locus for rights, the second model regards the self as historically embodied in actual communities, and not meaningfully abstractable from these communities. The idea of a 'neighbour' relationship is, I believe, crucial to a modern view of citizenship which also incorporates a sense of community. The structure of the old 'gemeinschaft' community may have been replaced by 'gesellschaft' relationships, but there must remain the potential for people to live as neighbours (Tonnies 1887).

There are problems associated with the term 'community' (the first strand) since there seems to be no fixed or agreed meaning for it (p4). This model takes the communitarian view of the relationship between the state and the citizen. Even within the confines of such a view there is a wide diversity of interpretations of community and of the conditions most conducive to the practice of citizenship. The strands outlined, however, seem to combine to produce what I would regard as an acceptable meaning of true community.

The communitarian view rejects the liberal idea of the abstract self and focuses instead on the view that individuals flourish only as members of a community. The idea suggests the tightly knit community reminiscent of the past. However, many of these communities were restrictive and exclusive. Given the diversity of races and cultures in modern cities this exclusivity could take the form of discrimination.

Another element of community which is often overlooked, is that in the past communities evolved over long time periods and attitudes. Culture and history were handed down from one generation to the next, so that it was in fact the family which established both the emotional and the practical activities of the community. Social mobility and changes within the family have affected this process. It is therefore unrealistic for politicians to call for a revival of the old style community, since clearly the basic foundations have been altered.

The second strand, the concept of fraternity, might be regarded as outdated, given the extent of changes in communities. The idea of brotherhood and fellowship typical of earlier societies is also rejected by feminists on the grounds of sexual discrimination. Nevertheless the type of 'bond' implied by a sense of fraternity seems to be an important ingredient of the communitarian ideal (Phillips 1984). Its importance is seen in European and American history. It is suggested that the term 'fraternity' could be replaced by 'neighbourly solidarity', as an appropriate ingredient for the practice of citizenship. This alternative would also eliminate the confusion between the spirit of fraternity between members of a community and the type of fraternity found in fraternal organisations. Fraternal organisations display what Durkheim called mechanical solidarity in which members were indoctrinated to feel solidarity towards 'the cause' rather than towards individual members of the group (Durkheim 1893).

The third strand of The Neighbour-Centred Model is the General Will. The importance of individuals working together as part of a collective is seen in the philosophy of Hegel. Here the mind of the 'Folk' or 'Volksgeist' is identified with the action of The State. According to Hegel, freedom can only be achieved within the community via The General Will (Hegel). This General Will, is not the selfish will of particular individuals, but what each person wills just because he is a member of a community. Some of the earlier types of community, such as the 'gemeinschaft', are, in a sense, an expression of the general will.

1.3.3 The Client-Centred Model of Citizenship.

This model is concerned with the idea of citizens as clients of professionals. Three strands are identified. These are: talent, expertise and control. In relationship to these strands, an analogy is drawn between modern professionals and the guardians in Plato's 'Republic'.

Talent was an important element in Plato's guardians. They were chosen because of specific qualities which they held, and these qualities set them apart from other members of society. For the modern professional, talent is measured mainly on the basis of academic achievement and a certain standard is expected before professional education and training begin. The training undertaken by health and welfare professionals is quite specific and focused. In the 'Republic' education and training of the guardians was more wide-ranging and Plato recommended a general training of the mind and body for the guardians (Plato).

Expertise, the second strand of this model comes about as a result of individual talent; if you have talent it can be turned into professional expertise. The whole idea of expertise has become controversial in health and welfare services. The idea of a society of experts has evolved as a result of the Welfare State. Not all of these experts are professionals. Counsellors, for example, may not necessarily have professional training. An analysis, therefore, of the distinction between experts and professionals is relevant.

Health and welfare professionals gain expertise not just as a result of education and training but also by practical experience over time. Age is a relatively unimportant factor. The guardians, on the other hand were only elevated to the highest level (the philosopher rulers), after they had become highly experienced and competent. Usually this was in middle age when they might have gathered sufficient wisdom to be worthy of such a role.

The third strand in the Client-Centred Model is that of control. This follows from talent and expertise in the sense that if professionals have talent and expertise they will be socially sanctioned to control others. This is particularly relevant with regard to client/professional relationships. Professionals can exert control over clients in the context of these relationships and this controlling element can be in tension with the caring role of the

professional. This control can take many forms, from the possession of information pertaining to a client, to deciding who should receive specific treatment.

1.4 Health and Welfare.

Part Two considers the concepts of health and welfare both independently and as related to each other. This is relevant to future discussion of particular systems of health and welfare (Ch.7, Ch.8). Health emerges as a complex and ever-expanding concept. It involves more than mere absence of disease. It also includes the idea of well-being the achievement of which is dependent upon a number of social, environmental influences and individually determined factors (Ch.5).

Health must also be seen in terms of general welfare and in Britain this tends to be the case. In America, on the other hand, a distinction is drawn between the two, especially in relationship to the provision of services (p122). A high degree of political will is therefore necessary at government level for general welfare to be seen as important.
The discussion of health will include the following areas: the evolution of modern scientific medicine, theories of disease causation, social and environmental influences on health, individual responsibility for health, and health in the community. The issue of responsibility for health has received much attention as has individual responsibility for certain diseases. The responsibility of governments to the public has received less attention recently.

Community health has undergone many changes in the past five years which have had significant implications for the practice of citizenship in so far as the traditional view of 'caring community' has been altered. The changes were largely to do with management and the movement of people out of institutions to be cared for in the 'community'. A new system of need assessment was introduced and many welfare professionals were cast in new roles. The effects of the changes are discussed (Ch.8, pp152-4).

Welfare is analysed initially independently. In Britain the label 'Welfare State' continues to have connotations of a caring state in spite of the many attempts to dismantle it. In the

United States, on the other hand, the label was avoided initially and reference to welfare was mainly in terms of 'The New Deal'. Even now the concept of 'welfare' in the United States is associated with a form of stigma and the implication that an individual on 'welfare' must in some sense have failed. While the idea of a right to welfare is very much part of citizens' social rights in Britain, in America this is not the case. Duty and responsibility are seen to be more in keeping with the American vision of the self-reliant, hard-working, successful individual. Britain has no formal Bill of Rights but it does have a National Health Service, free at the point of delivery and available to all. The United States Constitution, on the other hand, incorporates Amendments aimed at protecting every personal interest except welfare.

1.5 Two Systems of Health and Welfare and Their Critics.

Part Three is primarily concerned with showing how the three models discussed in Part One are out of balance, that is, in tension. This is shown through the analysis and criticism of two particular systems as analysed by Illich and Marx. These systems can be seen in the United States and Britain respectively. They represent two quite different ideologies in terms of service delivery. The British system, in particular the National Health Service, has been seen by many as an ideal to aspire to. American health care on the other hand, is more often portrayed negatively as an example of an advanced capitalist country in which a substantial number of people have no health-care cover (p119). The disequilibrium caused by this inadequacy has caused tensions in the system just as the 'cradle to the grave' mentality has been responsible for tensions in the British system.

Analysis of health and welfare in **the United States** is initially concerned with the background both to health and to welfare. A distinction is evident between the two insofar as welfare remains a stigmatising possibility only for those who have no other option to pursue. The Clinton Health Bill, which subsequently failed, is examined in some detail. Opposition to the Bill came not just from politicians but also from large organizations such as The American Medical Association. The failure shows how deeply entrenched attitudes and values can persist in spite of a massive campaign to reform them.

The history of **the British Welfare System** (Ch 8) begins with a discussion of welfare proposals as documented in the Beveridge Report. The five giants identified by Beveridge have provided a platform for political debate since the welfare state emerged. Based on a collectivist ideology, and arriving in a time of post-war euphoria the welfare state began with the best of intentions. Beveridge was fully aware of the desirability of balancing individualist and collectivist tendencies. He aimed to give only what was needed in terms of social security benefits and was careful not to 'stifle incentive, opportunity and responsibility' (Beveridge 1948). It was only in later stages that it became clear that a reconciliation between the two ideologies would not work and charges of a 'nanny state' came about.

The National Health Service is one branch of British welfare which has undergone many reforms. These are usually associated with the Thatcher government when the idea of a market system was introduced, based loosely on the American system. A more efficient service was called for with a new management structure, privatisation of some ancillary services, an audit system for welfare professionals, and more emphasis on consumer choice. This was basically the theme of the Griffiths Report (Griffiths 1983). Further changes followed, all related to market forces.

The area of greatest change was in the community and this is analysed (in Ch. 8). These changes have particular relevance to citizenship in terms of active participation by service users (Ch.11).

The final chapters in Part Three (Chs.9,10) take the form of **Critiques** of both systems by **Illich** and **Marx.** These critiques provide useful tools for analysing both systems in terms of tensions. So far the tensions have been seen as disequilibrium between two ideologies. The writings of Illich and Marx illuminate more specific tensions. Illich for example has strongly criticised professionals in health care and medicine generally for the dangers they represent to health. Although Illich's arguments have been regarded as extreme, their usefulness lies in the questions which they raise. The idea of individual responsibility for health is one of these questions. In that sense Illich shows the tension between expertise and self-care. These two undoubtedly lie uneasily alongside each other just because they are frequently presented as 'either or' alternatives, in other words out of balance.

Illich did not confine his criticisms to health care. In fact if widely interpreted they can be seen as criticisms of the results of progress. Industrialisation is seen as the beginning of the problem, and all professionals are in some way 'disabling' (Illich *et al,* 1992). An overall tension, then, for Illich must be between progress and tradition.

Marx is more usually cited as pointing to actual flaws in welfare and economic systems. Capitalism is seen as flawed and full of contradictions (Marx 1845-1846). Under such a system values such as fraternity and equality are impossible goals since it is the interests of the system which are being served. Institutions like the welfare state are seen as a pretence at caring for peoples needs. Many of the flaws referred to in Marx's work are actually manifested as tensions. His portrayal of the inadequacy of class structures in society points to the divide between certain groups. In America where class is rarely referred to the difference and the imbalance between rich and poor is quite clear. Similarly Marx's graphic vision of the concept of alienation of workers can be seen as tensions which effect health and wellbeing. Work-related stress is often cited as an example of this type of alienation. These ideas are discussed in chapter 10.

1.6 Citizenship and its Tensions.

Part Four returns to the subject of citizenship and its tensions. The history of citizenship shows that it is a concept which is complex and multi-faceted. Its various dimensions, whether it is the idea of status, identity, nationality or the issue of participation provide much scope for political debate. These are detailed issues which are taken up in the Appendix in order not to interfere with the main movement of the argument. The main movement of the argument has led to a review of three models. The outcome of this review has been that the most satisfactory of the models is the Neighbour-Centred one. In Part Four I shall show how the defects of the Neighbour-Centred Model can be remedied. There are two aspects to this portrayed in chapters 11. These aspects are: **firstly** the idea of participation as an expression of the idea of the 'active citizen', and **secondly** the role of specific institutions and organisations within the Neighbour-Centred Model of Citizenship.

The idea of participation involves a discussion of each of the following:

a. The Community Health Council.
b. The Patients Charter
c The Oregon Experiment.
d. British studies based on Oregon.
e. Self-Help, Mutual -Aid and Voluntarism.
f. The University Settlement.
g. The Health Promotion Movement.

a. The Community Health Council was initially set up to deal with dissatisfaction with services by patients in the British National Health Service. In line with recent reforms they have taken on a more active role in encouraging patient participation in care. Due to a confusion about their actual role their potential to act on behalf of patients has been underutilised.

b. In Britain the Patients Charter has been a step in the direction of the idea of participatory citizenship, focusing as it does on the notion of consumer choice and rights. Further analysis however shows it to be a superficial attempt to involve patients in their own care.

c. The Oregon Experiment was a project which involved members of the public, and was basically a cost effectiveness exercise in which a given number of treatments were graded in order of agreed priority. Certain conditions would receive low priority.

d. Various projects, based on the Oregon Experiment are in progress in Britain mainly in inner city areas of the country. Details of their effectiveness have yet to be revealed. There is strong emphasis on citizen participation in the projects.

The idea of voluntarism is a broad term which encompasses a wide range of services. The voluntary organisation itself has been recognised as an important area of welfare even before Beveridge. Recent structural changes in health and welfare services have renewed the perception of voluntarism as a positive step in the quest for active citizenship.

e. The notion of self-help and mutual aid pre-dates the Welfare State and has taken many forms such as Friendly Societies, Working Mens Clubs and Charitable organisations. Interestingly, many self-help groups evolved just because professionals were unable to supply the support and services needed. This is particularly true of the rarer disease categories. Sufferers and their families were forced to use their own initiative to seek out fellow sufferers in an attempt to pool scarce information and to provide mutual support. In many ways self-help has remained independent from all other helping organizations, while at the same time encouraging citizen participation.

f. Yet another strand of participation can be identified in the University Settlements, like self-help this movement is at least a century old. Not only was there a strong sense of community within the Settlements, but those who had the benefit of education were committed to sharing their knowledge with the less fortunate. These pioneers provided moral rather than economic support. The history of The Settlement demonstrates the potential for citizens and professionals to work together towards a common goal. It also demonstrates the possibility of a similar project being successful in the future.

g. There is potential for citizen participation in the Health Promotion Movement. There is also, however, a high level of professional involvement. Empowerment of individuals to take an interest in, and responsibility for their health is a key element of this venture. To the extent that its success depends on feedback and cooperation from members of the public, the idea of participation is desirable. As with Health Education, however, there is a sense in which the health-care professional in this sphere has been too dominant. By this I mean that some health care professionals have overstepped their specific remit by effectively 'disempowering' their clients through their exertion of undue pressure regarding their activity and behaviour, eg instructing rather than encouraging them as to what they should and should not eat. The participatory element of Health Promotion is therefore seen to be limited.

1.7 Pluralism.

The second aspect of Part Four (Ch. 11) is concerned with the role of various institutions within the context of a Neighbour-Centred Model. The main thrust of the argument is that no one agency should dominate. A pluralist view of the state is advocated but with a stronger role for the state than usually visible within the pluralist doctrine. This final section will, therefore include a discussion of the following: the concept of a. pluralism, b. intermediary bodies c. the state and the market. Prior to this the idea of tensions is briefly re-visited with a view to drawing a conclusion as to the importance or otherwise of their presence in the systems.

a. In the context of the Neighbour-Centred Model the proposed role of the state centres round the idea of pluralism. This is because the idea of the strongly interventionist state on the one hand and the minimal action state on the other are seen as inappropriate for the practice of citizenship. To this end an analysis of pluralism is carried out with the aim of finding an acceptable role for the state alongside various organisations and the market. The crucial factor is the degree of intervention by the state. If intervention means certain benefits as rights then it must be acknowledged that for every right there is a restriction, in other words more government interference into citizens lives. If on the other hand intervention is limited, so that the States' role is limited to protection of life and property, then the most vulnerable groups in society may suffer. It is here that institutions other than the State can play a major part.

b. The idea of the Intermediary Association is not new. In his work on suicide Durkheim saw the work association as an important vehicle for drawing the individual out of his moral isolation (Durkheim 1897). Hegel also advocated the corporation as a means of integrating individuals into the State (Hegel). Recently there has been a revival of interest in the concept of The Intermediary Association in relationship to the idea of 'active citizenship'. Whether these involve participation in small scale projects such as 'Neighbourhood Watch', Tenants Associations or larger Trade Unions, each involves active citizenship.

c. The idea of the market as being morally flawed is frequently articulated by critics of the system. Self-interest, competition and profit motives are the elements which are usually criticised. However there are many people who are not against markets *per se* , but who object to them in the context of health and welfare services. The idea of health as a commodity, and of patients as customers is seen as inappropriate. The idea of competition, so the argument goes, means in reality that patients will compete with each other for specific treatments. Within The National Health Service there is the additional problem of purchaser/provider status which is still in its infancy. Several difficulties have been encountered with this to date. These problems include priority setting, location of provider-where the actual treatment centre or service may be geographically inconvenient for service users and the problem of mismatch between cost-effectiveness and service quality.

Within the context of the British system of health and welfare the type of market in existence is a quasi-market (Le Grand and Bartlett 1993). This is distinguished from other types including the pure market which is typical of the American system.

The foregoing elements will, together form the basis of a model of citizenship which is seen as compatible with the idea of the 'active citizen' within the context of a predominantly neighbour-orientated view (Ch.11).

References

Aristotle. **Politics** Ed. E Barker, Clarendon Press, 1946; pp95-98.

Beveridge WI. **Voluntary Action; A Report of Social Advance.** London: George Allen & Unwin, 1948.

Cameron JR, Skofronick JG. **Medical Physics.** New York :John Wiley & Sons, 1978; pp164-6.

Durkheim E. (1893) **The Division of Labour in Society.** Translated by George Simpson, London:Collier Macmillan Ltd, Ch. 2.

Durkheim E. 1897 **Suicide,** Translated by JA Spaulding & G Simpson, Routledge Kegan Paul, 1952; pp373-4.

Fine S. **Laissez-faire and the general welfare state: A study of conflict in American Thought (1865-1901).** Oxford University Press, 1956.

Griffiths R. **The NHS Management Inquiry Report** DHSS, 1983.

Heater D. **Citizenship:** The Civic Ideal in World History, Politics and Education. London: Longman, 1990; pp319-10.

Hegel GWF. **Lectures on the Philosophy of History.** Translated by J Sibree, New York, 1956.

Illich I, Zola IK, McKnight J, Caplan J, Shaiken H. **Disabling Professions.** 4th Edition London: Marion Boyars, 1992.

Le Grand J, Bartlett W. **Quasi-Markets and Social Policy.** London: Macmillan, 1993.

Locke J, (1690) **Two Treatises of Government** by Peter Laslett 1963 Mentor, New American Library, p111-121.

MacPherson CB. **The Political Theory of Possessive Individualism,** Hobbes to Locke, Oxford: Oxford University Press, 1964.

Marx K, Engels F. (1845-6) **The German Ideology**: Part One. Ed. Arthur C. J, New York: International Publishers, 1991 edition.

Oxford Dictionary. In: Sykes JB. (ed). **The Oxford Dictionary of Current English,** London: Clarendon Press, 1978; pp161.

Pinker R. **The Idea of Welfare**. London:Heinmann, 1979; pp85-86.

Phillips A 'Fraternity'. In: Pimlott B, (ed). **Fabian Essays in Socialist Thought.** London: Heinmann,. 1984.

Plato. **The Republic of Plato.** Translated with Introduction by Francis MacDonald Conford, 20th Printing 1962. New York and London: Oxford University Press.

Rescher N. **Welfare: The Social Issues in Philosophical Perspective**, University of Pittsburg Press, 1972; Ch.One, pp3-8.

Ryle G. **The Concept of Mind**. London:Hutchinson's University Library, 1949; pp8.

Telfer E. 'Justice, Welfare and Health Care'. **Journal of Medical Ethics**, 1976; 2:107-111.

Titmuss R. 'The Welfare State: Images and Realities'. **Social Services Review,** 1963;37 (1): 1-10.

Tonnies F. (1857) **Community and Association** (Gemeinschaft and Gesellschaft), Translated by Charles P. Loomis, Routledge & Kegan.

WHO (World Health Organisation) **Constitution** New York. 1946.

PART ONE:

THREE MODELS OF CITIZENSHIP.

Page

PART ONE: THREE MODELS OF CITIZENSHIP.

Chapter 2 The Consumer-Centred Model of Citizenship.

2.1 Introduction.

This first model focuses on the idea of the individual as a consumer, a user of services, a customer. As stated in the general introduction (p8) there are five strands to this model, these are: the concept of individualism, natural rights theory, property, laissez-faire capitalism and consumerism itself. Together these strands create the background for a view of what we now call consumerism. It will be shown that this modern concept is in fact rooted in history. Each of the strands can be traced to antiquity although the evolution of consumerism has been gradual alongside the growth of capitalism. Some of the strands have undergone considerable transition - natural rights for example have expanded to produce a bewildering vocabulary of rights which is now crucial to the notion of consumerism. Other strands such as individualism have, in some countries at least, remained firmly grounded. Still other terms have become out-dated in terms of language but have left a legacy both economically and politically. I am referring to the concept of laissez-faire which has been replaced by modern capitalism.

Let us now consider the five strands in turn.

2.2 The Concept of Individualism.

There are many senses in which the term 'individualism' is used. Historically it is related to 'the individual' and 'individuality'. With the break-down of feudal systems came a vision of man existing independently and for the first time separated from his function in the system. Later a further distinction was made between individuals and collectives. This occurred around the seventeenth century and from this the political thought of the Enlightenment arose (Williams 1988). Within the context in which I am using the term 'individualism' there is necessarily some overlap between the political and the philosophical perceptions.

There are many dimensions to the notion of individualism. One can identify for example, religious, economic or political individualism. Religious individualism is usually associated with Calvinism in which the individuals relationship to God was intense and personal as opposed to other religions in which the relationship was between God and mankind generally. Economic individualism is concerned with economic freedom which found expression in the system of laissez-faire capitalism (Lukes 1973). Political individualism is mainly concerned with the function of government in relationship to the individual. These categories are simplified versions of much more complex systems and serve only to create a boundary for the particular elements to be discussed. Throughout all of them runs the notion of the abstract individual.

Historically individualism has been portrayed in a number of ways. Variations in perception of the concept are evident in different countries (Lukes 1973). An example which might clarify this point is the difference in connotation between for example, German and French perceptions of individualism. Historically the French version has been mainly pejorative and to some extent remains so. Individualism was negatively perceived as a kind of exploitation which was embodied in the capitalist laissez- faire system. This was the dominant viewpoint in the thinking of the disciples of Saint-Simon who saw the idea of 'progress' as enshrined in the concept of individualism as threatening harmony and the co-operative spirit of society (Raison 1972).

The German interpretation of individualism by contrast had a distinctly romantic connotation. This romantic image was embodied in the *folk* or *volk* in which the uniqueness of each individual was idealised. From this early individualism emerged a particular form of community in which individuals were engrossed in the unity of the state and in which the *volk* became, part of the state. In a sense the individual found expression for his individuality by merging with like-minded individuals into the spirit of the volk (Barker 1951).

Additional variations of individualism were seen in the English and American experiences. In England it tended to be linked to non-conformity in religion. The Victorian image of the self-reliant, hard-working individual who helped himself was part of this notion. The

possessive nature of individualism as described by MacPherson is associated with this period in history (MacPherson 1964).

American individualism is of interest because not only has it been consistent through history, but apart from a brief period after the war it has continued to be an indelible part of American culture. It is associated with the economic system of capitalism. It also relates to a specific type of individual - the entrepreneur, the competitive self-reliant person who views government power or interference with suspicion. It is concerned with individual rights. It also relies on a particular religious ethos which originates in the Puritan settlements. It is therefore a complex combination of factors which makes individualism so prevalent in American culture. A paradox is evident in relationship to American individualism which is rooted in history. Individualism grew and prospered alongside and in spite of a huge potential for 'community.' The early settlements contained all the necessary ingredients for true community. However it is doubtful whether this potential was realised (p216). In the Puritan setting in which individuals were required to display a certain degree of moral fibre and in which opportunities for trade and competition abounded, not surprisingly these were tempting inducements. In addition the leaders in government were themselves committed to promoting self reliance and minimal state interference. The individualism, therefore, which is observed today is entrenched in the very earliest experience of the new country. The desire to succeed, the competitive instinct, the quest for self-improvement have become the hall marks of American culture (Bellah et al, 1996).

Central to the concept of individualism is the notion of the abstract self. This is in direct opposition to the communitarian view of 'situatedness' which sees the individual in the context of his particular community and in which the community is seen as crucial for individual development (Plant 1992). The idea of the abstract individual embodies a vision of the market-orientated alienated individual. It takes into account the subjectivism and the atomism which is often attributed to the individualist/liberal ideology (Plant 1992). It is these same features which communitarians reject. The assumption behind this view is that individuals themselves are self-interested and that no government policy is superior to the individual.

What is referred to as the period of classic individualism began to emerge in the early part of the seventeenth century. This was a gradual process and was a result of modernisation in the widest sense. Social, economic and to some extent religious factors were responsible for this. Changes in economic aspects led to changes in individual behaviour. The growth of commerce and improved communication systems meant more social mobility. The emergence of a middle class was evident. The concept of the hardworking self-reliant individual began to emerge.

Individualism was also manifested in another area. This was the theory of natural law which also implied natural rights. Up to the seventeenth century there were two elements to social control. One was custom whereby rules were implicit in that they were handed down from one generation to the next. The other element was Common Law which was an intermediary between law and custom. There was a degree of security both economically and personally in this system. However with the rise of individualism and the emergence of the nation state came the beginning of statutory laws in various forms. Questions arose as to the nature and legitimacy of the relationship between the individual and the state (Benn and Peters 1959).

The idea of accepting rules and laws because they were customary had been challenged by philosophers as far back as the Stoics. Custom, it was argued, was not sufficient ground for obedience. Instead they promoted the idea of a common bond between men in that they all shared a common nature. Rules which respected the individual, and assumed that the individual would in turn respect life and property were the only kind of rules appropriate for human beings. This theme continued through many centuries from the Romans to Thomas Aquinas and onwards into the Renaissance period. Frequently the law of nature was in conflict with the Common law or customs of particular states (Benn and Peters 1959).

Arising from natural law and manifested in individualism of the seventeenth century was natural rights theory to which I now turn.

2.3 Natural Rights.

The concept of rights is, I believe, inextricably linked to the whole concept of citizenship. To be a citizen, that is to have the status and identity of a citizen, is to assume the existence of various rights. But a language and a vocabulary of rights have evolved which have on the one hand served to clarify and explain certain rights, and on the other hand have contributed to a confusion of the issue of rights. This is because the whole concept of natural rights is obscure and subject to scepticism by its opponents (MacDonald 1949). The question therefore of the origin of rights is important in locating the relevance of specific rights to various contexts. The language of rights is not static, but constantly evolving and necessarily so in the light of 'progress' in social, economic and technological spheres. Medical science in particular continues to produce research environments conducive to and in need of investigation of individual rights hitherto unknown. A half century ago the idea of transsexual rights was unheard of as was the question of surrogacy rights. These are but two examples of areas in which new rights require consideration.

In an attempt to disentangle what has become a complex issue it is relevant to consider firstly the transition from the early natural rights theory to the modern perception of them. Having done that, the next question concerns the distinction between certain kinds of rights. The reason for this is to set the scene for the future discussion of welfare rights (Ch. 6).

The earliest documentation in respect of rights can be traced to the early Roman era. At that time the meaning attached to a right was different from the modern interpretation. The Latin term 'ius' was similar to 'law' and was used by the Romans to denote some kind of divine judgement, something which was fair and good (Tuck 1979). With the growth of the Empire the notion of 'ius' developed a wider meaning. Roman kings and priests had a whole system of rights called *patria potestas* (Tuck 1979).

The theory of natural rights which developed in the seventeenth century was basically a rebellion against the old ordered societies of the medieval kingdom. A number of factors contributed to this breaking away from the designated status of individuals. Individualism was establishing itself in religious, economic and political ways. In addition the social contract form of government was emerging. The idea of natural rights was beginning to

replace the old idea of duty and obedience. The idea of people having rights by nature had nothing to do with political or legal institutions. Instead it was a matter of individual conscience and the will of God. These natural rights were regarded as being part of each individual and no government could deprive him of them (Benn and Peters 1959). Natural rights theory was a special kind of moral right which although criticised for its lack of legal status, was deeply entrenched in the individualism of the seventeenth century. It was embodied in the French and American revolutions as well as the English civil war.

The concept of natural rights was criticised on a number of grounds. It was regarded by some as being too abstract (Ritchie 1894). Others objected that natural rights placed too much emphasis on the individual and not enough on the individuals function in the community to which he belonged. This was the thinking of Bosanquet (Bosanquet 1930) and Laski (1948). Marx was also a powerful critic of natural rights (Marx 1843). This point is taken up in chapter 10 (p178-9).

The transition from natural rights theory to the current language of rights involves a change in the perception of rights. We now speak of human rights rather than natural rights. Rather than being grounded in an abstract concept of nature the idea of human rights is concerned with the treatment we expect as human beings. This is the basis for various international rights groups such as the United Nations Declaration of Human Rights. The question of which rights should be included in this category has been the subject of disagreement. Some argue that human rights mean only civil and political rights while social and economic rights belong to a different category. Furthermore political and civil rights are more likely to be seen as having 'international' status than social and economic rights which depend on the strength and commitment of individual states. Clearly there is a distinction to be drawn between the rights which can be claimed as a 'person' and those which can be claimed as a 'citizen' of a particular state.

The complexity of the notion of rights has led to many attempts by philosophers and political writers to provide a means of distinguishing between certain types of rights and the criteria for such rights. Raphael for example simply says that to have a right to do something is to be allowed to do it and that no rule or law stops one from doing it. Raphael

calls this a 'right of action'. He draws a distinction between this and a right of recipience which is a claim against someone for something (Raphael 1970).

Benn and Peters emphasise the idea of rules in relationship to rights, classifying them according to the interest that they protect: thus economic rights are rights to work; political rights are rights to vote and civil rights are rights which allow people to appeal to a court. They further distinguish between legal rights which are upheld by the state and moral rights which depend on majority opinion (Benn and Peters 1959).

Having identified various types of rights the justification for rights needs to be addressed, in other words which conditions are necessary for the fulfillment of particular rights. The answer to this must be related to the function of particular rights. One theory is that rights provide a moral platform for the proper treatment of individuals (Plant 1992). If rights emphasise the inviolability of individuals then they can act as trumps and uphold individual interests over the interests of the majority. However in order for rights to have the power to uphold individual interests they must themselves be grounded in some recognised set of principles. If not then it could be argued that claiming certain human rights is merely a way of satisfying preferences. Again various philosophers have put forward ideas as to what these principles should involve. Some argue that the doctrine of rights should be self-justifying and that they are morally viable in themselves (Almond 1991). Gewirth argues that rights are necessary for human beings to function as such (Gewirth 1982). The Christian view on the justification of rights is enshrined in the natural law theory and puts forward the idea that each individual has a personal worth which transcends cultural, educational and class differences. Rights should therefore be grounded in the idea of individual dignity and respect (Plant 1992). This argument seems to be relevant only to those who hold Christian beliefs and would therefore be regarded by non believers as arbitrary.

Even if there were a universally accepted foundation for some rights this would not necessarily mean that in practice these rights could be applied without problems. For it is the application and practice of certain rights in daily life which is problematic. Even if a particular right can be ascribed in a given situation there are circumstances where moral issues arise and cloud the picture. There are many examples of this in medicine. 'Right to

life' issues occur in cases of abortion, comatose patients and many others. This may be a reason for saying that rights cannot be absolute since individual cases must be treated individually as is frequently seen in medical legal cases.

This discussion has been concerned with rights as a general concept. Specific rights such as welfare rights are discussed in chapter 6 (p106). But there is another specific right particularly relevant to the notion of consumerism and that is property.

2.4 Property.

Historically the importance of property was a dominant feature of the individualist ideology. The idea of ownership was part of what MacPherson called possessive individualism (MacPherson 1964). Most accounts of this particular aspect of individualism confine discussions to the period of the seventeenth century and Locke is often seen to personify the thinking of that period. At that time property usually meant land and anything issuing from the land which would involve manual labour. Property at that time was invested with the idea of control over particular goods.

The issue of ownership is of interest not only as providing an insight into relationships between people but the interaction between the state and society. The main interest and importance of property lies in its own power to dictate who was eligible and who was not for the status of citizenship. In the Greek city this trend was slightly different in that in order to own property the individual must in the first place be a citizen (Appendix p257). Until the mid eighteen hundreds most European countries as well as America, possession of wealth usually in the form of land was the main restriction on the franchise. One theory is that only those who could show ability and reliability and therefore stability were fit to hold the status of 'citizen' (Heater 1990). The struggle to abolish this rule continued into the nineteenth century.

Let us look at the way in which property ownership was regarded by Locke. Locke was not the only philosopher who deified the right to property but his particular philosophy is relevant to this discussion because of its effect on British and American politics. The

United States Constitution was in fact framed with reference to Locke. The right of the individual to protect and to have protection of his property even allows physical force to be employed by an individual if this right is threatened. Locke began from the premise that men are born into a state of nature in which they are all free and equal and accountable to nobody but God. The state of nature was accompanied by laws of nature, again issued not by man but by God. Within this framework Locke assumed that most individuals were an altruistic, rational group , living in harmony without the need for supervision or rules other than from the divine source. A minority of criminals was assumed to exist - hence the need for every man to defend himself (Locke 1690).

From birth men have a natural right to everything that nature offers for subsistence. These rights are given to mankind en masse rather than to any specific individual. There must then be a way of deciding how particular individuals can claim ownership of such goods. Locke reconciles this conflict by suggesting that everyone has a right in his own person. If an individual mixes his labour with the goods concerned then he has a right to own it. This means that if a man works on the land then anything that issues from that land becomes his. The only condition is that he leaves enough for everyone else. Locke's theory on property is complicated by the fact that he was apparently not consistent in his use of the term 'property. At times it meant property such as land , at other times it meant 'Lives, Liberties and Estates' (Locke 1690). Shimokawa draws a distinction between 'internal' and 'external' meanings of property according to Locke. His analysis shows that by 'external' property Locke meant - those objects over which man had an exclusive right of disposal. The 'internal' sense of property meant the exclusive right of man to dispose of parts of himself i.e. his life, health limb or his labour and goods (Shimokawa 1985). Property for Locke then, had a wide range of meanings. The fact that there was inadequate protection of property led to the setting up of government by social contract.

Interestingly the concept of ownership in Locke's philosophy did not appear to take account of the acquisitive nature of property accumulation. Although there was the implication that men were self-interested insofar as property was of paramount importance for subsistence, on the whole it is the idea of property as a right which is the dominant feature. How then did this philosophy come to be associated and embodied in modern capitalist culture? One explanation might be that Locke's theory was primarily geared towards the early American

settlements where the economic conditions and the Puritan individualist ethos created a suitable environment for acceptance of the doctrine of property rights. However it has been argued by Weber that the notion of acquisition is not part of the spirit of capitalism which is based entirely on the profit motive. With regard to acquisition Weber says -

this impulse exists and has existed among waiters, physicians, coachmen, artists, prostitutes, dishonest officials, soldiers, noblemen, crusaders, gamblers and beggars (Weber 1930).

Weber's statement seems to attempt to distinguish between a psychological impulse towards greed, and the desire to accumulate profit independent of such an impulse. However I think it is difficult to see how a system based on profit is not highly personal and that an acquisitive instinct does not become part of this equation for some individuals. If we accept that historically ownership of property be it land or capital, has given a sense of power and control to one group of individuals over another, this must surely mean that an acquisitive nature was part of this control. For the capitalist to suggest, as Weber has, that profit is never accompanied by a sense of greed is to deny the existence of the self-seeking, competitive individual who is certainly part of the American culture.

A conclusion which can be drawn with regard to acquisition of property is that it invests individuals, that is the property owners, with a degree of power and so illuminates the divide between the 'haves' and the 'have nots'. Those with power can then control the life and work of those without it. A prime example of how large scale holders of power and property can affect the lives of individuals is the question of health insurance in the United States. People are often forced to remain in dissatisfying jobs merely because to change would mean losing their insurance plan (p130). Workers in other occupations, particularly production and factory workers may find themselves in repetitive boring routines in which there is emphasis on mass production and new consumer needs to be satisfied. Marx has written extensively on the alienation of the worker (Ch.10.5).

Property ownership is one of the main characteristics of capitalism, the development of which I now consider.

2.5 The Rise of Laissez-faire Capitalism

The concept of laissez-faire literally translated means simply, leave them alone. In its context of economic history this implied lack of government interference towards individuals in their business and market relationships. The coining of the popular phrase 'laissez faire laissez passez' is attributed to a predecessor of the physiocrats the Marquis d'Argeson (Fine 1956). The physiocrats were a group of French economists who believed that the land was the ultimate source of wealth. In Scotland the idea was further developed by Adam Smith and in America by Paine and Jefferson.

The beginning of capitalism as a distinctive doctrine of economic life goes back to the thirteenth century. The idea of free enterprise sprang from the opposition of the emerging class of merchants and bankers to the restrictions of feudal society. From the sixteenth to the eighteenth century governments operated via a system of mercantilism. This system was aimed at the building of a self-sufficient and powerful state. It involved a method of organising business in every field particularly the precious metal trade. The government in turn encouraged new industries and expanded the labour force. The mercantilist system eventually fell due to the greater complexity of business which it failed to handle effectively (Wasserman 1944).

The mercantilist system was rejected by those who believed in the philosophy of minimal government. The physiocrats in France among others, believed instead in the natural order of things and that individuals, in following their own selfish interests, were in fact, also contributing to the general good. Adam Smith also subscribed to this view, the individual he said 'intends only his own gain but he is led by an invisible hand to promote an end which is no part of his intention' (Smith 1776). Because of the profit motive enterprisers would endeavour to accumulate wealth which in turn would mean better goods for all. Smith also criticised mercantilism and advocated instead a system of individual economic freedom, encouraging competition in both industry and capital.

The importance of laissez-faire as an economic doctrine lies not just in the method of its delivery but also in its association with and effect on various stages of history. It is for

example linked with the individualist ideology already described. It is particularly relevant to the concept of welfare since a widely accepted reason for the creation of welfare states was to settle the defects of laissez-faire. Its relevance today is twofold:

1. it has formed the foundation of modern market systems implicit in the capitalist economy;

2. a modern variation of it survives and is crystalised in the American system of health and welfare as outlined in chapter 7.

There has probably been no obvious transition discernible from the period of laissez-faire to that of modern capitalism. It was at the time of the Industrial Revolution that capitalism came of age as it were. Laissez-faire appears to have been a term relevant to the early unsophisticated version of capitalism. Accumulation of capital by the merchant class and the introduction of machinery formed the basis of modern capitalism. Up to the time of the First World War there was an era of enterprise and inventiveness in all aspects of life. This slowed down during the war. Until that time the role of government had indeed been minimal in terms of intervention in business affairs (Wasserman 1944). The desirability of more state intervention was being acknowledged particularly in relationship to enterprise. There was a feeling that government should take a more active role in the welfare of citizens. The war itself was significant factor in reshaping society. The state was now seen in a more positive light. In Britain this was the beginning of the collectivist era (Pinker 1979).

The defects of laissez-faire are similar to the flaws in modern capitalism and are reflected in predominantly market systems. These are addressed in a discussion of the market (Ch. 11.8.1).

2.6 Consumerism.

The final strand in this Consumer-Centred Model is the concept of consumerism itself. In many ways this is the most important element in that it encompasses threads of the other

four strands. By this I mean that consumerism entails an individualist viewpoint. It concerns rights and in fact it could be argued that property rights have given way to consumer rights. The notion of consumerism is also as we have seen, rooted in the capitalist market-orientated economic system.

For the purpose of this discussion two aspects of consumerism are identified. One is the idea of consumerism as a political movement which will be addressed briefly and the other is concerned with the consumerism as it relates to health and welfare systems and will be discussed in more detail. Each of these aspects of consumerism takes into account a particular view of citizenship and indeed the various citizens charters in public services generally, address, albeit superficially, the rights of citizens. The philosophical element which considers the morality of viewing patients as consumers and health and welfare as commodities is necessarily laced with political and economic views as well.

Let us begin by considering the idea of consumerism as a term in the general sense. The original French meaning of 'consume' was to 'devour, waste or spend'. The term 'consumer' has more or less displaced 'customer' which traditionally portrayed a buying/selling relationship (Williams 1988). The concept of 'consumer' is more abstract and very much part of a market-orientated relationship. The idea of the 'consumer society' suggests a pre-occupation with all aspects of consumption and production of goods and with need satisfaction (Sulkunen 1997).

In the United States the whole individualist culture is infiltrated at every level with some aspect of consumerism, so much so that it has led to the expression 'the throwaway society' due to the dominant nature of bureaucratic consumer capitalism. The dominance of consumerism is also reflected in the growing area of professional workers. The therapist and the manager are typical examples (Bellah et al 1996). Health and welfare services are also run on a predominantly market/consumerist basis (Ch7).

In Britain the introduction of a consumerist ideology occurred during the Thatcher era. In practice this meant the introduction of market forces into various public services including health and welfare. But it involved much more than structural changes. The concept of consumerism could be seen as a modern re-labelling of citizenship. The most significant

factor in terms of outcome of this re-labelling has been the change in relationship between the citizen and the state, between citizens themselves and between the citizen qua consumer and the professional. The citizen as consumer is no longer the passive recipient of services. He is now invested with a 'voice' and rights which allow him a degree of choice as well as services of a guaranteed quality which he has a right to accept or refuse as he chooses (Prior et al 1995). Furthermore, as a consumer he is compartmentalised in that he is identified as a patient, a recipient of welfare benefits or a public transport user according to the context of service use. He is in competition with fellow citizens for use of services.

The introduction of the idea of consumerism to British public services (I refer to health and welfare services in particular), came about as a result of various investigations into how services were run. This was a result of long-standing dissatisfaction with poor management, inefficiency and little consumer input. At the time these changes were seen by many as an improvement on the bureaucratic, paternalistic nature of state-run services. The changes which followed were based on the American model of service delivery and focused attention on market-based strategies such as choice, empowerment and competition. In many ways it was the idea of choice which was the main selling point of consumerism, for inherent in the notion of choice is the idea of control by the consumer over service use. The idea of consumer rights as laid down in the various charters was another attraction.

Critics of the new consumerism maintain that the very factors which some see as benefits are in fact weaknesses since patients and other service users are thrown into competition with each other for scarce resources. Altruism is diminished and self-interest dominates (Prior et al 1995).

There are some moral issues which arise as a result of the consumerist ideology. These are mainly related to what are often claimed to be the more negative elements of markets in general, and are taken up in chapter 11. I am not suggesting that all elements of the market ideology are flawed and indeed there is a case for saying that even those elements which are often negatively regarded may have some positive aspects. What is clear however is that a purely consumerist model of citizenship is undesirable.

2.7 Conclusions.

1. The individualism of the seventeenth century could be said to be a result of the breakdown of the restrictive nature of state/society relationships of the Middle Ages. It was manifested in various forms of life from political to religious areas.

2. The right to property was an important component of the individualism of this period of history and the Lockean version of it has been maintained, particularly in the United States where it is embodied in the Constitution.

3. The idea of property ownership as a criterion for citizenship was not dissolved until the mid- eighteen hundreds.

4. Early natural rights theory has given way to a new vocabulary of rights including human rights. Rights in general now constitute a significant place in our perception of citizenship. This trend is expanding as recent government attempts to underline consumer rights have demonstrated, albeit in a superficial fashion.

5. The concept of laissez-faire capitalism has been overtaken by a more modern equivalent which in America at least retains all of the original elements of self-reliance and self-sufficiency. There, the market system controls health and welfare systems almost exclusively. In Britain there has been an increasing trend in the same direction since the early nineteen eighties.

6. The concept of consumerism has become the most modern version of citizenship. Moral issues arise when the concepts of health and welfare are regarded as commodities to be bought on a par with other utilities. Property rights have now become consumer rights.

7. A predominantly Consumer-Centred Model of Citizenship would seem to reveal major tensions. An element of consumerism however might well be beneficial.

References

Almond B. 'Rights'. In: Singer PA, (ed) **Companion to Ethics**. Oxford:Blackwell, 1991; pp259-265.

Barker E. **Principles of Social and Political Theory.** Oxford: Clarendon Press, 1951; pp20-21.

Bellah N, Masden R. Sullivan M, Swindler A, Tipton SM. **Habits of the Heart: Individualism and Commitment in American Life**, Los Angeles: University of California Press, 1996.

Benn SI, Peters RS. **Social Principles and the Democratic State,** London: George Allen & Unwin pp23-28.

Bosanquet B. **The Philosophical Theory of the State;** London MacMillan, , 1930; pp96.

Fine S. **Laissez-faire and the General Welfare State:** A Study of Conflict in American Thought (1865-1901), Oxford University Press, 1956; pp3-25.

Gewirth AS. **Human Rights,** University of Chicago Press, 1982.

Heater D. **Citizenship: The Civic Ideal in World History, Politics and Education,** London: Longman,. 1990; pp 25.

Laski II. **Grammar of Politics,** 5th Edition, George Allen & Unwin, Yale University Press, 1948.

Locke J. (1690) **Two Treatises of Government** by Peter Laslett, Mentor, New American Library, 1963; pp111-121.

Lukes S. **Individualism:** Key Concepts in Social Sciences. Oxford:Blackwell,. 1973.

MacDonald M. 'Natural Rights'. **Proceedings of the Aristotelian Society**, 1949; pp33-55.

MacPherson CB. **The Political Theory of Possessive Individualism**: Hobbes to Locke, Oxford University Press, (1964).

Marx K. (1843) 'On The Jewish Question'. In: **Early Writings,** Translated by R. Livingstone & Benton G, Penguin Books, 1990, pp228-9.

Pinker R. **The Idea of Welfare**, London:Heinemann, 1979.

Plant R. **Modern Political Thought,** London:Blackwell, 1992.

Prior D, Stewart J, Walsh K. **Citizenship, Rights, Community and Participation.** London: Pitman Publishing, 1995.

Raphael DD. **Problems of Political Philosophy.** London:Pall:Mall Press, 1970; pp197.

Raison T. (Ed.) **Founding Fathers of Social Science,** London, 1972.

Ritchie D. **Natural Rights:** A Criticism of Some Political and Ethical Conceptions, London, 1894; pp ix.

Shimokawa K. **Property and Justice:** A Critical Historical Study of Lockes' Liberalism, PhD Thesis, Glasgow University. 1985.

Smith A. (1776) **The Wealth of Nations**: Books I-III. With an Introduction by Andrew Skinner, Penguin Books.

Sulkunen P. In: Sulkunen P, Radner H, Schulze G (eds) and Consultant Ed. Campling J. **Constructing The New Consumer Society**. London:Macmillan, 1997; pp2-3..

Tuck R. **Natural Rights Theories; Their Origins and Development**: Cambridge University Press 1979; pp6-8.

Wasserman L. (1944) **Modern Political Philosphies and what they mean.** Philadelphia:The Blackiston Company, p35-46

Weber M. (1930) **The Protestant Work Ethic and the Spirit of Capitalism,** Translated by Talcott Parsons, London:Routledge, 1992; pp17-18.

Williams R. **Keywords: A Vocabulary of Culture and Society**, London:Fontana Press, 1988;162-163 & 29.

Chapter Three : The Neighbour Centred Model of Citizenship.

3.1 Introduction.

A neighbour-orientated model of citizenship involves a Communitarian approach to the relationship between the State and the individual as opposed to the individualist/liberal view of the previous chapter. The idea of the abstract, atomistic individual is rejected by Communitarians who maintain that the 'self' is at least partly constituted by the particular circumstances in which an individual finds himself (Sandel 1982). It has been suggested that the Communitarian view came about as a means of correcting the flaws of the market-oriented, alienating character of individualism (Plant 1992). There is a great deal of diversity among Communitarians as to the conditions necessary for a type of community which would be most likely to enhance the practice of citizenship. Not all Communitarians view community in the same way, Miller for example sees the nation as the community (Miller 1989). Sandel sees Liberalism as the politics of various rights and Communitarianism as a theory which defines the common good. (Sandel 1984).

As already stated (p11) three strands have been identified in this Neighbour-Centred Model. These are: community and communitarianism, the concept of fraternity and the general will. Together these strands encompass the main features of community in relationship to the individual. The concept of 'neighbour' is central to this relationship since modern perceptions of community cannot deny the existence of neighbours in the context of citizenship whether we are using 'neighbour' in the global or in the local sense. The neighbour relationship in modern society need not and will not necessarily be consistent with the notion of 'brother.' Neither should the notion of 'stranger' be any more appropriate.

Let us now consider the three strands in turn.

3.2 Community and Communitarianism.

The idea of 'communitarianism' is relatively new and is generally used to remedy what are seen as the flaws of individualism (Plant 1992) However the communitarian is concerned with more than just a positive vision of community and its superiority to individualism. The communitarian concern is aimed at the core of the relationship between the individual and his particular community. Contrary to the views of some writers who see individualism and communitarianism as being directly opposed to each other, this is an over simplification. The idea of the abstract, self-interested individual at one end of a scale and an ideal community at the other does not allow for the many variations in between. It is more likely that both sides are in a state of constant tension with each other. This point is borne out by Rosenblum who suggests that the idea of 'abstractness' is sometimes carried too far. Instead of using it in a general sense it seems to imply isolation as an accurate description of individuals (Rosenblum 1987). That this is not the case can be substantiated by the evidence of certain liberal ideas within communitarian doctrines.

Although communitarians are divided on some issues there seems to be agreement on others. The notion of the necessity of community for human flourishing is one such area. This view recognises individual circumstances, not just in a geographical sense, as being an important element in human development. It rejects what Charles Taylor calls the 'atomism' of individualism (Taylor 1985). The idea of the abstract self is generally rejected by communitarians. Sandel argues that individuals must be seen in the context of their aims and values and this cannot be achieved if the individuals values are seen as separate from himself (Sandel 1984).

It has been suggested that communitarianism implies a vision of the interventionist state while individualism implies a minimal state (Sandel 1984). However this may be too restrictive . Anarchism for example, preaches a doctrine extolling the virtues of community. The work of Kropotkin in particular comes to mind . He saw the concept of mutual aid and co-operation as being important, and in that sense community was essential. The basis for this Kropotkinite mutual aid and co-operation is said to be grounded in the idea of respect for persons.(Kropotkin 1927). Whereas the individualist sees respect for

persons as non-interference, the communitarian sees helping others to achieve a good life as self- respect. Kropotkin's argument for respect via communal reciprocity is flawed because it assumes that all individuals will agree and behave according to the rules. Indeed Kropotkin recognised the need for some form of rules although these should not come in the form of government rules. Even if people were motivated by self-respect and respect for others to obey certain rules, it still cannot be assumed that they will do so. Therefore the potential for deviance is a constant threat and the risk of unfair treatment of such deviants is high.

Another reason for the weakness of anarchism, is the assumption of a universal feeling of goodwill within the community. By this I mean the idea that the views of the communal unit will necessarily reflect those of the individuals themselves. Dworkin in his defence of liberalism makes the point well when he says 'integration does not equal altruism' (Dworkin 1989). Of course this depends very much on how much we expect from the concept of integration. Integration in the context of a fraternity such as the Free Masons would require, as mandatory, that the good of the Free Masons as a whole was as important to individual members as their own particular good. To expect the good citizen in everyday life to behave in such a way would seem to me to resemble the instrumental solidarity described by Durkheim (p12) in which members eventually began to articulate the view of the group rather than their own.

What then are the characteristics of true community according to the communitarian view? Many commentators on the subject of community seem to take a nostalgic, even romantic, view of past communities. This assumes that at some time there was in existence an ideal community, and that efforts should be made to revive a similar type. Thus political parties will frequently invoke this as part of the rhetoric of their campaigns. It is possible that what is being called for is a return to a spirit of community, and in the case of left wing politicians, a return to fraternity. It is unclear what form such a revival should take. What is clear is that the concept of community must now be expanded in order to tailor it to modern societies. Therefore the characteristics of community which appear to be generally accepted by communitarians, cannot be regarded as definitive.

The first characteristic is the idea of territory (Phillips 1993). I take this to mean geographical boundaries and location. Sandel saw the idea of situatedness as being significant on the basis that all other aspects of the community relationship would follow from this (Sandel 1982). This view must assume that a community based on a criterion of common territory applies to those who have either inherited membership or who have voluntarily chosen it. There are problems attached to this. For example, to what extent can people choose their location? The answer is that only some people can, while many cannot. For those whose location is allocated by the state there may be no natural affinity with long-standing members. Furthermore, the same people may well change location at regular intervals thereby reducing even further the possibility of community for those individuals. The element of 'no choice' is in fact one of the main criticisms of communitarianism by liberals. To carry the argument even further, one could say that the traditional territorial requirement for community has always been part of its exclusive nature. Although citizens are not excluded for the reasons that prevailed in Aristotle's time, nevertheless there is an exclusive element in the way in which some immigrant groups are discriminated against. The exclusivity of community was also evident at later periods of history. In the foundling American settlements the Puritan community leaders had a system of screening new arrivals, from England and elsewhere. If they were not considered to display the desired level of godliness and commitment then membership was refused (Phillips 1993).

Another characteristic of community is the idea of participation. This continues to be one of great importance to all political parties today (p194). As my discussion in the final chapter shows there is a wide variation in individual perceptions of the 'active citizen'. Whether this should be confined to charity and voluntary work in the community or whether it should include a degree of political decision-making is one of the crucial questions for citizenship.

The Greek Polis is frequently referred to as a community in which those with citizen status had the opportunity to participate in politics. Even those who were not members of the Council of Five Hundred or of the assembly were entitled to attend public meetings on issues relating to community life. But not all citizens who were eligible attended all of the meetings (Barker 1925). Interestingly the notion of the passive citizen was apparent even then.

The final characteristic to be discussed is the idea of communal or social solidarity. This appears to embody the idea of neighbourly concern between members of communities and is often misleadingly referred to as fraternity among groups. I shall return to this idea presently in my discussion of fraternity. Communitarians tend to focus on the idea of solidarity to convey the feeling of a common bond and sometimes a common history and culture in specific communities. Phillips regards this type of relationship as special in so far as the bond formed holds only to the community in which membership is shared. The bond is also personal since it runs from one member to another (Philips 1993). The degree to which this solidarity has been realised in the course of history is debatable. While some commentators depict the medieval kingdom as embodying close bonds of community others deny this. For example Durkheim and Tonnies both referred to fraternity among the guilds as though these were representative of society in general (Durkheim 1893, Tonnies 1887). The history of the medieval guilds shows that the spirit of brotherhood was confined to the guilds themselves and was not applicable to non members. Therefore the guild fraternities were independent of the rest of the community. To say then, that the medieval kingdom embodied a sense of communal solidarity is probably inaccurate (Reynolds 1984). However even if there is disagreement as to the presence or absence of overall communal solidarity in the Middle Ages, there was according to Tonnies a specific type of community relationship which he traced to this period of history. This was the concept of 'gemeinschaft' which is analysed in the next section under the heading the general will (p52-3).

Finally the idea of communal solidarity has received much attention in commentaries on American history. The idea of cohesive community appears in the work of Tocqueville and Bellah among others. Both of these writers portray a vision of close-knit community life and neighbourly concern (Tocqueville 1835, Bellah et al 1996). From the history of America it is clear that there was a sense of community in the early settlements. In the sense that the colonies were territorially defined, and therefore relatively compact, there was the potential for sharing and even a kind of fraternity based on similar individual circumstances. However, there is a tendency for writers to classify all colonies as being the same. More detailed histories of individual colonies reveals several differences. This is significant, I believe, if the predominantly individualistic nature of modern American society is to be understood.

There were in fact three separate groups of colonies, each with different populations and different trading interests. The first was New England. The settlers were mainly puritans from England, who were middle class, educated and religious. They would arrive , often as a church congregation (Simons 1929). Obviously this group would have shared a common bond. This group also contributed to the exclusive element already discussed (p44). The middle colonies were more agrarian and comprised a fairly diverse mixture of people from various parts of Europe. Finally the southern colonies comprised the area of plantations. By this time the puritans had stopped arriving from England and it was the Cavaliers who came, including Madison and Washington. These were wealthy, powerful business men. (Simons 1929). The history of the colonies will not be pursued in this context. The element of importance is that from the earliest point in its history America has been home to a diverse population who brought with them various cultures and customs. Entrepreneurial skills were evident at every level of business and labour, and no doubt the mixture of cultures contributed to this. There were hierarchical divisions of slaves, workers and gentry. Accounts of the conflicts between various groups within the colonies, as well as the discrimination against blacks all create a picture of disharmony and exploitation. From this perspective it is difficult to imagine a feeling of benign communal solidarity or fraternity.

So far the discussion shows that the characteristics associated with community are ideals which communitarians feel are superior to the idea of the isolated individual. Yet the prevalence of these ideals in history is questionable. Perhaps it is the territorial characteristic which is the most accurately defined. Furthermore, if these elements of community were present, and together contributed to a sense of harmonious living, then it was still not a perfect situation, for it ignores the coercive and exclusive notion of communities. What is more likely is that the sense of community so often referred to nostalgically, created a 'safe' structure in society in which the 'rules' were locally defined and each individual had a specific role and a 'place' in the general order. This characteristic is well defined in feudal society. Indeed it was in rejection of such cohesiveness that the individualism of the seventeenth century came into its own (p24).

The idea of neighbour relationships seems preferable to the more restrictive and often exclusive community. The concept of 'neighbour' would also appear to acknowledge the

notion of choice within communities so that individualist and communitarian views are respected.

Of the various characteristics depicted in early communities, one of the most powerful in terms of social bonds was the concept of fraternity which I shall now consider.

3.3 The Concept of Fraternity.

There is a common assumption which suggests that the concept of fraternity belongs to a time past, part of the romanticised image of early community life which I discussed earlier (p11). According to that image fraternity is related to the 'blood- brother' type relationship of the 'gemeinschaft' (p53). If we look at communities generally in the Middle Ages we can observe this tendency in many cases. Fraternity however does not confine itself to this one interpretation which I see as part of the problem with the concept. While at particular times in history the idea of brotherhood was consistent with particular lifestyles, it has since become the subject of criticism.

Various elements of the concept of fraternity can be identified historically as areas of concern, largely because the *label* has not been consistent with the *use*. This is not necessarily a problem of definition per se, but rather that the idea of fraternity which implies mainly benign connotations has been associated with events which were not so benign. This applies both historically and more recently.

The concept of fraternity came into its own at the time of the French Revolution when it was linked with liberty and equality. As I have described in the Appendix (p261) this was a time when the emotional tone of the term was powerful in that it promised a solidarity among citizens. This proved to be a false promise and in fact fraternity was confined to the various groups of uprisers and informers whose efforts contributed to the 'terror' (Phillips 1988).

While the concepts of liberty and equality both in the context of the French Revolution and in history generally, have received much attention this has not been the case with fraternity.

Although the idea of fraternity has been crucial to socialism as portraying a bond between the individual and the community further amplification of the concept has been vague. There are two possible reasons for this. The first reason (suggested by Pateman) is grounded in feminist thought and proposes that there has been a desire to skim over the association between fraternity and patriarchy. This idea has to do with conflict between social contract theorists and patriarchialists and is separate from the more ancient forms of patriachalism in which political power and social order were based in the family (Pateman 1988). According to the patriachalist doctrine kings and fathers ruled in a similar manner as exemplified in the writing of Filmer. Filmer argued that the contract theory in which all men were free and equal was flawed, and that all law in fact originated from Adam. As a result all subsequent generations were born into political subjection. All fathers were kings in their own families and the king's word was law. The role of the women was entirely subordinate to men because, according to Filmer 'man is the nobler and principal agent in generation' and women are procreatively and politically irrelevant (Filmer 1680). From a feminist perspective then, it could be argued that with the defeat of patriarchalism fraternity has replaced patriarchy as the modern equivalent and that women remain on the periphery. The ongoing struggle for equal rights is testimony to the strength of the 'brotherhood' in political life.

The second possible reason for the lack of clarity in discussions of fraternity generally is its exclusivity. The brotherhood which it seeks to portray is in fact enshrined in secrecy and available only to selected groups. This was apparent in the Puritan history in America among the early settlers. Here the idea of brotherhood was a strong feature and this was reflected in the various covenants upon which the system was based (p46). The covenant, (according to McWilliams) was defined by the values and goals to which its members committed themselves and which gave to individuals a common soul. There were four covenants in puritan life. These were: the covenant of grace and brotherhood of man, the covenant of nature and brotherhood of blood, the church covenant or brotherhood of visible Christians and the political covenant or brotherhood of citizens (McWilliams 1973). What is clear from analysing the covenants of puritanism is that fraternity was not something which existed as a form of mutual concern and bonding between members of a community. It was more in keeping with the fraternalism found in certain organizations which observe strict rules and are highly exclusive in nature. I have already indicated that the early

colonial settlers were screened upon arrival and admission to these groups was selective. The case of fraternity in puritanism highlights an important point in relationship to fraternity in general. It points to the confusion inherent in the label 'fraternity'. Similar misconceptions existed in relationship to the guild system of the Middle Ages (p45). These too were exclusive to chosen members and not part of ordinary community life (Reynolds 1984).

Fraternalism as opposed to fraternity is a characteristic of fraternal organisations. It involves a specific code of behaviour and indoctrination. Historically various political organisations incorporated this idea. The three which have been most evident are the Nazi movement in Germany, Fascism in Italy and Imperialism in Japan (Brooker 1991). In developing this idea Durkheim described a mechanical type of solidarity or common consciousness which was typical of such groups. The collective conscience became the individual conscience so that the individual was trained to think in terms of the 'cause' (Durkheim 1893). This presumably was the kind of depersonalisation which enabled members to act on behalf of the organisation without regard for any sense of morality.

Having identified the problems associated with the concept of fraternity the question remains as to its relevance or otherwise in the modern community and for citizenship generally. On the grounds of discrimination between the sexes it is non viable. This view is supported by feminists such as De Beauvoir (De Beauvoir 1953).

To the extent that there is confusion pertaining to the use of the term 'fraternity' it calls for reassessment. We must clearly differentiate between 'fraternity' as a form of social bond and the 'fraternalism 'of organisations. Since this distinction appears to be problematic in ordinary discourse, and since the modern community is no longer consistent with 'brother' relationships, an alternative label is desirable. This label should incorporate the idea of neighbourliness therefore it is suggested that *neighbourly solidarity* should replace *fraternity*. This compromise would allow the notions of 'community spirit' and an *esprit de corps* to remain essential ingredients of the perception of community.

Both the concept of community and fraternity are implicit in the theory of the general will. Hegelian philosophy emphasises the importance of the community for human development.

The harmony expected by Hegel to exist between the members of communities amounts to an ideal type of fraternity however unrealistic that might be.

3.4 The General Will.

The strands of the Neighbour-Centred Model already discussed, i.e. community/ communitarianism and fraternity imply a certain relationship between the state and the individual. In the context of the communitarian ideology the state occupies a place altogether more prominent than that observed in the individualist ideology. One way of investigating the nature and importance of this role is via the idea of the general will. Central to this whole issue of the states role is the question why do we obey the state. In the context of a community-based view why do we allow the state the degree of input and intervention into our lives that it has? Is it in recognition of the protection of our welfare by the state which also includes various services and welfare benefits? Or is there some other motivating factor such that we perceive that the government is acting towards the common good and therefore that we should comply?

The general will theory is one means of justification for political obligation and therefore a possible answer to the question of our obedience to the state. Many accounts of the theory are obscure and it is uncertain how they are translated in a practical sense. For the purpose of this discussion in which 'community' is the overall concern, I shall refer in general terms to this theory rather than explore its complex philosophical foundations. My aim is to show how various types of community are expressed via a particular interpretation of the general will. I shall then attempt to relate this to specific community relationships such as the 'gemeinschaft' and 'gesellschaft' as depicted by Tonnies. Although the general will theory is mainly associated with Rousseau I shall refer mainly to the work of Hegel who brings out more sharply how the 'will' is seen as important in influencing the way individuals (according to Hegel) revere and deify the state.

Let us consider the idea of general will. An oversimplified explanation might be that it is based on the idea that individuals regard the state as being superior to their everyday wants, and they are enabled to hold such a view because a higher level of consciousness allows

them to do so. That is the Hegelian view which draws a distinction between what people think they want and what they really want which is dependent on a will which is rational. This rational will also enables individuals to perceive their actions in terms of the common good. According to this image the rational will is the general will. It involves the common good, the moral person and the total unity. The total unity implies a degree of fraternity between the members of the community and through this fraternity runs an appreciation of the good of fellow human beings (Hegel 1821). I shall return to the more complex basis of Hegel's view of the state presently.

But how does the idea of a desire to realise the common good come about given the human capacity for self- interest and self-satisfaction? One possible answer to this question is that the self-interested individual who was the focus of attention in the Consumer-Centred Model (Ch.2) belongs to an ideology based on natural rights theory and that the notion of the general will is in opposition to that theory. Proponents of the general will theory therefore assume not only a different view of the state but also of the individual himself. According to the general will theory the individual, so it is proposed, has at least the potential for pursuit of the common good unlike the theory of the abstract individual who is presumed to hold no such potential. (He may of course be assumed to have the potential at a higher level of consciousness but the circumstances prevailing upon him ensure that he is mainly concerned with the selfish will).

If we accept the idea of individuals desiring the common good more than their own personal good. and many do not, then we need to ask what is the mechanism for such altruism? There are several possibilities and all require that the meaning of the general will be spelt out. Clearly, as Raphael reminds us, the general will cannot simply mean the will of all because if everyone spontaneously agreed to the same policy then there would be no question to answer (Raphael 1970). A more likely possibility would be that the general will is the will of the majority and in reality this is usually the case. This might explain the reason why some government policies are accepted but it does not necessarily justify them. It cannot justify them because to say that the majority view is better than that of the minority can not be proven. Most importantly it is the motivating factor in the majority decision which is crucial. If in fact the majority, that is each individual within that group, genuinely believed that a proposed policy was best for all then the general will is a viable proposition.

However if the motivation was based on something like the herd mentality where one person aimlessly follows the other then the argument for the general will falls down on the basis that the view of the majority did not reflect what they felt was morally right (Nietzsche 1887).

It could of course be argued that most people know what they want and therefore a majority decision is usually correct. However the idea of the general will involves more than individual preferences. It is concerned with the view that each individual, as well as being capable of identifying what it is he wants, is also capable of knowing what he ought to do and that as a moral person the action which he ought to take is the same action that he would choose if he had more wisdom. In other words a man may know what in fact he wants but not necessarily what he really wants and what he really wants amounts to the common good. Proponents of the general will go on to argue that the individual real or general will must be in harmony with the will of others. This is the Hegelian idea in which individuals not only join forces to deify and obey the law of the state but they become the state or the Volk and it in turn becomes the supreme and universal will of the community. The relevance of the will in Hegelian philosophy lies in the fact that the community and therefore mans behaviour in it, is vital for individual development. All activities and aspirations are meaningful only in a social context (Hegel 1821).

The way in which a variation of the general will is expressed in community life is demonstrated in the work of Tonnies. In his work on 'gemeinschaft' and 'gesellschaft' he attributes the notion of 'gemeinschaft' to the natural will and the 'gesellschaft' to the rational will. Here the two levels of will are seen in the context of specific relationships. The natural will is inborn or inherited and develops alongside the development of the organism. Rational will is the product of thinking (Tonnies 1887). The idea that all social relationships are willed is central therefore to the work of Tonnies. In some cases people associate with each other because they attach intrinsic importance to the relationship. But in other cases people do so only for the purpose of attaining a specific goal. The natural will has many dimensions the most important of which are unity and understanding. In such relationships each individual understands the other and is interested in his welfare. Rational will on the other hand involves careful calculation of desired goals between two people. (Tonnies 1887).

According to Tonnies all activities pertaining to living together are part of the gemeinschaft. The central element of such relationships is the family. So the 'gemeinschaft' demonstrates 'true' community which includes the family, close bonds between members, and benevolence and mutual concern. This ideal type, the 'gemeinschaft' of Tonnies, is difficult to locate historically. it is recognised that elements of the 'gemeinschaft' were present in some communities and some of these elements may remain today among neighbours.' There were nevertheless conflicts among members as my discussion on early American colonies (p46) and the previous section on fraternity shows.

Tonnies' exploration of 'gesellschaft' appears to have more relevance to modern society. This is true of organisations as well as individuals. The mechanism of the rational will as part of the 'gesellschaft' is complex. Both rational and natural will can be present at the same time just as 'gemeinschaft' can remain alongside 'gesellschaft' (Tonnies 1887). Here Tonnies highlights the individual's potential for true community and at the same time his desire for market type relationships. Although the two wills are separate they are nevertheless part of the whole person.

A combination of both 'gemeinschaft' and 'gesellschaft' is anticipated in Hegelís' view of community. The emphasis on the importance of the family for social order combined with the working of industrial organisations amounts to the external realisation of Right (Hegel 1821). The state is glorified and supreme and this is reflected in the individual's perception of community. Ethical life is communal life since man can only see himself and be seen by others as a moral person in the context of the community. Hegel identifies three powers within the state. These are: legal power which determines the universal will, the executive power which deals with conformity to the universal will and the power of subjectivity which is the ultimate and sovereign power which defines the unity of the state. Since the community reflects the supremacy of the state it too is invested with similar powers.

A community, according in Hegelian terms is more than a label describing a group of people.

A community being a community depends more on how its members behave, on how they feel and think about it.....there is a sense therefore in which a human community is what it is because it is reflected in the minds of its members' (Hegel 1821).

General will theory emerges as a complex concept which is subject to many interpretations. It is further complicated by the notion of duality of wills i.e. Tonnies speaks of natural and rational will, Bosanquet refers to real and general will (Bosanquet 1930). Similarly Hegelian philosophy is concerned with universal and particular will (Hegel 1821). Even if the idea of the various wills is accepted either independently or in combination the problem of the purpose of the general will remains. If the general will means the pursuit of the common good then the term 'common good' is vague and fails to clearly define who should decide the common good, the individual as part of a community of others, or the state. If the common good amounts to the good of the majority what about the minority? It is <u>because</u> there is no really satisfactory answer to these questions that the general will theory is weak.

3.5 <u>Conclusions</u>.

1. Of the various characteristics of community described by communitarians it is the territorial element which most accurately reflects 'community' in its historical context.

2. The romantic and sometimes nostalgic accounts of early community belies its exclusive and potentially discriminating nature.

3. The concept of fraternity in its true and original sense <u>can</u> pertain to modern communities only if it is re-labelled. The reasons for this are largely related to misapplication of the term. The implied 'brother relationship inherent in the concept is frequently confused with the 'fraternalism' of organisations. The idea of 'neighbourly solidarity' is suggested as an alternative.

4. 'Neighbourly solidarity ' would relieve fraternity of its historical association with the 'brotherhood 'of ideal types of community. It would also remove the obvious element of sexual discrimination.

5. The theory of the general will as reflected in various community-type relationships is difficult to apply except in the context of totalitarian systems. The Hegelian view is particularly relevant here.

6. The idea that the general will seeks to promote the common good cannot be upheld since the meaning of the common good is itself ambiguous.

7. The concept of The Neighbour-Centred Model, involving a communitarian approach, emerges at this stage of the analysis, as a potentially desirable possibility for the practice of modern citizenship.

References

Barker E. **Greek Political Theory**: Plato and His Predecessors 2nd.Edition, London: Methuen Books, 1925; pp32-3.

Bellah N, Masden R, Sullivan MA, Swindler A, Tipton SM. **Habits of the Heart: Individualism and Commitment in American Life**. Los Angeles: University Of California Press, 1996.

Bosanquet B. **The Philosophical Theory of the State** , London: Macmillan, 1930; pp96.

Brooker P. **The Faces of Fraternalism: Nazi Germany, Fascist Italy and Imperial Japan**. Oxford:Clarendon Press, 1991;pp1-7.

De Beauvoir S. (1953) **The Second Sex** Translated by A.M Parshley Picador, 1988 Edition.

Durkheim E, (1893) **The Division of Labour in Society** . Translated by George Simpson, London:Collier Macmillan, pp 70-85.

Dworkin R. 'Liberal Community'. In: Avineri S, de Shalit A. (eds). **Oxford Readings in Politics and Government: Communitarianism and Individualism**. Oxford University Press, 1989;pp 210-211.

Filmer R. (1680) **Patriarcha and other Writings**, Ed. J. P Somerville, (Patriarcha The Natural Power of Kings), Oxford, pp 1-10.

Hegel GWF. (1821) 'The Philosophy of Right' quoted by Plamenatz J. in **Man and Society**, Volume Two, 1963, London:Longmans, p200, 216-226, 241-2.

Kropotkin P. **Revolutionary Pamphlets: A Collection of Writings** by Peter Kropotkin, Ed. Roger Baldwin, New York:Dover Publications, 1927; pp3-17.

McWilliams WC. **The Idea of Fraternity in America**, University of California Press, 1973; pp122-6.

Miller D. (1989) **Market State and Community**, Oxford University Press 227-52.

Nietzsche F. **The Gay Science, With a Prelude in Rhymes and an Appendix of Songs**: Translated by Walter Kaufmann: New York:Vintage Books, Random House, 1887;116, p174.

Pateman C. 'The Fraternal Social Contract'. In: Keane J, **Civil Society and the State: New European Perspectives**, London: Verso, 1988;pp101-123.

Phillips A. 'Fraternity'. In: Pimlott B. (ed) **Fabian Essays in Socialist Thought**, London: Heinmann, 1984;pp231-3.

Philips DL. **Looking Backward: A Critical Appraisal of Communitarian Thought**, Princeton University Press, 1993;14-32.

Plant R. **Modern Political Philosophy.** Oxford:Blackwell, , 1992;pp325-7.

Raphael DD. **Problems of Political Philosophy.** London:Pall Mall Press, 1970;pp197.

Reynolds S. **Kingdoms and Communities in Western Europe 900-1300**, Oxford:Clarendon Press, 1984.

Rosenblum N. **Another Liberalism: Romanticism and the Reconstruction of Liberal Thought**, Cambridge, Mass. 1987;pp178-81.

Sandel M. **Liberalism and the Limits of Justice,** Cambridge University Press. 1982.

Sandel **Liberalism and Its Critics.** New York:New York University,. 1984;pp8-10.

Simons AM. **Social Forces in American History.** New York:The Book League of America, 1929.

Taylor C. (1985) 'Atomism'. In: Avineri S, de-Shalit A. (eds) **Communitarianism and Individualism**, 4th Edition , Oxford University Press, 1996:pp29-31.

Tocqueville A de (1835) **Democracy in America**: Translated by George Lawrence, Ed. J.P Mayer, New York: Doubleday, Anchor Books, 1969.

Tonnies F. **Community and Association** (Gemeinschaft and Gesellschaft) Translated by C.P Loomis, London: Routledge Kegan Paul, 1887;pp119-120, 152-3.

Chapter Four: The Client-Centred Model of Citizenship.

4.1 Introduction.

So far the individual has been considered as a consumer of services (Ch. 2) and as a neighbour (Ch. 3) in the overall context of citizenship. Both of these roles have shown the individual in a particular relationship to the state. This Client-Centred Model includes not only the individual's relationship to the state but also to particular professionals. For the purpose of this discussion it is the health and welfare professional who is most relevant although clearly many of the points identified relate to professionals in general.

The strands identified for discussion are: talent, expertise and control. It will be shown that each of these is related. An analogy is drawn between the modern professional and the guardians of Plato's Republic using the three strands as the focus of comparison. Taken in sequence the three strands reveal tensions which are most apparent in the aspect of control.

Although there are obviously differences between the guardians and modern professionals, there are also many similarities. The idea of talent for example, sets groups apart in the sense that they may claim certain privileges. Once the talent is recognised then training and education begin leading to expertise. Today this tends to be focused and sometimes specialised. In the Republic on the other hand education was much wider and the achievement of wisdom could lead to an elite status for a few (Plato).

The idea of expertise has grown alongside professionalism which itself has proliferated with the development of the Welfare State. Of increasing concern is the growing number of self-proclaimed experts within health and welfare agencies particularly counsellors. Despite the warnings of Illich and others this is the 'age of the expert' (Illich 1981). An immediate tension arises between the notion of 'consumer' and 'client.' The former is urged to fend for himself while the latter is expected to bow to the allegedly superior knowledge of the professional qua expert. There is also tension between the professional expert and the help of a neighbour.

Control follows naturally from the above description. This control lies uneasily alongside the idea of caring. If it is accepted that health care professionals are employees of the state, then we can say that the client/patient is under the control of the state, albeit indirectly. Caring on the other hand is owned by the individual professional. It is something which he may or may not regard as part of his professional role. Control can be part of caring to the extent that it can be justified in some instances. In other situations it merely highlights the inequality of power in the relationship between the professional and the client.

Before considering each of the three strands and comparing the modern to the ancient perception, let us consider the notions of professionals and professionalism and their evolution in general terms.

4.2 Who are the Professionals?

The way in which we use the term professional is often unrelated to the idea of membership of a profession. When used as an adjective 'professional' usually implies a measure of ability or performance - a professional result as opposed to an amateur one. Equally, when used as a noun 'professional' does not necessarily mean membership of a profession. Thus we can refer to a 'professional cook' to attribute our approval of the standard of the work. The saying 'leave it to the professionals' is similarly used to emphasise a degree of difference between amateur and skilled work.

Membership is confined to those professions which are 'recognised' according to specific criteria. In other words they must fulfill certain conditions and have certain characteristics which distinguish them from other occupations. This of course avoids specific definitions and is the path chosen by many commentators. Given that the idea of professionalism is not static, but constantly evolving then this may be adequate.

If we consider particular characteristics necessary for membership of a profession then these must retain a degree of flexibility since many occupations can fulfil some but not all of the criteria. Jenkins concluded that all of the following were necessary conditions for membership of a profession,

Professions:

1 possess a unique set of abilities,
2 are based on a systematic body of knowledge.
3 are client-centred,
4 bond members together in associations,
5 have licences to protect standards.
6 have a code of ethical conduct.
7 assume responsibility for professional acts,
8 operate on a fee for service basis
9 undergo prolonged training,
10 possess specialised knowledge (Jenkins 1983).

Others emphasise the importance of specific features. Downie, for example, underlines the relationship aspect between client and professional. He also attaches importance to the necessity of a broad education as opposed to training in the narrow sense (Downie 1990). These characteristics are taken up again in the context of the three strands for comparison with Platos guardians (pp62-3).

Having identified the characteristics which professions ought to have let us now consider the difference between the idea of a professional and that of an expert. Since the notion of expertise is an integral part of a future argument (p66) I shall confine my discussion here to this distinction. There is often a degree of confusion in everyday language between the meaning of an expert and a professional. Politicians frequently refer to experts when in fact they mean a specific profession, for example doctors. The label 'expert ' can in these instances have a derogatory implication. It is not surprising that the two terms are used interchangeably since one can be both an expert and a professional. In that sense the professional may be so specialised in his particular field that he is indeed an expert on his subject. If specialisation is the criterion for expertise, then the implication is that only a few are worthy of such acclaim. This however runs contrary to the more usual sense in which we use the term expert. The idea of a 'society of experts' was certainly the cynical view of Illich whose work on the subject deplores the lack of that very thing which experts ought to

have i.e. 'expertise' (Illich 1981, Illich et al 1992). The idea that almost anyone can set himself up as an expert has been the most alarming aspect of the rise of the professional not just because the two terms are used interchangeably but also because not all professionals achieve such a standard of excellence as to constitute expertise. Doctors and nurses for example can have some knowledge of counselling as part of their training but only a few take this to a higher level. Not all of those will have the qualities necessary to be an effective counsellor. Similarly the general practitioner may have some skill in the practice of obstetrics or paediatrics but special knowledge, training, and practice are required if specialisation and expertise are to be achieved.

The idea of a society of experts is not without foundation. In Britain the Welfare State has been responsible for the rise of the health and welfare professional. In the United States there is a similar situation although the New Deal equivalent in no respect equals the British welfare system. In fact it is consumerism which in America has led to the need for more experts in order to cater to the constant new needs of the production consumption cycle. The two main areas which have flourished under this need for experts are therapy and management. Both of these exercise a degree of control in the work place (Bellah et al 1996).

In discussing the characteristics of professions it is relevant to trace their development briefly in a historical context. This is of interest because although the concept of a professional is not new, it was not a gradual evolution. Many of the established professional associations that we know today emerged over a fifty year time span with little if any new professions emerging between the mid sixteenth century (the beginning of the scientific age) and the early part of the nineteenth century. This was true of both Britain and America (Larson 1977).

The concepts of professional and professionalism can be traced to the beginning of associations around the eleventh century. A clear distinction existed between those which belonged to the craft guilds and those which belonged to the university system. The church to a large extent dominated both. The specialist professional tended to be affiliated to noble

households while the ordinary practitioner was employed in the medieval market as tradesman or artisan. Lawyers and doctors were regarded as members of the church who had undertaken special functions. Professions such as divinity, law and medicine were seen as professions fit for gentlemen. Surgeons and teachers were excluded from this category (Carr-Saunders 1933).

The public perception of professionals at this time was one of growing interest mainly because of the specialist knowledge possessed by doctors, lawyers and parsons. To consult an expert was to have access to a kind of information not available to others (Corfield 1995). If we go back even further to the time of Plato we can see that it was not so much the specialist knowledge but special ability which made the elite group of guardians fit to become philosopher kings who could rule the rest of the citizens (Plato).

4.3 An Analysis of Plato's Guardian Class.

In order to understand the class divisions in the Republic it is necessary to consider briefly the reasons behind Plato's desire for the ideal state. According to Plato there were three main flaws in the Greek City State. These were: class war, bad government and inadequate education (Crossman 1937). The government of the time alternated between oligarchy and democracy. Oligarchy was seen by Plato as pandering to the interests of the wealthy with an emphasis on private property. The result was a domination of the poor by the rich (Crossman 1937).

Plato attributed many shortcomings to the idea of democracy. Since men are incapable of choosing a leader on the basis of ignorance then the least suitable member could easily be elected. Furthermore the 'liberty' inherent in democracy causes a general lack of respect for authority and a lack of cohesion. The leaders themselves may exploit people since power leads to control which must be carefully monitored (Plato).

The result of democracy is dissension and even tyranny. The main dangers of tyranny are violence, incompetence and disunity (Plato). Plato envisaged a change in the way

governments were run. Political power should be confined to those with the ability to exercise it. This power belonged to an elite minority which should be specially trained for the task. The main focus should be on the education of children by experts so that future generations might benefit from their superior knowledge. The ideal to which Plato aspired was based on Sparta. He saw the success of that scheme as being due to three main factors.

These were:

1 Sparta had a self-sufficient economy which was predominantly agricultural;
2 the government was in the hands of a specially trained, hereditary ruling caste;
3 education was rigidly controlled (Crossman 1937).

Even Sparta was not perfect according to Plato. There was corruption in the army and Spartans as men left much to be desired both intellectually and morally. Plato wanted a system in which the serfs would voluntarily submit to the rule of law rather than being slaves terrorised by the secret police. The Academy was the institution which Plato thought his ideal state would be realised. It would offer a reasoned and self-disciplined morality where the individual will would be nurtured and where he would learn the principles of law which because he understood them, he would therefore submit to.

There were three orders in Plato's ideal state. These were: the Rulers (Legislative and deliberate), Auxiliaries (executive) and Craftsmen (productive) (Plato). The guardians comprised the first two groups chosen at the two levels on the basis of talent and merit. The higher grade were the philosopher rulers, an elite group who had achieved the ultimate degree of success in training and education. The Auxiliary group formed the military and were subject to the same life-style as the higher group. The third group are assumed to have lived a more conventional life although there is relatively little documentation of this in the Republic. Children from this group could move up to higher levels if a certain standard of education was achieved. Equally children born into the higher classes could be demoted if unsuccessful (Plato).

The main emphasis in the guardian class was on talent and at a later stage the development of expertise. The main point to be stressed before continuing with an analysis of the guardians is that history seems to have placed Platos ideal state in a position in which it has been challenged on a number of grounds. By this I mean that different accounts of the Republic are reflected in relationship to specific times in history. For example, with the rise of totalitarian regimes and fascism the Republic began to be criticised whereas previously it was hailed as an example to be followed. As time passes the charge of Utopianism becomes more relevant. The modern commune of which the Israeli kibbutz is an example, is now being analysed in terms of the negative aspects of separating parents and children and for the whole notion of the 'communal family' (Bowes 1989).

The guardians were chosen on the basis of talent and a certain standard of academic achievement. Let us begin by considering the notion of talent in relationship to the guardians and to the modern professional.

4.4 The Concept of Talent.

The idea of a small minority being singled out for the office of philosopher ruler or auxiliary was part of Plato's idea for the pursuit of excellence. The guardians were trained and educated for the specific function of ruling the other two classes. As such they were invested with immense power and were seen to possess a degree of wisdom superior to other groups. On the basis of success in various examinations they were granted this power. But there was a price to pay for such distinction. They were denied an ordinary life including a family. Relationships were restricted and procreation was planned and designed to create a specific type of individual - one whose parents were of the correct calibre for reproduction of the ideal citizen (Plato).

The talent which the guardians possessed was not only based on academic achievement but also on the wisdom accumulated by virtue of being part of the community of philosopher kings. The fact is that this talent was derived from closely monitored and strictly controlled education. The quality of wisdom was usually achieved in middle age. Censorship was used to eliminate any material deemed unsuitable in the education of young people. The result

was that education was 'uniform' as were the individuals who emerged from the system. *'A potential guardian must also be gentle and just, own no property and generally live in harmony with his fellow guardians'* (Plato).

Because of special abilities which the guardians were assumed to have they would see life from a stance of philosophers and as such their perception would be sharper than that of the ordinary citizen. Various similae are used to emphasise this difference. 'The philosopher would literally see things more clearly. The world of ideas is clear only to a few while the world of passing things is clear to everyone (Plato).

There are several problems identifiable in the notion of 'chosen talent' and some of these are relevant to modern professionals. The most obvious is the idea of indoctrination which might lead to the mechanical solidarity defined by Durkheim and referred to in chapter 3 (p49). In a sense the guardians portrayed the ultimate fraternalism. A variation of this is sometimes seen in professions such as medicine where members join forces and maintain a united front or solidarity when for example the position of 'professional' is threatened by adverse publicity for example.

The assumption of competence which Plato invested in the guardians was based on their superior intellect and wisdom and also on high moral standards. The idea of individual growth was less important than that of the collective. In such a system the notion of particular individuals surpassing others was not encouraged. In reality in those circumstances not all members may have the same degree of competence or motivation. In the same way we can say that some professionals are more competent than others. Certainly there are some professionals whom we would choose to treat us medically or to represent us legally over others, if that choice was available. An assumption of competence may therefore constitute a danger to the client. It may also affect the professional who because he is expected to be competent may be carried along by the system unaware that he is in fact incompetent. Academic achievement does not necessarily mean that a professional will be talented, competent or knowledgeable about every aspect of his particular field. There is also a case for saying that it is unnecessary for talent to be demonstrated in all aspects of a profession and that so far as the client is concerned it is competence which is

most important and that special talent is found among experts who specialise in one area (p72).

Plato's guardians were specially chosen for a specific role. Although it is difficult to imagine a modern organisation choosing talented individuals for the same reasons that Plato did, the idea of 'spotting talent' is not unknown today. The idea of individuals being chosen because of a particular talent or ability is seen in sports. In Russia for example athletes are frequently 'spotted' at an early age, then trained and cultivated with the aim of achieving a standard of excellence. This talent is entirely specific to the individual in question and the sport to which it relates. This is similar to the idea in the Glass Bead Game in the novel by Hermann Hesse in which the most talented scholars are creamed off in childhood and placed in elite schools and isolated from ordinary life rather like Platos guardians (Hesse 1960).

The problem with isolating chosen individuals in the pursuit of excellence is that they may become obsessed with the task at hand to the detriment of other areas of life. As mentioned earlier (p66) Plato's guardians were denied the right to family life as we know it. Professional sports players may be similarly denied some aspects of ordinary living. In another sense professionals may become intellectually isolated, unwilling to contribute to any topic other than that in which they are talented. Talent identified in such a way is to be distinguished from the modern idea of 'head-hunting' of already established talent. This trend is evident in many professions and in politics. In this case the 'chosen' individual may not necessarily be the most highly qualified but may have a specific interest or direct focus in a particular field which makes him more desirable than other candidates.

Talent or special ability can lead to expertise in many professions. It often depends on further education and specialist training. Let us now consider the idea of expertise.

4.5 The Concept of Expertise.

I have already drawn a distinction between the concepts of 'expert' and 'professional' (p60). In fact expertise can be found in any occupation. It is therefore necessary to discuss

the idea of expertise acknowledging the fact that it applies to professionals and nonprofessionals. This is relevant because the claim to expertise by some individuals is at the heart of the controversy inherent in statements like 'the age of the expert'. The implication here is that there is an expert for every ill and it is difficult to differentiate between real and pseudo expertise. It is therefore crucial to decide what the concept of expert entails and who is justified in claiming such a title. This clarification is important because it is the client who is central to the idea of expertise, at least in health and welfare fields, for without clients many experts would be redundant.

An expert, then, is someone who in his particular field, professional or otherwise has knowledge practical ability and skill as a result of training over and above standard levels. He also has a special interest in this area and it is this interest which fuels his enthusiasm and makes him credible to others as a practitioner. He may be one of many experts in that field or he may hold the monopoly of expertise as for example is seen in the more unusual occupations for example porcelain restorers or clock makers.

If the idea of special ability is the standard by which talent is gauged then which are the factors which contribute to expertise? Training is obviously important in order to learn the particular skills of the occupation. This applies to the recognised professions as well as the many occupations which may be seeking professionalisation. The negative side of this is that unlike professions there is no statutory body for regulation of experts. Hence the risk of the self-proclaimed expert.

Assuming that training is important in gaining expertise the question arises as to what this means. How for example does training differ from education? To say that an individual is trained in some field implies that he has successfully learned a specific set of skills e.g. manual in the case of a machine operator, highly technical in the case of a technician, or a combination of both as in the case of an airline pilot. But this is a rather limited view. While training usually implies the acquisition of technical expertise only, it could be argued that training is a prerequisite for exercising intellectual skills as well. (Plato's guardians underwent rigorous training of the mind and body). There are two aspects to this view. First, the development of creative thought as in philosophy or mathematics requires a certain 'technical know-how'. For the student just has to know certain rules of mathematics

e.g. multiplication of two negative numbers results in a positive number. Similarly, philosophical analysis must conform to certain basic rules even if the analysis itself invents new rules.

But to say that an individual is trained is not necessarily to imply that he understands what he has been taught. After all, monkeys can be trained to perform a number of manual tasks but it is unlikely that they have any understanding of the concepts involved (as far as we can assess). The same may apply to humans. An individual may perform some manual task with the utmost perfection and dexterity and even expertise but have no concept of the theory underlying the procedure.

The question of education in relationship to expertise is less clear. Education can be either narrowly or broadly defined. Clearly there are standards of general education which are required for particular occupations. This does not necessarily mean that a person is 'educated' in the sense that he is knowledgeable about subjects other than those related to his own interest. Doctors for example may be highly trained and educated in the conventional specific sense and yet be relatively uneducated in the wider sense. They may for example know little about art and culture despite being an expert in some aspect of the medical sciences. This 'narrow' view is quite likely to affect relationships with clients or patients when the professional may be so rooted in his 'ivory tower' as to be unable to perceive the kind of life the client has outside. The widely educated doctor is also more likely to be particularly skilled at detecting and assessing symptoms and signs of disease. This may be because he has travelled more and therefore seen more cases or it could be that he is generally more open to the possibility of a wide range of potential causes of disease. It could be concluded then that education as well as training is crucial for professionals. The wider the education both inside and outside the chosen field then the more clients stand to gain in their interaction with professionals. Equally the professional will gain in terms of self-development.

The idea of the truly educated versus the standardly educated and trained individual is highlighted in Plato's plan for the guardians. Sacrifices were necessary to achieve this goal. To a lesser extent modern professionals may feel they have 'missed out' on various aspects of life in pursuit of their goal. There are two main features about the life of the guardians

which are of interest in relationship to modern professionals. One is the degree to which their lives were controlled. This included not just their education and the lack of family life but aspects of everyday living such as diet and exercise (Barker 1925).

The other feature is their apparent lack of choice at any stage of the transition from one level of education to another. One conclusion to be drawn from this is that because the guardians had been indoctrinated towards a specific model of citizenship from an early age, that they were conditioned not to wish for anything else. This in itself constitutes a form of control.

The idea of control was central to all aspects of life in the Republic in ways which would be quite unacceptable to the modern professional. This is not to say that the idea of control is irrelevant to modern professionals. Let us now consider the concept of control in relationship to professionals.

4.6 The Concept of Control.

The idea of control in health and welfare services is manifest in a variety of ways. The Marxist certainly sees the professional as an instrument of the state and to that extent he is controlled by the state (p178). There is some truth in this statement in so far as professionals in health and welfare services (in Britain) are ultimately employees of the state. It must therefore follow that there should be some accountability on the part of the employee to the employer. If this is the case then a degree of control is justified within the bureaucratic structures of welfare and health services. However in the British system, in the health service in particular it was doctors who controlled the delivery of service until relatively recently (Harrison 1988). A similar situation exists in the United States where the American Medical Association was able to exert pressure against the Clinton Health Bill. Thus there is evidence that substantial power rests with the medical profession.

In any bureaucratic structure there is likely to be an undercurrent of control between the layers of the organisation concerned (Weber 1946). Most professional organisations therefore will display some level of this. In this discussion I shall confine myself to health

care in particular although many of the social service institutions are also relevant. What is significant about this control is the fact that the client is usually situated at a distance from the original source of the control so that decisions made at 'the top' will eventually filter down towards him but rarely will this be by direct contact with the professional. The kind of control in this situation is very much linked to bureaucratic organisations. Prior to the reorganisation of the National Health Service this was one of the main areas of concern (Griffiths 1983). It remains a concern to some extent in all public service delivery although the recent wave of consumerism has cast these relationships in a new light (p154).

It is possible to identify two main areas in health and welfare services in which the idea of control is particularly relevant to a Client-Centred Model of Citizenship. Both identify the client as the main focus of attention and both can be problematic and tension- producing. They are: control of services delivered to clients via professionals and control of clients by professionals in the context of the caring relationship. These two elements are but examples of control in the context of the client/professional relationship and are not intended to imply the complete picture of control in bureaucratic institutions generally.

4.6.1 Control of Service Delivery.

Let us begin by briefly exploring the idea of service control by professionals in health services particularly.

In the British National Health Service doctors have held a great deal of influence over the issue of health policy. Only recently, with the publication of the 1989 White Paper 'Working for Patients' has this situation changed (Flynn 1992). The introduction of new management structures challenging the traditional self-regulating independent medical profession led to a tension which may eventually be balanced. A third party, the manager, now stands between the professional and the client. I shall not provide a detailed analysis of management objectives at this point except to say that they cast professionals in a new role which at the time threatened their autonomy.

There are various ways in which the medical profession has had control over the delivery of services. At government level and below influence is brought to bear on aspects of service delivery which directly or indirectly affects the population as a whole. As the Black Report reveals there are inequalities in health care at several levels. Concentration of centres of excellence in the most residentially-desirable areas is one example (Black et al 1992). Furthermore the new management structures still include senior influential doctors on committees, some as medical directors.

At another level there is control over the training of medical students. This control tends to favour the medical model of health and to pay less attention to environmental and social causes of disease. Major fund-holding organisations are also more likely to sponsor research into diseases which can be scientifically proven than those which are preventable. Relatively low status continues to be attributed to areas such as health promotion and health education (Ch.11.5).

4.6.2 Control and Caring.

The second aspect of control exercised by professionals in service delivery affects clients more directly. This kind of control may have more to do with individual personalities than with professionals in the collective sense. I refer to the control that is sometimes found within the so-called caring relationship. The first step towards analysing this control is to consider the idea of caring in the client/professional relationship.

It is unclear how the term caring professions came about, whether it is an extension of the overall view of 'welfare' as implied by the Welfare State, or whether it is simply an assumption that people involved in certain types of client-centred work will be of a caring disposition. The latter is unlikely since caring for people who are ill or needy is by no means confined to the professions. This fact is acknowledged by the government as the new Community Care structure shows (HMSO 1989).

Two areas need to be addressed with regard to professionals and the concept of caring. The first involves the nature of caring itself and the various uses of it. The second questions the desirability of caring as a necessary attribute in the so-called caring professions.

A distinction can be made between 'caring for' and 'caring about' (Blustein 1991, Hugman 1991, Scott 1995). 'Caring for' usually involves a degree of activity on the part of the carer. Thus a doctor cares for the sick or looks after them. 'Caring about' on the other hand involves emotion. As individuals we all care about issues that affect us personally e.g. family and friends. We may also care about more global issues such as environmental issues or human rights. In order to 'care about' something we are usually motivated to do so or have an interest in that issue for a specific reason. This does not mean that in order to care about something or somebody there must be a degree of self-interest involved since it is obviously possible to care about somebody because we like them. We may also care about the general well-being of a person without actually liking them.

As far as the professional is concerned both aspects of caring may be relevant that is he may 'care for' and 'care about' his clients. 'Caring for' is that part of the relationship which is necessary and may even be a legal requirement. 'Caring about' is more emotionally-based. Professionals may be committed to their clients or patients in so far as they represent their particular specialty and they may have additional interest in the research aspect of this. Thus a specialist in eye pathology may well be the person to whom all patients with a similar condition are referred. The specialist may therefore be assumed to care about his patients in view of their diagnoses and also in view of an additional 'case' for his statistics. Neither preclude a sense of 'caring about' which is independent of these two variables but neither do they necessarily include it. From the patients point of view 'treatment' and 'cure' are of paramount importance and 'caring about' him in any other respect is secondary to this concern. The idea that many sufferers could potentially be cured is plausible as a contribution to the common good. In this situation three parties interests are served, the state insofar as the professional is its instrument, the professional since this was the outcome of his efforts, and the client who gained the advantage of treatment. The important point here is that the clients perception may be that he is 'cared about' by the professional on the ground that he received care and treatment. However only the professional knows whether the client was 'cared about' or merely 'cared for' as part of the statutory

requirement. The idea of 'caring about' emerges as irrelevant to the outcome in this instance. It can therefore be concluded that 'caring for' is essential in the context of the professional/client relationship. 'Caring about' on the other hand could be seen as an added bonus but with no real effect on the outcome of care generally.

Returning now to the idea of control it is possible to identify potential for control in the context of 'caring for' patients or clients. It is a fact that since the time of the Poor Law the idea of the deserving and undeserving poor has been a preoccupation of distributors of resources (Marsh 1980, Whelan 1996). Titmuss described welfare professionals as arbiters of the Welfare State and key holders of equality of outcome (Titmuss 1968). In this respect the 'caring ' element is at the heart of the notion of control. If we consider the doctor/ patient or nurse/ patient relationship we are aware that this is a unique situation. In no other professional/client confrontation is the client so vulnerable. The client becomes a patient, and dependent to some extent on an individual professional for a given period of time. In other settings such as the lawyer/client relationship the client is clear about his case and if he is not then help is available without any loss of dignity to the client. In medical cases however the patient usually seeks medical help because something (often he does not know what) is wrong with his health. If the setting is the hospital the trauma is multiplied. Much has been written on this very aspect by Goffman, Statz and others about how patients become part of the fabric of the institution (Goffman 1962, Statz 1971). Added to this the patient must in a sense surrender himself to the assumed knowledge, expertise and professionalism of the medical and nursing staff. The professionals knowledge together with the patients lack of knowledge and his uncertainty immediately put the patient at a disadvantage. The professional is now in a position of power. From then on there is potential for control and tension. The assumption that professionals will be impartial and non-judgemental must be balanced against the fact that the professional brings with him a set of values and attitudes derived from training, social background and moral beliefs (Downie et al 1974). The extent to which any or all of these can be put aside in relationships of this kind is individually determined. Indeed in some cases it may not be in the interest of the client or patient to be nonjudgemental.

Some aspects of control can be seen as part of the professional duty and therefore statutory requirements which are protected by the regulations of the institution and the professional

code of ethics. These include control of specific treatment such as drugs diagnostic tests and surgery. This kind of control is of course desirable and justified and specific rules in these instances must be adhered to in order to protect both the client and the professional. However there are other situations where control is neither justified nor desirable at least in the majority of cases. Control of information by professionals is an area of concern whether it is exercised in the hospital or in the community, in health or welfare services. Controlling information can take the form of not making specific facts available to clients such as eligibility for certain benefits or failing to help understand the small print in social security forms. In the health care setting information regarding diagnosis or progress of illness may be withheld or minimised so that the patient does not have the total picture of his condition.

The idea of control emerges as an apparently inescapable element of modern professional practice. Although the discussion has focused on health and welfare professionals it is clear that control in some form is part of the fabric of bureaucracies. It is now possible to identify tensions in this particular model of citizenship. These could be seen in terms of professional interests versus the interests of the state and also between professionals themselves. Recently a new tension has arisen between the manager and the professional.

The main tension concerns the relationship between the carers i.e. the professionals and the patient qua consumer. As indicated in chapter 2 (p10) the notion of patient as a consumer is relatively new. While the various charters aim to take account of the views of clients and patients the reality is that in an atmosphere of uncertainty and vulnerability these are difficult to implement without the full commitment of individual professionals. This topic is revisited in the final chapter in terms of possible solutions.

4.7 **Conclusions.**

1. The notion of citizen as 'client' differs from other roles such as neighbour and consumer. In this context the citizen qua client is involved in a relationship with professionals in which there is an unequal balance of power in favour of the professional. This is particularly true in the context of health and welfare.

2. A distinction exists and must be emphasised between the terms 'professional' and 'expert'. These tend to be used interchangeably in ordinary discourse and this can lead to confusion between genuine and pseudo expertise. The result can constitute a threat to the true characteristics of professionalism.

3. In drawing an analogy between the guardians in Plato's Republic and modern professionals it is evident that some similarities exist. These similarities are reflected in an analysis of three strands: talent, expertise and control.

4. Talent emerges as a necessary attribute for modern professionals although not to the same extent as in the Republic. There, individual worth was measured in terms of ability and the extent to which this could be useful to the system.

5. The guardians gained expertise through extensive training. In modern life expertise can be achieved in any occupation and indeed anyone can set himself up as an expert. The idea therefore of a 'society of experts' is not without foundation.

6. The concept of control appears to be an integral part of bureaucracies. In the so-called caring professions two facets of control are significant. On the one hand control can be seen as necessary and justifiable in the context of organisation, efficiency and safety in the delivery of services. At another level it has a less desirable connotation. This is when it is exercised by professionals in a climate of uncertainty and vulnerability on the client's part.

7. Several tensions, actual and potential, emerge from the Client-Centred Model of Citizenship. These include tensions between professionals and the state, between professionals themselves and between managers and professionals. The overriding tension may be in the evolutionary stage. This is the tension between professionals and the client in his new role of 'consumer'.

References

Barker E. **Greek Political Theory:** Plato and His Predecessors London:Methuen, 1925.

Bellah N, Masden R, Sullivan MA, Swindler A, Tipton SM. **Habits of the Heart: Individualism and Commitment in American Life.** Los Angeles:University of California Press, 1996;pp44-47.

Black D, Morris C, Townsend P. .In: Townsend P, Davidson N. and Whitehead M. (eds) **Inequalities in Health: The Black Report: The Health Divide,** Penguin Books 1992;pp278-80.

Blustein J. **Care and Commitment: Taking the Personal Point of View,** Oxford University Press 1991; pp 27.

Bowes AM. **Kibbutz Goshen: An Israeli Commune.** Illinois:Waveland Press, 1989;pp22-126.

Carr-Saunders CM, Wilson PA. **The Professions.** Oxford:Clarendon Press, 1933.

Cm 849 **Caring for People: Community Care in the Next Decade and Beyond.** London: HMSO 1989; (para 1.11).

Corfield P. **Power and the professions in Britain 1700-1850.** London and New York: Routledge, 1995.

Crossman RHS **Plato Today. Second Impression.** London:Unwin Books 1937; pp72-76.

Downie RS, Loudfoot E, Telfer E. **Education and Personal Relationships: A Philosophical Study,** London:Methuen, 1974.

Downie RS. 'Professions and Professionalism'. **Journal of Philosophy of Education,** 1990; l 24(2:)147-50.

Flynn K. **Structures of Control in Health Management,** London:Routledge, 1992; pp29.

Griffiths Sir R. **The NHS Management Inquiry Report,** London:HMSO. 1983.

Goffman E. **Asylums: Essays on the Social Situation of Mental Patients and other Inmates,** Penguin Books, 1962.

Harrison S. **Managing the National Health Service: Shifting the Frontier**? London: Chapman and Hall,. 1988

Hesse H. 1960 **The Glass Bead Game.** 7th Edition, Penguin Books, 1977.

Hugman R. **Power in the Caring Professions.** London:Macmillan. 1991.

Illich I. **Limits to Medicine Medical Nemesis: The Expropriation of Health** , Penguin Books, 1981.

Illich I, Zola IK, McKnight J, Caplan J, Shaiken H. **Disabling Professions,** London:.Marion Boyars, 1992.

Jenkins KD. 1983 'Code of Professional Conduct for Teachers'. **Scottish Education Review** 1995; 27 (1).

Larson MS. **The Rise of Professionalism: A Sociological Analysis.** Berkeley:University of California Press, 1977;pp5-8.

Marsh DC. **The Welfare State Concepts and Development.** London:Longman, 1980;pp3-4.

Plato. **The Republic of Plato** Translated with Introduction by Francis MacDonald Cornford, 20th printing, New York and London: Oxford University Press, 1962: III403-421C; V457-459; VI 484-495A.

Scott PA. 'Care Attention and Imaginative Identification in Nursing Practice'. **Journal of Advanced Nursing,** 1995;21:1196-1200.

Szasz T. **The Manufacture of Madness.** New York:Routledge & Kegan Paul, 1971.

Titmuss R. **Commitment to Welfare.** London:Allen & Unwin, 1968.

Weber M **Essays in Sociology,** edited and introduced by C. Wright Mills, Oxford University Press, 1946;196-244.

Whelan R 'The Corrosion of Charity: From Moral Renewal to Contract Culture'. **IEA Health and Welfare Unit Choice in Welfare,** Series No. 29 1996; pp 6.

PART TWO:

HEALTH AND WELFARE.

PART TWO: HEALTH AND WELFARE.

Introduction.

Having explored three models of citizenship in Part One it is now relevant to consider two important conditions of citizenship. These are: health and welfare. These two concepts draw together social, political, economic, philosophical, and legal considerations and are applicable to all styles of government regimes. Health and Welfare provide a forum for political debate in terms of delivery of services regardless of economic structures. These are complex issues which call into question not only how services ought to be distributed but also to whom. In other words concepts such as rights and needs become relevant. Clearly it is not possible to fully explore all aspects of health and welfare service delivery within the confines of this thesis. Given that the next section (part 3) is concerned with an analysis of two specific systems (British and American), this discussion of health and welfare will be in more general terms. Let us begin with the concept of health.

Chapter 5 The Concept of Health.

5.1 Health as a General Concept.

Despite the apparent simplicity of the term 'health' as used in everyday discourse, it is in reality a complex concept (p5). This complexity is borne out by the ongoing controversy at government level to secure a standard of health care which is both adequate and economically viable. When we speak about health **services** then, health becomes a concept with seemingly endless implications. Thus we refer to the health of the nation, health in industry, environmental health, and the health of particular groups of people in society. We might call this the collective sense of health. Indeed it could be argued that health has in a way been taken over by the state and that it is the negative aspect of health i.e. disease which is the main focus of attention. Again this latter observation is illuminated by the existence of the relatively large number of services for 'sickness' as opposed to the relatively small number for preventive services.

There is another level at which the concept of health remains an individual concern. Although health can no longer be seen as a private matter as was the case in previous centuries, the idea of individual responsibility for health has regained popularity in recent decades. This belongs very much to the individual's relationship to the state in particular to the liberal individualist ideology. This notion of individual responsibility however must be analysed in the context of government inconsistency. A clear example which demonstrates this inconsistency is the half-hearted campaigns to eliminate smoking in the presence of a thriving tobacco industry. I shall return to the question of individual responsibility (p87).

Since the concept of health appears to be so wide in scope it can be appreciated that any attempted definition must be inadequate (p3). Nevertheless some form of definition is desirable and relevant if only to provide a focus for discussion and more importantly as a reference for policy -making. The definition which appears to be most satisfactory remains that provided by the World Health Organisation in 1946 which states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1946). Although this definition has been criticised for its utopian statement it nevertheless incorporates all the components of an ideal of health (p5). It also implies the idea of harmony between positive and negative aspects of health so that no one aspect is superior to the other so to speak.

Health and disease are closely related and necessarily so for it is only when health is threatened by disease that many people consider the notion of health at all. It is therefore relevant to consider both concepts. The term disease embraces two separate ideas- one derivation is from 'morbus' which originates from the latin word 'mors' meaning death. The English version comes from the old French 'aise' meaning comfort. Disease therefore meant to be ill at ease or uncomfortable (Richman 1987).

Disease and illness are not synonymous. Disease has traditionally been confined to those conditions which are the result of invasion of the body by organisms or degenerative conditions (Bockington 1958). Illness on the other hand may be seen as the body's manifestation of certain symptoms which may of course be a result of disease. An individual may then feel ill without knowing that he has a disease. This might be the case

in infectious disease where the individual does not know that he is incubating the disease several days prior to the actual external manifestation of the disease (Downie et al 1996).

The idea of chronic ill -health is less clearly definable. There are individuals who report various symptoms in the absence of any physical signs and this, for them, is an on-going problem. Because they do not fit easily into any clear category of statistics investigation may not reflect the true nature of the ailments. Such cases are often erroneously categorised as 'depression'. This largely ignored category has significant implications in terms of mis-diagnosis. The technical model of health is clearly easier to define, treat, and label. The idea of the doctor as a mechanic with the ability to label a condition is part of the negotiation of disease (Rosenberg 1992). An example of the importance of labelling is demonstrated in the diagnosis of Chronic Fatigue Syndrome or Yuppie Flu as it was previously called. As soon as the condition was labelled Myalgic Encephalitis and therefore medically legitimised patients began to recover (Aronowitz 1992).

The social or mental aspects of health continue to be regarded as if they are part of the negative side of health but it is difficult to treat them in terms of any medical techniques. In addition there continues to be a degree of stigma attached to this form of illness. Although the lay perception of mental illness has moved on from the idea of possession by demons, and sufferers are no longer incarcerated, there is nevertheless a degree of fear born of ignorance surrounding the whole area of mental health. Attempts to re-integrate patients into the community with some unfortunate consequences have called into question the adequacy of care.

The more positive aspect of health includes the concept of well-being at least according to the Who definition of health. This suggests that health and well-being are really two overlapping concepts rather than two aspects of a single concept. Sufferers of cancer can experience well-being providing pain control is adequate. It seems that there is a sense in which well-being and health are dissociated. Equally, apparently healthy individuals may not necessarily experience well-being. It could be argued that the notion of wellbeing is highly individual and that the range of circumstances which can induce it are infinite. Thus, the cyclothymic individual may only ever experience well-being when the sun shines. The feeling of well-being reported by individuals under certain conditions is subjective well-

being. Objective well-being is more difficult to determine. Attempts to ascertain or measure well-being among various groups of workers have had limited success in separating the subjective from the objective state and concluded that using objective measurements alone in such studies was meaningless (d'Iribarne 1972).

Another way of analysing well-being is to distinguish between 'true well-being' and the 'feeling' or subjective kind already considered (Downie et al 1996). This true well-being is related to the notion of the good life. The good life was what Aristotle called 'eudaemonia' which literally meant being blessed with a good daimon or guardian (Aristotle). In modern life it is more likely to be interpreted as happiness. The distinction between the Aristotlean use of eudeamonia and our more usual sense of happiness is complex (Telfer 1980). However the way we use the term 'happiness' in ordinary discourse may indeed be linked to a sense of well-being and to feel happy may well be equal to a feeling of well-being.

Having considered the various components of health in the general sense it is now appropriate to focus briefly on the evolution of modern scientific medicine.

5.2 The Evolution of Modern Scientific Medicine.

When we speak of modern health services we are really referring to the period from the twentieth century as it was only then that the majority of the population had access to medical care. Therefore the earlier history is of some interest in placing our modern perception in some perspective. The current notion of disease and its multi-factorial causality is also new.

The very earliest attempts at formulating some system of recognising the nature of matter and living things were made by the Egyptians and Babylonians who thought that four elements, water, air, earth and fire were the main constituents of the world. This led to a theory of the human body known as the four humors. These were: blood, phlegm, yellow bile and black bile. (Weatherall 1995). The degree to which these humors were in harmony at a given time indicated the presence or absence of health (Morgan et al 1985).

The doctrine of the four humors was popular among the early Greeks from the time of Hippocrates and continued in the time of Galen. Galen studied philosophy as well as medicine and science and his influence spanned several hundred years. During the Middle Ages there was little progress in science in relationship to medicine. The end of the fifteenth century marked a period in which the old doctrine was challenged.

By the beginning of the nineteenth century a change came about in medical practice. This was the era of hospital medicine which led to changes in the way that medicine was practised. Patients were no longer seen as having individual symptoms but were now regarded as 'cases' with more emphasis on disease. Hospital medicine moved towards classification and diagnosis of disease. There was a growing realisation that disease could be due to malfunctioning of one particular part of the body.

By the latter half of the nineteenth century the mechanistic view of medicine was dominant. It was the age of laboratory medicine (Jewson 1975). Histology and pathology were being examined and the cell was becoming the main focus of illness. The notion of the scientist was emerging. Darwin described the process of evolution and Koch and Pasteur discovered bacteriology (Weatherall 1995). The idea of the cell had been introduced as early as the seventeenth century but it was only with the arrival of microscopes that an actual theory evolved regarding the nature of the cell. The age of laboratory medicine was also greatly enhanced by the ability to analyse blood. Psychiatric medicine and Public Health Medicine also flourished in the nineteenth century (Weatherall 1995).

5.3 Theories of Disease Causation.

There are two aspects of interest which I shall discuss under the above heading. One is the individual perception of disease as being rooted in history and therefore difficult to change. This perception had a significant effect on the way we regard disease either in ourselves or in others. The second aspect relates more directly to a particular theory of the specific aetiology of disease whereby disease is caused by one particular force.

It could be argued that many of the attitudes held today relating to how we perceive disease and how we regard those suffering from various diseases are based in much earlier ideas. These attitudes have implications for health education and promotion (Ch.11.5). If we consider some of the most modern diseases such as AIDS we see that the attitudes towards this do not stop at knowing the cause of the disease and there is a sense in which the sufferer is alienated and isolated.

The idea of a specific organism, a germ or a virus being responsible for a disease seems to be just as popular as it was two centuries ago . The idea of 'catching' a cold or an infection is one of the most prevalent public responses. The fear of 'catching' a disease even extends to those diseases not caused by invading bacteria or viruses . It is not uncommon for people to fear contracting cancer in this way. This set of beliefs may be one way employed by individuals in distancing themselves from the disease .

Because of the apparent stigma even in modern times attached to certain diseases it is interesting to consider attitudes to disease historically. As previously stated the idea of illness being due to disharmony was common from the time of the Greeks. Great emphasis was placed on the idea of harmony of mind and body. Disease was considered to be something which interfered with the idea of human perfection. In Plato's 'Republic' reference is made to the undesirability of cripples or children deformed at birth and the fact that these were destroyed (Plato). Similarly in the Middle Ages epidemics were often perceived as punishment upon men (Sigerist 1943).

Until this century mental illness was regarded as some kind of flaw in the individual as evidenced by the large number of long-stay patients in the Victorian institution admitted for purely social reasons such as teenage pregnancy.

Christianity changed the perception of the sick as inferior and also introduced the concept of caring beyond the realm of the immediate family. It became the duty of man to care for his fellow human beings. This situation was helped by the fact that in the Middle Ages most physicians were clerics and financially supported by the church (Sigerist 1940).

The idea that disease originates from a single cause can be traced to the eighteenth century to the work of Bretonneau. Bretonneau claimed that specific diseases are caused by an organism which is transmittable. This idea was demonstrated in the existence of various fevers such as diphtheria and scarlet fever which were rife in Europe at the time. Tuberculosis for example was identified as being due to the tubercle bacillus (Bretonneau 1892). Labels could then be attached to diseases and so categorisation according to signs and symptoms was possible. The body was seen as a machine whose parts were subject to faults at various times and under certain circumstances. Patients on the whole were viewed in terms of their particular disease label, and emotional factors were largely ignored.

Although this new conception of disease was a breakthrough at the time it was later revealed that there were other factors to consider. It became clear that not all diseases could be accounted for in this way and also that there were various ways in which these agents affected different individuals. The response to disease is therefore' individual' and is influenced by hormonal and emotional factors. Many recent studies reveal the mechanism by which emotion influences the immune system (Watkins 1995). This is seen in the aetiology of the repeated common cold for example. A more extreme but none the less accurate example of how an alteration in biochemistry can affect the individual is seen in the 'broken heart syndrome'. Here a sudden shock such as death of a spouse can trigger cardiac damage or even death in response to a chain of chemical changes (Nixon 1993).

The idea of specific aetiology remains important in modern medicine but is constantly being added to as new theories emerge. The idea of the body as analogous to a faulty machine has been overtaken by a more holistic approach as the influence of the mind in physical disease is being increasingly acknowledged. The ancient ideology of the healing power of nature is undergoing a revival particularly in the alternative therapies. This is due in part to a growing dissatisfaction with the medical model as well as the desire of consumers to have more control over treatment.

5.4 Social and Environmental Influences on Health.

In this century of sophisticated medical technology and research the idea of multiple causation of disease has gained ground. Factors other than actual disease pathology and degeneration are thought to play a major role. This is of course moving away from the medically-controlled view of disease and towards a more holistic approach. Some factors appear to be more popular topics than others. The effect, for instance, of unemployment on health tends to be ignored as evidenced by the lack of funding and government support for projects of this nature. Stress on the other hand receives much attention both in the media and in terms of research. Environmental issues are frequently pushed forward by interested groups with limited success.

Proponents of the social and environmental influences on health and disease appear on the whole convincing. Rene Dubos has written extensively in this area. According to his theory everyone carries the potential for any disease at all times. However through circumstances which vary with each individual, some will become ill while others, similarly situated, will not. Dubos does not deny the physical basis for disease but rather that this physical base must be triggered by events external to the individual. Some of the external factors are: weather, drugs, overcrowding and pollution. (Dubos 1965).

Sigerist has also written on the social aspects of health and disease. He believed that throughout history health and disease were intimately related to wars and famines as well as culture, religion and philosophy. He saw certain diseases as being a manifestation of particular time periods. The Middle Ages for example was a period of collectivism and the dominating diseases were of a collective nature eg. Leprosy and plague which attacked large groups of people. In the individualist Renaissance period syphillis was a major threat to health - a disease which was definitely contracted individually. The Baroque period was characterised by contrasting patterns of disease. On the one hand there were deficiency diseases and on the other the diseases of affluence such as gout and dropsy (Sigerist 1943). If we consider the so-called lifestyle diseases of the twentieth century we can see that Sigerists observation is accurate and that progress in economic and social terms may be at the expense of individual health. This theme is illuminated by Illich (Ch.9).

Those who favour the idea of a link between environmental and social factors to various diseases can justify this view with epidemiological proof and statistics of increased life expectancy. However these studies tend to deny any positive influence by medical science and this view therefore seems unbalanced. It is accepted that factors such as clean water supplies and generally improved living standards have contributed in the elimination of those diseases linked to over-crowding and poor nutrition. However new diseases such as AIDS have been identified due to scientific and laboratory advances and clinical investigations.

One critic of the medical model of health , McKeown argues that too little attention is paid to preventable causes of disease and public health in general. Many diseases he argues can be traced to early stages of evolution. (McKeown 1988). More recent research shows that apart from the effects of the particular environment into which we are born, some diseases such as cardiac disease can be pre-determined by inadequate nutrition in pregnancy and are therefore preventable. Yet more studies are in progress exploring the idea of genetic predisposition for certain conditions. The question of why some individuals succumb to heart disease when there appear to be no risk factors while others with more than one do not continues to puzzle experts (Weatherall 1995).

Clearly then the cause of disease is not confined to environmental factors and new evidence continues to appear to support this view. Furthermore, changing patterns of disease may be linked to the increased life expectancy so that a greater diversity of disease is now seen in the elderly population.

5.5 Individual Responsibility for Health.

I have considered the individual origin of disease and the social and environmental factors which influence health. There is another area which has gained momentum in recent years in relationship to individual health. This is the idea of individual responsibility for some diseases. This aspect is more complex than it seems and is bound up with political, economic and moral issues. At the simplest level we can observe that in recent decades a

trend emerged whereby sufferers of certain diseases were confronted with the knowledge that particular lifestyles resulted in either disease or some form of debilitating illness. At first this seemed to be confined to the so-called habits of addiction such as smoking, drinking and drug-taking. Health education programmes aimed to supply the public with information about these substances as risk factors to health. These campaigns have had little effect as statistics show: about thirty percent of all adults smoke cigarettes and death due to smoking is responsible for about a third of all deaths in middle age (Weatherall 1995).

Smoking is but one example of victim -blaming and there are many supporters of this idea. Moral questions arise periodically as to whether such people should receive hospital treatment on the ground that their illness is self-inflicted. The argument used is that the person chose to continue his habit in spite of the known danger to health and therefore he chose to compromise his health. The important point to be drawn from this example is that other actors in the scene remain unaffected. Thriving tobacco industries and expensive advertising continue while governments remain passive. Blaming the victim diverts attention away from politics and economics towards the individual. While it is true that most people are aware of the dangers of smoking, and also true that efforts to discourage the habit have failed, the question remains why is this the case? Usually at this point reference is made to the inequality in health generally as identified in the Black Report which shows a higher rate of smoking -related deaths among the socially deprived and lower income groups (Black et al 1992). Clearly these are the groups which must be targeted in attempts to reverse the trend. However the fact remains that people must ultimately choose for themselves and many, because of various beliefs, attitudes and values will decide to continue.

If we consider other life-style diseases or diseases of affluence the picture is less clear. Obesity for example is often attributed to lack of exercise and over-eating. Again the individual is considered lazy and irresponsible. The food industry on the other hand continues to produce foods which are nutritionally unsatisfactory and the so-called health foods are more expensive and less easy to obtain.

Since the capitalist system depends on the cicycle of production and consumption a degree of speed of delivery is necessary for the viability of the manufacturing and production industries. Food which may be less satisfying due to fibre deficiency has a faster turnover and is therefore a primary aim of producers.

There are at least two aspects of the idea of individual responsibility which can be discerned. Both of these involve the relationship of the individual to the state. Each represents a particular political slant to the argument. The first is found in the conservative/right ideology which assumes that individuals ought to be responsible for their health. This view is rooted in the Victorian belief in self-help, self-reliance and hard work. It is the view emphasised and perpetuated by the Thatcher government. It is also the view which is firmly embedded in the American system of health and welfare. In this situation the state assumes the role of night-watchman (Nozick 1996). There may be a case for saying that this limited role of the state in health and welfare is satisfactory providing that those who need it have access to health care and to social security. The counter argument would of course be, that in promoting the desirability of limited state help the government is in fact denying responsibility towards the needy.

The second aspect of individual responsibility belongs to the leftist/collectivist ideology which via the Welfare State has made services available to all who need them. In this instance, the individual appears to have responsibility for his health but with a different focus. By this I mean that the state, having made these services available now recommends that they are utilised by the public. While the general perception may be that services are available for use, as and when they are needed, the situation is actually more complex In the first place it could be argued that certain vulnerable groups in society feel obliged to take up services. In the second place having done so they may then be regarded as 'victim citizens' (Green 1996). The paradox here is that the service was offered but somehow the user/recipient becomes part of the dependency culture. This is particularly relevant to social security recipients.

There is another way in which individual responsibility is reflected. This is where refusal to accept certain health services results in a negative perception of the client. The following example may serve to show how responsibility can be interpreted differently.

I shall use as an example the case of childhood immunisation. It emerges that a whole system of rules and government guidelines are involved here;

1. Government issues guidelines as to desirability of specific immunisations.

2. Health Education departments and the media make this information available to the public,

3. Professionals encourage uptake of the service providing the public with facts relating to the diseases in question. To all intents and purposes the client is left to decide for himself. However those who decide not to opt for immunisation will have that information recorded (and possibly held against them in some future encounter). I have said (p69) that professionals are agents of the state and in a sense are controlled by it. This example shows that in state provided services the element of decision-making is to some extent taken over by the state and the individual is responsible only if he accepts the advice and conforms to the rules.

Individual responsibility for health can therefore be interpreted in a number of ways. Whether the individual is assumed to be responsible or whether this is imposed upon him, either way there is tension.

5.6 Health in the Community.

So far the discussion has focused health in relationship to the individual. But the concept of early public health and the subsequent development of community medicine is highly relevant. The fact that individual health and public health are usually regarded separately is of interest and serves to illustrate my earlier point that the concept of health is multi-faceted and complex and always subject to compartmentalization. Even the WHO definition of health (p3) distinguishes physical from mental health while at the same time attempting to portray the idea of 'total' health. So on we must be aware of artificial divisions while at the same time thinking 'holistically'.

Just as we distinguish elements of health in individual terms similarly we think of public health as historically related to various government measures to improve aspects of social health. Community health tends to be linked to medicine as carried out in the community although it is in fact an extension of early public health. The notion of community health creates a more global view of the health of local communities and the measures involved in promoting and maintaining it. It distinguishes the social setting from the hospital environment.

If we consider the early history of public health we can see that in the eighteenth century public health policy was mainly aimed at controlling infectious disease. From around 1800 the effects of industrialisation were more obvious and there was no government control over child labour and excessive working hours. Engels has provided an insight not only into the exploitation of workers, but also into poverty and disease during this period. From the point of view of health Engels notes that the average working man was deemed unfit for work at forty five due to the nature and severity of factory work (Engels 1892). The Factory Act of 1833 improved this situation (McKeown and Lowe 1977).

In both Britain and the United States similar public health policy was enforced around the same time. The 1848 Act was the first real attempt to improve the general environment. More clauses were added in 1875 when most essential features of environmental control came into effect. These included: water supply, sewage disposal, isolation hospitals and the beginning of housing control (McKeown and Lowe 1977). From 1900 onwards there was continuous improvement in hospital services and a very small community health provision was supplied by some general practitioners.

The issue of poverty as a possible cause of ill-health was not admitted until the end of the nineteenth century when recruits for the army were found to be in poor physical condition. Various studies were carried out by Booth and Rowntree to investigate this. It appears that the idea of poverty, though prevalent, in reality was not widely publicised within Britain or outside. Newspaper reports of that period create the impression of tranquillity and relative

prosperity (Marshall 1979). When Alexis de Tocqueville visited England in 1833 he wrote down his first impression.....

'Magnificently maintained roads, clean new houses, well-fed cattle.....the most refined and gracious standard of the basic amenities of life to be found anywhere.' .....Now look more closely at the villages; examine the parish registers and you will discover with indescribable astonishment that one-sixth of the inhabitants of this flourishing kingdom live at the expense of public charity '(Tocqueville de 1835).

Once the problem of poverty was acknowledged progress was made towards dismantling Poor Law legislation.

The issue of poverty has continued to challenge governments up to the present time . The various reforms effecting public health and community medicine are discussed in chapter 8.2.

5.7 Conclusions.

1. No definition of health can be entirely adequate due to the complexity of the concept. For purposes of policy-making the WHO definition remains the most satisfactory. Though criticised for its utopian statement it does however make a distinction between positive and negative health.

2. The idea of specific causation of disease has made a significant impact in the understanding of certain types of disease. Lay people continue to claim that many diseases whether bacterial or viral in origin can be 'caught'. This perception has contributed to the stigmatising effects of some diseases such as AIDS.

3. The stigma associated with some diseases can be alleviated to some extent by correct diagnosis. The case of Myalgic Encephalitis is used as an example to show how 'labelling' a condition in medical terms legitimises it in the eyes of the patient and may even contribute to its cure.

4. The fact that some individuals succumb to particular diseases while others in similar circumstances do not, continues to puzzle medical scientists. It is recognised that factors such as environment and social factors can influence health. More recently additional information has shown that individual potential for certain diseases such as heart disease can be predicted prior to birth.

5. The notion of individual responsibility for health is growing in popularity. Tension can be identified in the various implications of this. The government can be seen to avoid responsibility while the individual assumes it. At the same time industries such as the food and tobacco manufacturers stand to profit from substances which constitute a threat to health.

6. Lifestyle diseases which are often a direct result of affluence, have evolved from progress in the widest sense which paradoxically aimed to improve the quality of life. Even for those who are not affected in this way there are other ways of achieving victim status. Physical fitness has now become a profitable business. Teenagers in particular may be impressionable as to the ideal type of body. In this way eating disorders can also be seen as a problem associated with progress.

7. Historically there has been a distinction between public and individual health. Early public health measures were geared towards collectives where epidemics had to be controlled. Public health today focuses mainly on environmental conditions.

References

Aronowitz RH. 'From Myalgic Encephalitis to Yuppie Flu: A History of Chronic Fatigue Syndrome'. In: Rosenberg C, Golden J. (eds). **Framing Disease : Studies in Cultural History.** Rutgers, New Jersey University Press, 1992;pp170.

Black D, Morris C, Townsend P. 'Towards an explanation of health inequalities'. In: Townsend P, Davidson N, and Whitehead M. (eds). **Inequalities in Health: The Black Report: The Health Divide**. Penguin Books, 1992.

Bockington F. **World Health.** Pengiun Books, 1958;pp16-17.

Bretonneau P. 1892. 'Bretonneau et ses correspondents'. Quoted by Major RH. in: **Classic Descriptions of Disease**, Illinois:Charles C Thomas, 1965,156-8.

d' Iribarne P. 'The Relationships Between Subjective and Objective Well-Being'. In: Strumpel B (ed). **Subjective Elements of Well-Being: The OECD Social Indicator Programme**:, Paris:OECD, 1972; 34-35.

Downie RS, Tannahill C, Tannahill A. **Health Promotion: Models and Values** 2nd Edition, Oxford University Press 1996; pp19-20.

Dubos R. **Man Adapting,** New Haven:Yale University Press 1965; pp247-253.

Engels F. 1892. **The Condition of the Working Class in England.** London:Panther 1969; pp137-138.

Green D. **Community without politics. A Market Approach to Welfare Reform.** London: IEA Health and Welfare Unit, Choice in Welfare, No 27. 1996.

Jewson ND. 'Medical Knowledge and the Patronage System in Nineteenth Century England'. **Sociology,** 1975;83: 309-85.

Marshall TH. **Social Policy In the Twentieth Century**, Hutchinson of London, 1979.

McKeown T, Lowe C. **An Introduction to Social Medicine.** Oxford:Blackwell. 1977.

McKeown T. **The Origins of Human Disease.** Oxford:Blackwell, 1988.

Morgan M, Calnan M, Manning N. **Sociological Approaches to Health and Medicine**, London:Croom Helm, 1985;pp12.

Nixon PFG. 'The Broken Heart'. **Journal of the Royal Society of Medicine**, 1993;86 (8) 468.

Nozick R. **Anarchy, State and Utopia.** Oxford UK, Cambridge USA: Blackwell, 1996.

Plato **The Republic of Plato.** Translated with Introduction by Francis MacDonald, Cornford, 20th printing 1962 Oxford University Press, New York and London, V 460.

Richman J. **Medicine and Health,** Longman UK Ltd. 1987.

Rosenberg C. 'Framing Disease: Illness, Society and History'. In: Rosenberg C, Golden J. (eds). **Framing Disease: Studies in Cultural History**, New Jersey:Rutgers University Press, 1992;xxi.

Sigerist HE. 1940 'The Social History of Medicine'. In: **Henry E Sigerist on the History of Medicine** Ed. Marti-Ibanez 1960. New York: MD Publications, p27.

Sigerest HE. 1943 **Civilization and Disease,** University of Chicago Press, Chicago, p186.

Telfer E. **Happiness.** London :Macmillan, 1980; pp37.

Tocqueville A de 1835 **Memoir on Pauperism** Translated by S. Drescher: Rediscovered Riches No 2: May 1997, p 17-18, IEA Health and Welfare Unit, London.

Watkins AD. 'Perceptions, Emotions and Immunity: An Integrated Homeostatic Network'. **Quarterly Journal of Medicine**, 1995;88: 283-284.

Weatherall D. **Science and the Quiet Art Medical Research and Patient Care.** Oxford University Press, 1995.

WHO (World Health Organisation) **Constitution.** New York:WHO,. 1946

Chapter Six: The Concept of Welfare.

6.1 Introduction.

In chapter 1, I introduced the concept of welfare in the context of its use particularly in relationship to the Welfare State. I suggested that the origin of the idea of using the term welfare in connection with the state was uncertain. Welfare as a general term also emerged as ambiguous and with a wide range of implications (p6). Recognising these difficulties and attempting to locate 'welfare' on a map in relation to other concepts such as health I shall now endeavour to analyse the concept of welfare in the sense in which it is usually regarded, that is in terms of delivery and distribution of certain services. I shall be concerned mainly with the moral basis for welfare services and the extent to which these are grounded in issues such as rights, needs or philanthrophy. If we look at the history of welfare we can see that a trend evolved over the centuries which crudely moved from charity to need to rights.

In considering the moral basis for welfare it is clear that the concepts of charity, need, and rights have all been the subject of controversy throughout the history of the Welfare State. It emerges that whether welfare is based on need, rights or charity none of these is entirely satisfactory, and therefore the merits and demerits of each must be spelled out if welfare as a manifestation of citizenship is to be understood. The most satisfactory situation may be to opt for the fulfilment of basic need where the meeting of a need becomes a right.

The charge by individualists against collectivists that the Welfare State, particularly social security as a right, has created an 'entitlement culture' cannot be ignored. According to this charge there is a tension between the idea of 'rightless duty' as portrayed in the days of pre-welfare philanthrophy, and the 'dutyless right' which it is argued has resulted from state welfare (Green 1996). The bases of this charge are grounded in exploratory studies on poverty both in the United States and in Britain which aimed to prove that far from

eliminating poverty state welfare has in fact led to family breakdown and a general demoralisation of society (Murray 1994, Green 1996, Mead 1997).

Recent reforms in health and welfare services in Britain have attempted to augment the old conception of welfare in its nanny state capacity by various devices. One is the introduction of quasi-markets into public services. The other is by appealing to the concept of citizenship. The introduction of quasi markets into public services are still in the process of evolution. I shall begin by considering welfare in its historical perspective. I am concerned here with the concept of welfare generally up to the time of the Welfare State. The evolution of the Welfare State itself is the subject of Part Three of the thesis (Ch.8.1).

Many commentaries on the history of welfare begin with an analysis of the Poor Law, the reasons for it and the effects of it. It is from this that the idea of deserving and undeserving poor evolved. However it is interesting to note that before the Poor Law of 1597 there existed a system of charity and the relief of poverty known as the 'dole'. This usually took the form of gifts of money or food distributed at the funerals of rich men or other social gatherings. In this medieval system there was no judgement or question of desert. Unfortunately this system attracted many who were unemployed and even then the idea of dependency was apparent (Jordan 1959).

The Poor Law aimed to remedy this situation and to ensure that only those in need received help. At this time the social aspects of poverty were beginning to gain recognition. The plight of the poor was highlighted by the economic and religious changes of the time. The destruction of the monasteries by Henry V111 and the decline of agriculture brought the problem of vagrancy and poverty to the fore (Marsh 1980). Some historians reject the idea of abolition of the monasteries as a major cause of poverty. Instead it was a consequence of the change from arable to pasture land as well as massive inflation due to the import of precious metals which were to blame (Fraser 1984). Whatever the true causes it is clear that poverty and vagrancy were established facts at this time.

Reminders of the conditions attached to the Poor Law show that the stigma suffered by recipients, the control exercised by authorities and the intervention into peoples' lives are indeed rooted in history. Also, although the idea of welfare rights had not yet been

considered, the Poor Law illustrates that for every benefit there is a restriction and even then recipients were denied other rights . In many cases the immediate relief of poverty was traded for other rights. In his work on the subject, Fowle cited three main objectives of Poor Law legislation:

1. relief measures to support the indigent,
2. repressive measures to put him down, and
3. remedial measures to prevent the abuse which was likely to arise from state relief (Fowle 1890).

Apart from the segregation of the deserving from the un-deserving poor the Act also shows that poverty was now being regarded as something to be dealt with at a social level i.e. by individual parishes and not by the church as had previously been the case (Whelan 1996). The Poor Law was strictly a safety net for times of emergency (not unlike Beveridges vision of the early Welfare State.

Alongside the Poor Law charitable organisations were very much in force. In fact the Statute of Charitable Trusts was passed in the same year as the poor Law 1597. The purpose of the Statute was merely to guarantee benefactors that gifts would be used in accordance with the law. Acknowledgement of this fact is important because it provides evidence of the presence of philanthrophy always running parallel to any other form of aid. The charitable organisations were distinct from the mutual aid societies such as the Friendly Societies which came later and whose philosophy was based on people helping each other in times of need.

The nineteenth century was the time when charity was most evident. The average middle class family gave ten percent of its income to charity. There was no socially disadvantaged group without a charity to support it. Charities including the voluntary hospitals employed twice as many workers as the Poor Law institutions (Whelan 1996). In the presence of a laissez-faire economy citizens effectively kept state intervention to a minimum by helping their fellow citizen in any situation.

The most frequently asked question with regard to this degree of altruism is 'why'. What was the motivating force?. The idea of the minimal state is obviously a plausible explanation though not a sufficient one. This is borne out by the fact that charity seems to have been more deeply entrenched in individuals than might be the case if lack of interference by the state was the only motivating factor. In fact it was the rejection of Calvinism and the return to evangelical practice which were instrumental in this situation. The idea of sin was an important factor and philanthrophists took on the task of saving people from hell (Whelan 1996).

The other question which is of interest is the degree to which people were willing to accept charity. There appears to be little in the way of commentaries on the idea of stigma in respect of this early form of charity. This however may be because the alternative system--poor relief via the Poor Law was known to be ruthless in its distinction between paupers, poor and idlers. Charity of the kind described must then emerge as relatively benign and the idea of stigma irrelevant.

A more idealistic version of a reason for the strength of the ethos of charity is embodied in the view that charity among people enhanced the feeling of solidarity of community. This was consistent with the philosophy of individual and family responsibility with the state in the background. This is what Green calls 'community without politics'. There was also according to Green a sense of 'duty without rights'. The rich were seen as having a duty to help the poor (Green 1996).

Having put the concept of welfare into historical perspective I shall now consider in turn how far claims to welfare can be grounded in charity, needs or rights.

6.3 Welfare Based on Charity.

The idea of charity and mutual aid is particularly relevant to modern citizenship if we accept the idea of 'neighbour' as the most appealing of the three models discussed in Part One (Ch 3). However there are problems with charity as we shall see. It is accepted that the ideas of charity and altruism can and often do exist in communities among neighbours. In the Pauline sense of neighbourliness in which we are each one of another the idea of charity is

commendable. If however we are looking towards charity as means of welfare distribution for the population, or at least for those who require such services, then several issues must be considered.

Firstly, in order for charity to be accepted there is the assumption of need. Charity must then be mapped in relation to concepts, one of which is need. As we shall see in the next section (p64) need was, and still is the foundation stone of state welfare. The question which must be answered here is, how and why did charity which, as we have seen, was so deeply entrenched in the nineteenth century become eroded in the twentieth century? The main reasons for this change were:

1. The desirability of minimal state interference was now being revised.

2. The idea of the alleviation of poverty being the responsibility of citizens alone was difficult to maintain in the face of growing social problems and increased poverty.

3. Once the State became involved in education its role expanded, and as this happened there was growing public demand for action by the state. We can therefore say that state intervention did not entirely replace philanthrophy but it pushed it to a less prominent position (Whelan 1996). The importance of charitable and voluntary organisations was later endorsed by Beveridge who envisaged a strong role for them alongside state welfare (Beveridge 1948).

But what of the moral significance of distribution of goods based on charity and altruism? The idea was that welfare ought to be given by the state as a form of altruism on the ground that this would engender a sense of community (Plant et al 1980). However it is unlikely that this would constitute a strong case for creating a sense of community given the problems associated with the modern community and the acknowledged exclusive nature of these already referred to. Titmuss emphasised the case for giving as altruism without the need for welfare benefits. He spoke of the ultra-obligation and made his case based on his study of blood transfusion services. To explain the altruism he envisaged Titmuss looked to Tonnies study of the 'Gemeinschaft' and 'Gesellschaft' relationships. In the' Gemeinschaft' relationship (p53) gift exchanges were mutual with no strings attached. By

contrast the 'Gesellschaft' exchange was more contrived, '*Do ut des'(I give to you that you will give (*Titmuss 1970*).* Although this highlights the altruistic versus the egoistic perception of giving it does not make a case for saying that such giving increases the sense of community. As far as Titmuss's study on blood transfusions is concerned it would appear that this sense of giving differs significantly from other types of welfare benefit. This is because the idea of blood donation is unique. As Titmuss himself asserts it is blood which draws people together (Titmuss 1970). Titmuss placed great emphasis on the 'stranger' relationship whereby the idea of are gifts given where neither the donor nor the recipient are necessarily known to each other. The idea of extending this type of policy to recipients of welfare benefits might reduce the possibility of stigma which is clearly what Titmuss had in mind. However if there was a right to a particular benefit then the idea of stigma need not arise. Apart from his work on blood donation in which he emphasises the desirability of giving to strangers the extent to which this should be extended is vague.

From a philosophical point of view it is clear that if charity was the only means by which welfare was distributed then the most obvious problem might be with regard to deciding exactly how this should be done fairly. Given that some claimants are more vociferous and/or avaricious then the tendency might be for those with real need to be overlooked. There might also be a tendency for the charity to be abused so that the recipients used donations for pleasure rather than basic need satisfaction. In other words there would be no real way of knowing that the needy were benefiting.

That charity should not be the only means of helping the needy is not to deny its importance as an adjunct to other forms of aid. Proponents of pluralist ideology regard the part played by voluntary and charitable organisations as crucial to their plan. This point is developed in chapter 11.3.

6.4 Welfare and Need.

As I have already suggested the idea of need as a basis for welfare is rooted in history. From the earliest Poor Law to the evolution and development of the Welfare State need has been a central component and justification for state provision of services and particularly for

the input of the various charitable organisations. It is therefore relevant to look at this concept in a critical manner in order to ascertain whether need is indeed the most promising moral basis for welfare. This involves dissecting the term 'need' in various ways. There are six important points about the concept of need as it is ordinarily used.

1. The use of the term 'need' tends to trigger feelings. To say that someone has a need is to create a pro attitude towards the fulfilment of that need.

2. The second point follows from the first. Since the use of the term 'need' involves pro attitudes the term has a normative force conveying that someone ought to do something about fulfilling the need.

3. The term is 'instrumental' in that it suggests that the fulfilment of the need is for some further end, for example a ticket is needed to get into the theatre.

4. The term 'need' is sometimes used by welfarists in contrast with the term 'want'. But 'want' is also sometimes used as a synonym for need.

5. One of the problems associated with 'need assessment' (in the context of welfare and health), is that it tends to be carried out by a third party. It is therefore an objective view which does not necessarily reflect individual client need.

6. Finally, and particularly relevant to this thesis, the term 'need' is often pre-fixed with the adjective 'basic'. This illuminates all the points already made because to speak of 'basic needs is to involve very favourable attitudes. It is to suggest that someone, and particularly the state, ought to do something about fulfilling these needs and it is to suggest that the fulfilment of these needs is not just a matter of preferences but is necessary for a flourishing life. An important feature of need is the instrumental one, particularly the instrumentality of a flourishing life because this gives us something assessable and to some extent objective.

Let us consider these points in more detail.

6.4.1 Needs and Pro Attitudes.

The dictionary definition defines need as 'circumstances requiring some kind of action' (Oxford Dictionary 1978). But to need something is to invoke a number of feelings. Here the grammar of need is significant. Thus we speak of the 'needy,' 'individuals in need' or 'nations in need'. There is an underlying element to 'need' in this sense.

The emotional force of the concept of need is something which is learned at an early age. For example, even young children are capable of using the term in order to coerce or persuade an adult to provide a particular object. Children can also realise that in general the term 'need' elicits a more favourable response than 'want' since want can be dismissed as whimsical while need involves dialogue or argument and therefore more chance of success. To 'want' a pen with gold ink is less powerful than to 'need' it for a particular project. A pro-attitude is created from this appeal to need.

6.4.2 Need and Normative force.

Since the term need involves pro-attitudes there is a normative force inherent in the term conveying that something ought to be done about fulfilling the need. However there are those who disagree with the notion of the normative force being inherent in the term need itself and that it is in fact this normative force which lies in the 'end' or 'goal' for which the need is claimed.

6.4.3. Need as an Instrumental Concept.

In the case of both needs and wants it is necessary to identify the end or purpose for which the claim is made. It has been suggested that this is in order to make the claim intelligible so that having stated the need one must then say why he needs a particular thing (Plant et al 1980). If this is accepted as the instrumental sense of need then it would appear that this is highly relevant to welfare claims. In fact it is only at the point of identifying the instrumental sense of need, that is to say the purpose for which the need is claimed, that the

claimant has any significant part to play, in other words it is only then that the subjective sense of a particular need is taken into account. Thereafter it is the objective idea which takes over.

If we are concerned with welfare benefits then it seems appropriate to require a stated purpose for the need claimed and to work on the assumption that need is instrumental. This is in order to specify the precise nature of the need and what it is needed for. It has also be suggested that the reason for stating the end or purpose of the need is so that it can be justified (Barry 1965). This is particularly true of welfare benefits where specific needs can be fulfilled while others cannot.

Another argument frequently put forward in relationship to specification of needs is the notion of the harm which might ensue if certain needs are not fulfilled. This line of argument comes from the Aristotlean idea of human flourishing. This assumes that there is a state of flourishing which if an individual fails to achieve then he will suffer harm. This leads to the question of the nature of harm and the possibility that anyone can claim any state as producing harm since individual perceptions of harm vary. If needs are to be viewed in terms of potential harm, then it follows that almost anything could become a need.

6.4.4 Need and Want.

The distinction between need and want is not always clear. Yet the difference is important when distribution of goods is at stake. This is a complex area. Want can be both independent of need and closely related to it, so much so that the term need is frequently used instead of want. Various examples are frequently quoted suggesting that one can need something but not want it - medication for example. Equally one can want something but not actually need it, a new car for example.

The idea of want as a psychological state is a way of contrasting need and want (Benn and Peters 1959, Plant et al 1980, McTurk 1993). This type of statement is usually used to underline the fact that needs as opposed to wants are more likely to be identified or ascribed by another party whereas want relates to individual preferences. Many textbooks on welfare

suggest that wants are satisfied by the market while need depends on some element of welfare. However this association of markets with want and welfare with need in many ways oversimplifies the association between need and want. The notion of want being satisfied by the market is indeed part of the consumerist ideology in which the process of production and consumption maintains a state of permanent dissatisfaction so that new and better products will be wanted. This is also related to the relativity of need so that for example a commodity which is available to some will eventually be needed by all (Hoover and Plant 1989). But not all wants are satisfied by the market.

6.4.5 Objective Need Assessment.

The idea of need as a basis for distribution of welfare is problematic. It is interesting to note that Beveridge addressed the question of 'want' as one of his five giants. Let us consider the question of basic need fulfilment in relationship to welfare provision. Having stated the purpose of the claimed need the question arises as to whether the need ought to be met. In the case of a medical emergency the solution is clear. In other cases the issues are often difficult to decide. In the case of applications for certain benefits individual cases, in theory at least, are assessed individually, that is to say an individual's particular circumstances are taken into account. In reality it may be the client's ability to persuade the person in question of the force of his need claim. If on the other hand a more general assessment of need that is one applying to a whole community is being considered then it is unlikely that any one individual will be influential in deciding the outcome. The need for example for playgroups may be well recognised but the success or failure of the project depends on objective assessment. In all cases a judgement is required as to the value of the claim. This judgement invariably means professional judgement and this has caused problems. **Firstly** it shows that the subjective claim of need is unrecognised. Implicit in this is the idea that the individual is not the best judge of his own needs. **Secondly** it attributes the power of decision of outcome to professionals who may hold a very different set of values and cultural attitudes to that of the claimant. There are many examples of this in everyday practice and this criticism has been at the heart of the argument for participatory citizenship in which citizens have a 'voice' in relationship to the services provided and to the manner in which resources are allocated. This point is elaborated upon in some detail in my discussion

of the Oregon Experiment in chapter 11.2.1. In fact recognition of needs as rights is one of the main elements of the new consumerism.

It could of course be argued that in terms of allocating scarce resources some objectively defined criteria for need fulfilment is essential if the true needs of society are to be met. This statement calls into question the role of markets in a climate of decreasing welfare distribution by the state. Clearly a fully laissez-faire system cannot work in terms of need fulfilment. But there seems to be no reason why a combination of market and state provision could not be effective. This brings us back to the need versus want controversy. In some respects 'need' in the context of welfare provision is an unfortunate one. This is the view of Culyer who argues that need is too often used in an arbitrary sense (Culyer 1976). Beveridge identified want rather than need as one of his five giants yet the early system of social security aimed to satisfy need at its most basic level.

The concept of need it seems has received more attention in terms of welfare while want has been relegated to the domain of markets. Yet to the extent that the Welfare State has dealt with need the idea of want has been acknowledged. It could be argued that by emphasising the idea of safety net provision in times of need Beveridge and his successors were keen to ensure that want did not triumph over need (Beveridge 1944). Beveridge also emphasised the desirability of full employment thereby implying that wants should only be satisfied once basic needs were fulfilled.

Let us now consider the idea of distribution of services based on the idea of a right.

6.5 Welfare as a Right.

I have suggested that there are problems related to the concept of need as a basis for welfare provision. In considering welfare as a right we must take into account the fact that need and right in this context tend to merge together and that some needs will give rise to rights. The concept of a right must then be located in proximity to all other possibilities for the moral distribution of welfare services. Although the primary consideration is 'welfare rights' I would suggest that the whole idea of rights is of such importance in terms of their moral

foundation that to focus exclusively on welfare rights would not produce an adequate picture of why the idea of a right to welfare is controversial. In order to ascertain what type of right welfare might be it is necessary to locate it in relation to other rights such as human rights. The reason for this is that the idea of a right to welfare is entrenched in political, socio/economic as well as moral considerations. Indeed the question of whether welfare can be a right at all is also important.

In chapter 2 (p28) I introduced the idea of natural rights and their transition to what we now call human rights. I also distinguished between various categories of rights. For the purpose of this part of the discussion I shall address three specific points relating to rights. **The first** point addresses the question of what is achieved by a vocabulary of rights? **The second** point relates mainly to human rights and the various declarations of rights. **The third** point relates specifically to the right to welfare and questions a) whether welfare rights should be an extension of human rights and b) if not then to which category should they belong if any ?

My argument will be that welfare rights are positive claim rights. They are moral rights and in some states they are legal rights against the state. We can also see them as a subset of the 'social and economic' rights mentioned in the United Nations Declaration of Human Rights. As human rights they are not in the same category as rights to liberty, equality before the law etc. The latter are, in Cranston's terminology, universal, practicable and of paramount importance whereas welfare rights are ideals (Cranston 1973). None the less they are necessary conditions for a flourishing life and so can be seen as a kind of human right.

6.5.1 Justifying a Rights Vocabulary.

In recent years a language or vocabulary of rights has emerged. An important contribution to this vocabulary has been made by Hohfeld (1923). He distinguished claim rights, immunities, privileges and powers. An example of a claim right would be a right of a library to have book returned by a borrower. An immunity is the right of a tourist not to pay taxes. A privilege is the right of the master of the college to walk on the grass. A power is the right of a policeman to enter and search a building.

Claim rights can be analysed further as follows.

1. Some claim rights are negative and some are positive. A negative claim right is a right against the world to walk with hands in pockets. To have a claim right of this kind is to say that no one has a duty to stop me. Positive claim rights are rights against specific people for example, a library has a positive right against a book borrower who has a correlative duty to return the book on demand.

2. Claim rights can be moral or legal. They are legal if they are in a given set of statutes.

3. Rights can be actual or ideal. This distinction applies particularly to legal rights. Some legal rights are the rights which the people in a state actually have, but others are such that ideally they would have.

Using these distinctions we can now ask two questions.

1. How do human rights fit into this classification? And

2. How do welfare rights fit into the classification? and in particular are they a kind of human right?

Human rights are mixed. They are all claim rights but some are negative and some are positive, that is to say there are rights to liberty which are negative rights. These are the carrying forward of older documents of natural rights and the Rights of Man. These rights are what Cranston regards as universal, practicable and of paramount importance (Cranston 1973).

Other human rights are positive such as rights to health care, holiday with pay and the right to be given certain goods.

Human rights have an uncertain status. Many of them have been adopted by bodies like the European Convention of Human Rights and states who subscribe to this can be brought before these jurisdictions. For example the United Kingdom has been brought before the

European Convention for its treatment of prisoners in Northern Ireland. But it is clear that some rights (and this takes us on to the third point) cannot be legal rights because many states cannot afford to implement them. 3. These are the right to holiday with pay and free health care. They are clearly ideals rather than actual rights in some states.

It should be clear from this analysis that the language of human rights is confused because the rights belong to different logical categories. Let us now move on to the second question. How do welfare rights fit into this? A welfare right is a claim right against the state to be given certain goods or services. It is therefore a positive right and it is a legal right in the United Kingdom but not in other states. In these other states is it therefore an ideal? This is not absolutely obvious for some states, as we shall see. The United States, are very doubtful as to whether state welfare provision is an ideal. There is the suggestion that state welfare provision saps responsibility and manliness (p121). The same considerations will apply in considering whether welfare rights are human rights. If they are human rights they do not exactly fit Cranston's criteria. But on the other hand it is arguable that granting them is granting the necessary conditions for basic human flourishing.

Let us now consider in more detail the Declaration of Human Rights.

6.5.2 The Declaration of Human Rights.

What we now know as human rights are those listed in the 1948 Declaration of Human Rights. They range from the most general to the more specific. It is the very generality of these rights which has been problematic. In fact the 1948 document was flawed from an early stage with disagreement about what should and should not be included. Although the document finally emerged containing both negative and positive rights, in reality only the negative components have been widely recognised while the positive remain controversial. Earlier documents such as the English Bill of Rights enacted after 1689 and the subsequent French Declaration of the Rights of Man and Citizen were vague and abstract. Only the American Bill of Rights incorporating the various amendments which were part of the Constitution were more specific and detailed. This was because this document was to be translated into positive rights and enforced under American law (Cranston 1973).

The Declaration includes thirty articles, twenty of which are related to the more traditional human rights i.e. the right to life, liberty and the pursuit of happiness. The last ten articles are new social rights. These articles include the right to participate in government (article 21), the right to social security (article 22) and the right to equal pay for equal work (article 23) (General Assembly 1948). Article 25 is of particular relevance to a discussion of welfare, it states that:

'everyone has a right to a standard of living adequate to the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness and disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

It can be said that this is a human right to welfare.

We have already decided that according to Cranston's criteria welfare rights do not fit into the same logical category as the first twenty articles in the Declarations. Where then do they fit? There are those who would argue that there should be no right to welfare at all. Nozick takes such a view based on the highly individualist philosophy which is relevant to the system of health and welfare in the United States. In Anarchy State and Utopia Nozick says that there cannot be a right to welfare on the grounds that any claim by one group in society upon another is in effect a violation of property rights. This is because like Locke (p31) Nozick believes in the possession of property as of right. Whatever a man has made by his own labour is his unless he decides to give it away (Locke 1690, Nozick 1996). Enforcing a right by some against others is therefore a violation of this property right. Nozick rejects the idea of compulsory distribution as unjust but where it takes the form of charitable giving or philanthrophy then it is just. However we have already seen that philanthrophy on its own is not a sufficient basis for welfare distribution. In any case Nozick's view is flawed if we agree that welfare rights which would guarantee basic living conditions, are desirable and necessary for human flourishing.

Some might say that a justification for granting welfare rights is that it grants autonomy. Griffin, for example sees autonomy and well-being as a basis for rights (Griffin 1986). It

may be true that autonomy is a ground for welfare but there are two problems with using autonomy as a sole ground for welfare rights. Autonomy is neither necessary nor sufficient as a ground for welfare rights. 1. It is not necessary in that the non-autonomous eg the dying, the demented and the mentally handicapped also have welfare needs but they have no autonomy. 2. It is not sufficient because human autonomy is only one ingredient in a flourishing life. The granting of welfare rights is necessary for interest in sports and the arts which has little to do with autonomous decision-making but everything to do with a flourishing human life.

As far as well-being is concerned, to the extent that this is taken to imply human flourishing then well-being would appear to support the at least the necessity for welfare rights. Here there is a sense in which well-being is used as a synonym for flourishing. It appears to have a more modern connotation than flourishing. In the philosophical literature there are two views of well-being, one is the Epicurean view which comes from satisfying desire, but could be criticised on the grounds that human life is such that human desires cannot always be satisfied. The second view is the Stoic one which says that well-being consists in having as few desires as possible. Griffin regards well-being as the fulfilment of desires and as such suggests that well-being is necessary alongside autonomy for human flourishing (Griffin 1986).

A further confusion therefore surrounds rights in that we use modern interpretations for old terms. The right to welfare therefore should be based on need fulfilment. However this might also lead to a proliferation of new rights with corresponding duties upon the State to fulfill them.

If we take the view that welfare rights enable the fulfilment of basic needs and that these basic needs are necessary for a flourishing life (or well-being if we wish to use that term) then the case for welfare rights is clear. This is more or less the stance adopted by the British Welfare State as set out by Beveridge and Bevan. The problem is that not all states share this view and as we shall see the United States government is mainly opposed to a right to welfare. In opposing it many powerful arguments have been put forward. The problem of social welfare is portrayed as moral in nature. The perception is that welfare policies convey moral messages and in the case of welfare distribution the message is one

which endorses and encourages the idle, free-rider mentality. State dependency has led to a system of 'dutyless rights' (Green 1996). The idea of such critics of state welfare is that a certain behaviour has evolved in welfare recipients both in Britain and in the United States which has led to family breakdown and a lack of motivation to work. Far from enhancing community and fraternity the citizenship-orientated philosophy of empowerment via social rights has actually corroded these values.

Clearly these views belong to proponents of the market ideology who reject the idea of a right to welfare. Studies have been carried out which have aimed to prove that state welfare has failed to alleviate poverty. These studies were carried out mainly in America and have since been used to warn of a similar situation in Britain. A detailed account of American welfare is included in chapter 7.2.3.

Having discussed the moral basis for welfare and presented some of the counter-arguments of various welfare critics some conclusions can be drawn. These conclusions involve recognition of the significance of the three areas reviewed: charity, need and rights in relationship to welfare provision.

6.6 Conclusions.

1. Philanthrophy as a major form of poor relief constituted an alternative to the stigmatising Poor Law. It reached its peak in the nineteenth century but was gradually eased out in the twentieth century with the arrival of state intervention. In the context of pre-industrial communities the case for charity as a moral basis for welfare was strong since it served to enhance neighbourliness and solidarity. In the current political climate it can no longer stand alone as the main source of welfare distribution. There is however a strong case for its inclusion as a supplement to rather than as a substitute for state welfare.

2. The concept of need emerges as nebulous and complex as a general term. In the context of welfare provision it rests uneasily alongside the concept of want in an environment of tension between two competing forces--the market and the state.

3. While need may provide the strongest basis for welfare provision there are, nevertheless some problems regarding the assessment of needs. The main problem is that needs are assessed by a third party, usually a professional whose values and attitudes may differ from those of the claimant. The subjective recognition of need is therefore often ignored.

4. The idea of a right to welfare as an extension of other human rights fails Cranston's tests of universality, practicability and paramount importance. It is therefore agreed that welfare rights do not fit into the same logical category as the more traditional human rights.

5. The United Kingdom is one of a few states which accepts welfare rights as actual rights rather than ideals. Other states portray them as ideals because lack of resources prevent their actual fulfilment. Yet other states, and the United States in particular, see welfare rights as neither actual nor ideals, although it is important to point out that there are some individual politicians who are committed to such an ideal.

6. The allegation of a culture of dependency and 'dutyless rights' is part of the rhetoric of welfare critics. However these criticisms are based largely on studies undertaken on the lifestyles of American welfare recipients. They do not weaken the case for welfare rights but call for a reassessment of attitudes to welfare. In the United States in particular there is an inherent tension between the idea of wealth and poverty since it is doubtful that a balance can be struck between the two.

7. Overall it is concluded that the moral basis for welfare is not only reflected in but also depends on political will. The 'all or nothing' policies in Britain and the United States have failed to prevent the sense of public apathy and resentment towards welfare in general. There are grounds for optimism in the fact that all political parties now seem to recognise that welfare reform requires more than reducing cash benefits and that underlying problems must be addressed. Basic need fulfilment via a right to welfare is seen as desirable and necessary for a flourishing human life.

References

Barry B. **Political Argument.** Routledge & Kegan Paul, 1965;pp 48-49.

Benn SI, Peters RS, **Social Principles and the Democratic State.** London:George Allen & Unwin 1959;pp142-144.

Beveridge W. **Full Employment in a Free Society.** London: Allen & Unwin, 1944.

Beveridge W. **Voluntary Action.** London:Allen & Unwin, 1948.

Cranston M. **What are Human Rights?** London:The Bodley Head Ltd, 1973;p p65-71.

Culyer AJ. **Needs and the National Health Service.** Oxford:Martin Robinson, 1976.

Fowle TW. **The Poor Law.** London:Blackwell, 1890;pp17-18.

Fraser D. **The Evolution of the British Welfare State,** London:Macmillan, 1984;pp32-33.

General Assembly of the United Nations. **The Declaration of Human Rights.** Dec. 10th 1948.

Green D. **Community Without Politics: A Market Approach to Welfare Reform.** Choice in Welfare No. 27, London:IEA Health and Welfare Unit, 1996.

Griffin J. **Well-Being. Its Meaning, Measurement and Moral Importance,** Oxford: Clarendon Press, 1986.

Hohfeld WN **Fundamental Legal Conceptions: as applied in Judicial Reasoning and the Legal Essay,** Yale University Press, 1923;pp10.

Hoover K, Plant R **Conservative Capitalism in Britain and the United States: A Critic Appraisal,** London: Routledge, 1989.

Jordan KN. **Philanthrophy in England 1480- 1660**: A Study of the Changing Pattern of English Social Aspirations. London:George Allen & Unwin, 1959;pp55.

Locke J. 1690 **Two Treatises of Government,** by Peter Laslett 1963 Mentor, New American Library.

Marsh DC. **The Welfare State** Concept and Development. London:Longman, 1980;pp2-3.

Mead L 'From Welfare to Work: Lessons from America'. In: Deacon A. (ed) The IEA Health and Welfare Unit, **Choice in Welfare** No.39. London, 1997.

Murray C. **Underclass: The Crisis Deepens**. London.:The IEA Health and Welfare Unit, Choice in Welfare Series No.20, 1994.

McTurk LM. **Equity and Efficiency in the Management of Health Care Research,** Glasgow:PhD Thesis, 1993;pp129-130.

Nozick R. **Anarchy, State, and Utopia.** Oxford UK:Blackwell. 1996;pp27-29.

Oxford Dictionary. In: Sykes JB. (ed). **The Oxford Dictionary of Current English.** London: Clarendon Press, 1978;pp584.

Plant R, Lesser H, Taylor-Gooby **Political Philosophy and Social Welfare,** London: Routledge Kegan Paul, 1980p20-24.

Titmuss RM. **The Gift Relationship: From Human Blood to Social Policy**, New York: Pantheon Books, Random House, 1970;pp211-212.

Whelan R. **The Corrosion of Charity: From Moral Renewal to Contract Culture.** Choice in Welfare Series No. 29. London: IEA Health and Welfare Unit, 1996.

*Note: The discussions on 'needs' and 'rights' owe much to a number of helpful exchanges with Professor RS Downie.

PART THREE:

TWO SYSTEMS OF WELFARE AND HEALTH

AND THEIR CRITICS.

Page

PART THREE : TWO SYSTEMS OF WELFARE AND HEALTH AND THEIR CRITICS.

Introduction to Part Three.

Having discussed the concepts of health and welfare in chapters 5 and 6 I shall now consider these two concepts in relationship to two specific systems. These are the United States and the United Kingdom respectively. In tracing the history and *modus operandi* of these two ideologically opposite systems it will emerge that there are tensions in each system both independently and when any attempt at comparison is made. I have already shown that tensions exist in the context of the three models of citizenship discussed in Part One. Each of the three models the Consumer-Centred Model, the Neighbour-Centred Model and the Client-Centred Model have direct links with these two systems of welfare and health. These links can be assumed on the grounds that:

1. Welfare and health are major components of the notion of citizenship, and

2. The particular tensions identified within the citizenship models are readily identifiable within the health and welfare systems to be discussed.

After discussing and critically analysing the two systems mentioned above there will follow two critiques. These critiques will be from the views of Ivan Illich and a Marxist perspective. The main aim of these critiques is to enable a wider perception of tensions in systems of health and welfare. I have already identified specific tensions both in the models of citizenship and in my discussion of health and welfare. The critiques will endeavour to reduce these tensions to a more manageable form. Illich and Marx have been chosen as a means to this end.

Some of the tensions identified in earlier chapters can be seen as politically based, while others had social or economic foundations. Illich draws attention to the defects of modernity in general. He therefore provides a tool for discussion of the tensions arising

from what I shall loosely call 'progress'. Again this wide perception can include many tensions in health and welfare.

Clearly it would be impossible to cover all the intricacies of the Marxist doctrine where health and welfare are the main foci of attention. Rather this critique will serve to identify aspects of particular interest and relevance each of which touches on a core element of Marxism. The elements chosen from Marxism will act as compartments into which lesser tensions can be placed. If for example we take capitalism as a system criticised by Marx we find that some of the tensions already isolated fall neatly into specific compartments.

The two elements from Marxism chosen to highlight tensions are alienation and exploitation. Each of these are seen by Marx as defects of capitalist systems. To the extent that welfare systems in the United States and the United Kingdom belong to the capitalist economic system then the marxist criticism is relevant.

Let us begin by reviewing the systems of health and welfare in the United States of America. It will emerge that at the point of evolution of both the British and American systems there were differences, even opposite political/philosophical ideologies. Later on there appeared to be some similarities when the Great Society Projects were undertaken in the early to mid nineteen sixties. This was the period when the United States seemed commited to replicating an element of the British system. Then in the early nineteen eighties the trends were reversed. The British system during the Thatcher regime introduced a market-orientated strategy which resembled similar strategies in operation in the United States. In fact, since that time there has been a gradual move towards a more Americanised system in Britain. The two conservative governments looked to America for possible solutions to what they perceived as an inefficient, wasteful health service and a dependency-creating welfare system. The New Labour government promises to continue this trend particularly in the field of welfare benefits in respect of which there has been liaison between Mr. Blair and Mr. Clinton and between Ms Harman the Secretary of State for Social Security and her equivalent in the state of Wisconsin. The idea of promoting work rather than welfare is central to the latest reforms (Mead 1997).

Chapter 7 Health and Welfare in the United States.

7.1 Introduction

Health and Welfare in the United States can be seen as part of the consumerist, individualist market-based philosophy. From a philosophical point of view there are several questions of interest, the most cogent being: Why has this rich capitalist state remained so far behind other western countries with regard to health care in particular? This critical analysis of the system aims to explore some of the reasons for this situation, and in doing so to uncover tensions in the system. Some of these tensions have already been identified in the context of the models of citizenship (Part One). Other tensions will be more specific.

It is important to note at the outset that efforts have been made at various stages to remedy the health-care problem of the lack of insurance coverage for a substantial number of people. The most recent attempt was via the Clinton Health-Care Bill, which as we shall see failed for a variety of reasons.

Since the creation of the New Deal in the nineteen thirties by President Roosevelt, subsequent presidents have attempted to revise or improve the systems. Apart from President Johnson's Great Society Project in the sixties little improvement has been observed. Then during the conservative years of the Reagan and Bush administrations the whole concept of welfare was seen as a major cause of the economic problems of the country.

In attempting to explain and at the same time condense what is a complex situation the following points show clearly the decline of health care in the United States. Some of the statements are derived from a survey by the New York Times in the run-up to the campaign for the Clinton Health Bill.

The following facts are relevant:

1. Most Americans have health insurance coverage via their employment or via Medicare or Medicaid if they are elderly or poor (Eckholm 1993).

2. Thirty seven million, that is one in seven, have no cover and many more have such limited cover as to be unable to deal with any unforeseen circumstance or emergency (Eckholm 1993).

3. From the period 1980-1992 the proportion of people with no cover rose by 22%, while the profits of the pharmaceutical companies and the salaries of doctors increased significantly. In 1992 doctors earned 6.9 times the average wage (Navarro 1994).

4. In the United States the corporate class which controls the insurance industry exercises powerful influence financially, on members of congress who sit on committees legislating on health care policy. This process of funding is called Political Action Committees or PACs, and in 1991 $60 million via this system was donated to lay members on health care committees in congress (Navarro 1994). These PACs are seen by some as a way of buying citizen participation in government (Etzioni 1995).

5. According to a New York Times poll in 1992 Congress reflects the interests of the powerful economic groups and not those of ordinary people (Navarro 1994).

6. In the 1992 elections only 50% of those eligible actually voted and half of these were from the upper socio-economic groups (Navarro 1994).

Bearing these facts in mind let us now consider the background which has led to, or perpetuated this situation.

7.2 The Background.

Based on the literature and on the author's experience of living and working in the in the United States it would appear that America's unique history and development are crucial to the way that health and welfare services are understood and delivered. In

chapter 3, I outlined the specific problems related to culture and attitudes encountered by the earliest settlers. The entrepreneurial spirit and the strong work ethic inculcated in these settlers from various parts of the world by themselves, and by the early Puritan founders has spilled over and filtered down through the centuries to the present day.

Three strands can be identified to demonstrate the particular ideology of which health and welfare systems are a part. These are:

1 A particular view of the state which is rooted in the individualism of the early colonies and promoted by the founding fathers of America.

2. A particular view of the individual in the context of the capitalist state.

3. Following from these two, there emerges a particular view of the concept of welfare provision and health care which places the responsibility for both firmly in the hands of citizens rather than the state.

7.2.1 The Legacy of Early Individualism.

The notion of a 'good state', one which is perceived in a positive way by its citizens, conflicts with the idea of a welfare state. The argument is that the welfare state challenges the adequacy of a limited state. In a society where liberty is associated with limited government, the Welfare State is seen as a threat to liberty. '*A citizen who is dependent on the state, therefore, is not free from it.*' Whereas dependence on family and community is seen as acceptable, state dependence is seen as undermining self-respect (Marmor et al 1990). Viewed from this perspective it is easy to see how the term 'welfare' has derogatory connotations. To be in receipt of welfare is synonymous not just with poverty but with being in some way incapable of managing one's own life. This is clearly anathema to the individualist frontier mentality which prides itself on self-reliance and independence. This is all part of the individualism which typifies American life at every level. As we have seen in chapter 3 (p26) there has always been

an inbuilt suspicion of government interference, and a belief that whatever one possesses has been worked for by oneself. The idea of self-reliance is part of this individualism. Again this trait is historical. The Puritans were self-reliant and their influence affected the early colonies. Thomas Jefferson preached self-reliance and he even made reference to it in his draft of the Declaration of Independence (Bellah et al 1996). The individualism associated with American culture was first identified by Tocqueville in 1835 when he used the term 'individualism' to describe his personal observations of the way Americans lived and worked. Tocqueville saw the individualism as stemming from Benjamin Franklin who had promoted the importance of initiative and getting ahead by hard work and a desire for self-improvement (Tocqueville 1835).

The kind of individualism promoted by Franklin has been called utilitarian individualism where each individual fought to provide for his own interests. By primarily looking after his own particular interests the interests of all would automatically be taken care of (Bellah et al 1996). Undoubtedtly a strand of this early form of individualism has been retained throughout history.

7.2.2 The Individual in the Capitalist State.

The early form of laissez-faire and individualism in the free market was briefly interrupted in the nineteen sixties by the Welfare Liberalist ideology in which the concept of welfare seemed to flourish. This coincided with President Johnson's Great Society Programme in which the role of the state was seen as important in protecting citizens from the exploitative market. At this time there was a flourishing economy. However this was short-lived and by the early nineteen seventies a depression was evident. This was when the neo-capitalists blamed the welfare ideology for the economic situation. Then President Reagan took office and re-established the virtues of family, neighbours and community. Altruism and charity were applauded because individual capital was used voluntarily to help others. Welfare based on collective coercive 'giving' was seen as inappropriate. While the idea of a safety net for the truly needy was recognised, the actual help given, it was felt, should be absolutely basic and

temporary. The role of the state was primarily that of protection and therefore minimal. This view closely corresponded with individualist/capitalist ideology. Since the Reagan/Bush administrations there has been an underlying tension between capitalism and welfare liberalism, and this tension emerges occasionally, usually when it is brought to the attention of the government by the few who oppose the inequality of the capitalist system.

7.2.3 The History of Welfare Provision.

The concept of 'welfare' in the United States is regarded in ordinary discourse as being separate from health care. The former is a misforfune which befalls the poor that is one section of the population, while the latter concerns the entire population.

The background to the American welfare system differs from its European counterparts. One view of the reason for the introduction of social insurance in England and Germany was that this was aimed at creating some sort of stability in the political order by integrating workers into a system of welfare. In both countries there were pre-existing facilities for providing sickness benefits. In Britain there were the friendly societies (p210) while in Germany there were various guilds and mutual societies (Starr 1982).

In America the political institutions differed from those in Europe. From 1900 the American government had little control over the economy and had only a small unprofessional civil service. There was little control over social welfare and health care. Unlike Europe where the hospital system was largely government run, American hospitals were mainly private.

Politically there was further unrest particularly among the farming community. Socialism emerged at the turn of the century but by 1916 the socialist party took only 6% of the vote. This was the period of conservative-labour leadership. The trade union movement was slow to develop compared with Europe although there were in existence small fraternal orders and benevolent societies (Starr 1982).

At the turn of the century welfare benefits were confined to veterans of the civil war (Quadagno 1988). These pensions came to constitute an extensive system of social welfare. About one in two elderly, native-born, white North Americans received a pension from the federal budget (Katz 1986). However, as the number of veterans declined so did the pension schemes and no new or alternative system developed. The scale of need created by the Depression could not be catered for by the small number of agencies available. The insurance schemes which were available were attached to and run by corporate companies and businesses which provided company welfare and pensions for employees (Pierson 1991).

The Social Security Act passed in 1935 by president Roosevelt formed the basis of what came to be known as the New Deal. All subsequent expansion derived from this. The programmes developed by the New Deal were; a) a federal state employment programme, b) grants to help needy children and c) assistance for the elderly and the blind. There was also provision for infant and maternal health and an old age insurance programme. The degree to which these services were available varied from state to state but in all cases insurance payments were necessary. Otherwise benefits were means tested and granted at the discretion of individual local governments. There was no health insurance programme (Orloff 1988).

7.2.4 The Structure of Welfare Services.

It is already clear that the idea of a 'welfare state' is an inaccurate label to attach to the system so far described. There is the additional fact that since there are fifty separate states, each with its own federal control it is unlikely that the concept of one overall welfare state could apply. Therefore the New Deal mentioned above must suffice to describe the limited state input into welfare provision. That is not to say that the term 'welfare' is not used. In fact it is used in a fairly derogatory sense.

There was a point in the nineteen sixties during the Great Society Programmes when the idea of welfare as a right almost became a possibility. As part of the vision of the Great Society teams of professionals were drafted in to identify the poor and to ensure that all

who were entitled to benefit were receiving it. These teams included community case-workers, legal service advisors and many others. Numerous politicians, both Republican and Democratic, lent support to this ideal. Welfare provision during this time took the form of non-cash aid such as food stamps and Medicaid, referred to collectively as SSI Supplementary Social Security Programme. There were also smaller benefit packages including student loans, job corps, housing assistance and the school lunch programme (Marmor et al 1990).

The Great Society Programmes can be seen as a reflection of what is possible. Its failure to develop also shows that without public support and political will at a high level any such venture cannot thrive. Nevertheless this attempt at welfare provision stands out in American history. It is interesting to note that these programmes coincided with what has been called the 'golden years' of the British Welfare State (Pierson 1991).

The idea did not take hold and by the mid nineteen seventies the idea of welfare as a right had been dismissed. Apart from the conflict between welfare rights lobbyists and legislators it became obvious that the majority of Americans did not see welfare either as a right or a priority.

What then is the structure of the system which operates?

There exists a fragmented, complicated system of benefit provision arranged in a two tier system (Weir et al 1988). At the first level is Social Insurance under whose umbrella lie:

Social Security,
Medicare,
Retirement and Disability Benefits,
Unemployment Benefits,
Workers Compensation.

The Social Insurance Programme involves schemes linked to work and dependent on contributions through taxes and wages. These are not means tested and are not aimed

specifically at the poor. The benefits for the poor are means tested (Orloff 1988). The most frequently cited and the most frequently targeted for cost-cutting is the AFDC (Assistance to Families with Dependent Children) (Weir et al 1988).

7.2.5 Recent Proposals for Welfare Reform.

It is of interest to note that welfare reform came after health reform, again highlighting the split between the two concepts in American society. The proposed changes in welfare again focused mainly on the AFDC benefit. President Clinton called for an end to welfare as it stood and his proposals addressed the following facts:

a) That there were 14 million people in 5 million families receiving AFDC - a 30% increase since 1989,

b) That the average monthly benefit to families was $337,

c) That nearly one in every 7 children received benefit, this being partly accounted for by the rise in illegitimate births,

d) That the AFDC programme cost $23 billion per year plus $0.7 billion for administration costs,

e) That another $27 billion was spent on SSI (Supplementary Social Security Income) (Katz 1994).

Mr. Clinton proposed to gradually phase in the following changes:

1. To introduce a contract to those on welfare by which the government would pay for training and education to help with obtaining new skills because work is preferable to welfare.

2 This plan would apply only to those born after 1971. By focusing on younger age groups it was hoped to encourage teenagers to take responsibility for their lives.

3. Those capable of work would be limited to just two years of cash assistance from the government in a life-time, emphasising the fact that welfare benefits were to be seen as temporary.

4. Those unable to find employment within two years would be required to take part in a government-sponsored job program. This assignment would last up to twelve months during which time the individual would seek employment.

5. Since teenage pregnancy was seen as a major drain on resources, a national campaign would be set up to address this problem at a cost to the government of $300 million.

6. Every pregnant teenager of school age would be obliged to finish school. They would be expected to live with their parents. A subsequent pregnancy would mean loss of benefit.

7. Since parents should be responsible for children, and therefore the first line of support, paternity must be established and child support paid by the father. Lack of co-operation on the side of either parent would mean curtailment of benefit (Katz 1994).

The Welfare Bill was passed in 1996. It is clear that a tough line has been taken to stamp out the culture of dependency. There are obvious problems with this approach not least the assumption that all or even most teenagers will belong to a two parent family to begin with. There is also the dilemma of the children born into this system who will effectively be born into poverty.

7.3 The End of Welfare: the Wisconsin Model.

While the states try to ease in the new Welfare Bill some are further ahead than others. Wisconsin is now being cited as the model to be aspired to in its welfare policy. The Governor of that state, Tommy Thompson a Republican, has been instrumental in changing the system. His philosophy is that welfare dependency is harmful and destroys self-sufficiency. He has created a work requirement for all those in receipt of welfare. This means that each individual must work for a given number of hours each week. For those unable to find a job this time can be used to seek employment or to gain the skills required for particular work. The state in return provides child-care, transport and health-care. The plan is mainly aimed at single mothers and the aim of the scheme is to reduce the numbers on welfare. Anyone not complying with the work conditions loses welfare. Children are also being urged to stay in school and if absent without a legitimate reason, then welfare for the parent is withheld (Thompson and Bennet 1997).

Under the current Wisconsin scheme welfare benefits in the form of AFDC are still issued subject to these conditions. In the near future however the benefit system will end under the W2 scheme. Under W2 nobody will receive cash from the government. Wisconsin began its reform in 1987 and since then has cut its welfare bill by half (Thompson and Bennet 1997). In the last ten years the caseload for welfare in the form of AFDC has also been cut by half. One source says that uptake of this benefit continues to shrink by 2% per month (Rector 1997).

The Wisconsin Model is relevant not only to other states in America but also to Britain. Recently the Secretary of State for Social Security Ms Harman was visited by a member of the Wisconsin team. It appears that Britain is now focusing on single parents and 'workfare' as a means of weaning people off welfare. Although in Britain no action has been taken as yet there is evidence to suggest that a pattern similar to Wisconsin is being considered.

Despite the alleged success of the Wisconsin experiment (mostly reported by the government) some areas of concern are evident. Some of these concerns have already been addressed by Welfare Liberals. The main feeling seems to be that instead of

government cash aid for the needy there is now a worrying degree of control over peoples lives. Although the figures are impressive to show reduced numbers on welfare there is little feedback from actual recipients. The fear is that while the majority may join the workfares and self-sufficiency programmes others may not. There may be increased poverty and homelessness among the most vulnerable.

The problem of illegitimacy has yet to addressed, which some would see as the fundamental problem. In view of the stance taken with welfare benefits clearly a similarly tough line will follow for teenage pregnancies.

7.4 Health Care in the United States.

The idea of state -assisted health care for the poorest in society did not come about until 1965. Prior to that the main structure of medical finance was fee for service payment. The assumption was that most people could pay for basic and routine health care and would have insurance cover via employment to cover more expensive treatments. This was a misconception and as medical costs rose those without employment insurance were faced with a dilemma.

Before 1965 the financing of care for the poor came from charity hospitals, payment by state and welfare agencies and the altruism of a few doctors (Starr 1982). Medicare was designed to provide pre-paid hospital insurance for those over sixty -five under social security, and low cost voluntary medical insurance for the aged under federal administration. The voluntary component would pay for doctors' bills and other medical expenses financed partly by the individual and partly by general taxation.

Medicaid was intended to enable states to pay for medical care for the poor, usually those on other welfare benefits. No contribution is required towards the cost of care from those on Medicaid.

For those not covered by Medicare or Medicaid (that is the majority of people) employment insurance is relied upon to take the cost of hospitalisation or any other illness requiring treatment. It would appear that there have been two overriding problems associated with health care for the majority. One is access to care and the other the cost of health care (Eckholm 1993).

To some degree the problem of access to services was lessened by Medicaid and Medicare. This problem peaked in the nineteen sixties and has re-appeared in the nineties (Marmor et al 1990). In the period between these times it was cost which was the main concern. Three phases can be identified as significant for health care during the seventies according to Starr. These were:

1. A period of agitation and reform in the first half of the decade as welfare entitlements became popular in public opinion.

2. A period of inactivity in the second half of the decade as inflation became the main concern of government.

3. A growing trend of anti-government feeling culminating in the Reagan election in 1980 (Starr 1982).

Meanwhile various individual politicians tried to formulate health insurance plans. Some such as Senator Edward Kennedy have fought consistently to change the system. The Nixon Administration also tried unsuccessfully to introduce a plan. Meanwhile Congress proceeded to instigate its own plans including a failed attempt to unite Medicaid and Medicare under one 'Health Financing Agency. At the same time several small for profit hospitals were growing into large companies. The Health Maintenance Organisations also ran for profit organisations relying on fixed annual insurance premiums to finance health care.

There are several problems relating to the lack of a national health plan. There are frequent reports in the media of the way in which individual's lives and those of their

families are affected. Reports of patients being left untreated until proof of insurance status is produced are not uncommon. This situation is not confined to the poor. In fact one of the most vulnerable groups is the self-employed who are often unable to afford the high premiums demanded by companies. The New York Times review of the health care dilemma reported one case of a family where the self-employed husband had to choose between his own orthopaedic operation, his wife's pre-natal scan and his child's allergy (Eckholm 1993).

As far as businesses are concerned the larger the business the better the cover. Small businesses can not always afford the premiums without cutting wages. There is an additional problem in relationship to workplace coverage. Frequently employees feel pressurised into staying in unsatisfying jobs simply to keep the insurance coverage. This syndrome has now been recognised and labelled 'job-lock' now regarded as a major stressor in the work-place (Eckholm 1993). This is what Marx would have called alienation from the self which occurs when people remain in specific employment for economic existence rather than for job satisfaction (p185).

Another problem which has been evident in recent years is the idea of bad insurance risks. This is when people with some chronic illnesses such as AIDS are unable to secure health insurance because the cost of premiums have been increased to such an extent.

Lastly there is the problem of an increasing elderly population. Here there are parallels with the situation in Britain (p152). The burden of caring for elderly relatives is placed mainly on the family, usually women who themselves must work in order to maintain their own insurance status. Many elderly spend their life savings on nursing home care. Nursing home residence is regarded by many as a last resort. However with changing demography this may be the only option for the future. As is the case in Britain family structure is changing. It is not unusual for a 65 year old to care for an 85 year old on a twenty -four hour basis. Only a small amount of funding, 3% from the $15 billion allocated to long-term care of the disabled went to home care services in 1990 (Eckholm 1993).

7.5 The Clinton Health Reform Bill.

The background described above shows a system in which the main coverage of medical care costs was taken up by employers and a significant number of people with no cover at all (p119). The perceived crisis situation was taken on by Mr and Mrs Clinton and a package for reform was developed. Various experts from professional bodies, pharmaceutical industries and economists were called in to help organise and advise the president.

Managed competition was the new concept on which the Health Bill was based. Cost-consciousness was the main aim of the scheme. It was felt that since employers provided insurance cover for employees generally speaking Americans did not appreciate the cost of health care and that they over-used resources. The new plan would mean that employers would pay up to 80% of the cheapest plan for individual employees and the government would tax all health benefits above that level. Consumers would pay more for their insurance coverage and would be expected to select less expensive plans. The health industry would be under the control of insurance companies (Navarro 1994).

While this system of pruning costs and allegedly providing better quality care for less money was endorsed by many professional bodies, there were still criticisms from various political sides. The main complaint was that a third party ie the insurance company would come between the doctor and the patient. Doctors would be under pressure to select cheaper treatment and reduce diagnostic tests with possible detrimental effects on the quality of care.

The Clinton Health Bill consisted of a 1,342 page document (Rubin & Connonlly 1994). In his address to Congress on 27th September 1993 President Clinton said that there were six main principles involved.

1. The first principle was **security.** By this the president meant that all citizens should have health care coverage. A health security card would entitle each eligible person to

obtain coverage via a health plan covering a nationally defined comprehensive benefit package (AMA 1993). All individuals would be obliged to enrol in a health plan. Otherwise this would be done automatically.

The nationally defined benefit package would include all of the following services; hospital care, ER, physician services, preventive services, pregnancy-related services., home health and diagnostic tests. Vision and hearing care, health education classes and dental care for children would also be included (AMA 1993).

The state would have specific responsibility for implementing the plan. By January 1st 1997 all states would be expected to establish one or more health alliances and ensure that all individuals were enrolled and in possession of a benefit package.

2. The second principle addressed by the president was **simplicity**. By this he meant a reduction in bureaucracy and form filling.

3. The third principle was **cost-reduction**. The president aimed to reduce the budget deficit over five years from $91 billion to $60 billion (Rubin and Connolly 1994). Unless every citizen has insurance the president said health care inflation could not be reduced. This was because the uninsured often waited until their illness was more advanced and therefore more costly before seeking medical help. Then when people were unable to pay for their medical treatment the rest of the population must do so.

4 The fourth principle was **choice**. This meant that people could choose their own health care plan and their own doctor. Doctors would also have a choice of which insurance plans they would practice.

5. The fifth principle of the Reform Bill was **quality**. Higher prices do not guarantee higher quality. Providers of care therefore would be urged to make smarter choices about the kind of care they provide.

6. The sixth principle was **responsibility**. This must apply, the president said to all who give and receive care, including insurance companies who can no longer cast aside

someone who becomes ill. It also means changing individual behaviour so that the so-called lifestyle behaviours such as violence, smoking and other substance abuse, teenage pregnancy and AIDS which lead to ill-health should be reduced (AMA 1993).

According to the plan every employer and every individual would be asked to contribute so that there is shared responsibility for health care,Some would pay more than others. The self-employed would pay less as well as being able to deduct from taxes 100% of the health care premiums. Large employers would have more cash to direct towards wages and new jobs because the health care costs would no longer increase. Mr. Clinton had also tried to reduce medical spending by encouraging stiffer competition and if that failed, by imposing mandatory controls which would keep health costs in line with economic expansion.

7.5.1 Why the Plan Failed.

Democrats were divided over the plan, especially the proposal that employers should pay for most of the their workers health costs. Republicans were largely united in their opposition to the whole plan manly because it relied too heavily on taxes. Three main reasons are cited for the failure of the Clinton Bill.

1. It was too detailed and too complex to explain to the public and to low grade workers. It was also too large in terms of the volume of information. The public soon became bewildered by the barrage of news stories. The health insurance industry used this fault to maximum effect via television advertisements in which a yuppie couple were portrayed laboriously ploughing through the 1,342 pages of the document (Eckholm 1993).

2. The second reason for failure was a lack of consensus among their various committees designed to attend to the political and legislative details of the Bill.

3. The third reason for failure there was a refusal by the various political parties to compromise as to the actual details. No Republican in the House voted for the Bill and even the Democratic vote was low (Almanac 1994).

It can be concluded that the main problem was that the Bill was too detailed and extensive. It appears that a document which recommended so many radical changes could not be instigated in a given time frame. There were several positive aspects some of which had for the first time recognised the need and desirability for all citizens to have health care cover. Making employers responsible for the welfare of workers was also a welcome change to the burden of responsibility previously carried by employees. The idea of a nationalised system where each individual carried a card of entitlement to coverage sought to change the perception of the divide between the haves and the have-nots. The proposed amalgamation of Medicare under the insurance system , again severed the link between the poor and the rest of society. Overall the Health Bill showed how the best of intentions could not alter the deep- seated reluctance of 'the system' to offer improved health care provision. It also highlighted the limited power of the president and his party to overrule the opposition.

Since the failure of the Clinton Bill in 1994, various attempts have been made to instigate some kind of system based on the those in Canada and Britain. One of the most active campaigners for health reform has been Senator Edward Kennedy. The most recent change to the system has come from his Bill in 1996. This was the Kennedy, Kassebaum Steer Insurance Bill to Safety. This legislation, signed and passed by Congress, means that people would not lose their medical insurance if they leave or loose their jobs even if they become ill (Langdon 1996). Although this Bill does nothing to improve the lot of the now **43 million** Americans without insurance cover, it has nevertheless helped those with employment-assisted insurance and should eventually ease the 'job lock' situation (p130). The American health-care problem can be summarised by saying that despite continuing commitment to change by a few politicians the possibility of a nationalised health service remains remote at this time. The Clinton Health Bill provided a strong platform for the first election campaign. Since the Bill failed the notion of health reform has to some extent been cast aside.

Having presented the facts, some reasons for the current dilemma are clear. These are mainly related to historical factors such as the predominantly individualist ideology inherent in American society and perpetuated by successive governments. The capitalist system is maintained by large scale organisations and corporations and the many layers of workforces which keep the system in motion. But what of the fundamental question with which we began? Why has this rich capitalist country failed to deliver a system of health care for all its citizens? The possibility of achieving such an aim is not impossible as the Canadian experience demonstrates. Canada introduced a nationalist ed health service in 1972 and ended insurance run systems (Navarro 1993).

Various reasons have been suggested. As we have seen a powerful move in the right direction was led by President Clinton which failed. The cynical view might be to say that the area of health care provided a strong platform in the election campaign. The fact that the whole exercise was subsequently cast aside seems to lend credence to such cynicism.

The most frequently cited reasons for the lack of a health care programme is what is known as popular choice theory (Navarro 1994). Basically this assumes that, based on the views of various influential medical people and economists, the American people do not want a nationalised health programme. This assumption seems extraordinary given that we have already seen that only 50% of those eligible to vote actually did so in the first Clinton election (p119). We must therefore assume that a particular faction of the population only hold this view. In other words the very people who need health care cover did not have sufficient confidence in the government to feel that voting would represent any force on their behalf.

7.6 Tensions in the System.

The analysis of the American system has led to the identification of various tensions in the systems. These tensions can be interpreted either narrowly as specific areas of tension, or more widely as tensions deriving from a higher source. Chapter I outlined a definition of 'tension' as seen in physics using the pressure in the walls of blood

vessels as a means of describing disequilibrium (p6). I suggested that this type of analogy was relevant to systems of health and welfare and that too much pull in one direction can cause tension or disequilibrium (p7). I also stated that such tension is not necessarily negative. In the case of the systems described many of the tensions arising in health and welfare systems are in fact blueprints for change. Of course the desired change may not come about. As the American health care system shows some tensions remain unresolved. But even if they are unresolved they may be taken up at a future date (a presidential election campaign for example), and in the meantime they will provide a focus of attention for the few politicians who constantly strive for improvement.

In other cases the tension may be addressed, even resolved, but equilibrium does not automatically follow. The welfare system in America has been reformed, in some states already. However it remains to be seen what the outcome will be. It is likely that new tensions will replace old ones. In a system as radical as the Wisconsin Model it is difficult to envisage a state of equilibrium. The overriding tensions remain those between capitalism and welfare liberalism, between progress and poverty. The disequilibrium arising from these tensions will continue to provide a platform for political and economic debate until some form of balance is achieved. To this end the tensions described can be seen as necessary if positive reform is to be achieved.

7.7 Conclusions.

1. Analysis of Welfare and Health in the United States shows these two components as being regarded as separate concepts rather than parts of the same entity. Health is seen as applicable to all although a substantial number of people cannot afford basic health care. Welfare, on the other hand, is applicable only to the poor, those who cannot manage without government assistance. That assistance holds a stigma which time has done little to erase.

2. Successive governments have sought to reform the system of welfare and have usually targeted the benefit payable to single parents (AFDC). The most recent reform -

The 1996 Welfare Bill aims to eventually eliminate welfare benefits completely. Various incentives to work have been instigated by the government in order to reduce the numbers on welfare.

3. The state of Wisconsin has been involved in welfare reform since 1987. Since that time it has cut its welfare cost by half. This has been achieved by enforcing rules to work, learnfares and self-sufficiency programmes. Failure to comply with the rules means benefit payment is witheld. The apparent success of this scheme (in government terms) is now seen as a model for other states to follow. The British government has also shown signs of a desire to emulate this system. The scheme is still in an evolutionary stage.

4. The main issue regarding health-care in the United States is the lack of provision for a substantial number of people-43 million. This figure does not only represent the poor but also many self-employed people.

5. Various reasons have been put forward as to why this wealthy capitalist country has lagged so far behind other western countries in its health care. One theory is that the public do not want such a system. It is however more likely that the reasons are historical and associated with the individualist ideology which can be traced to the founding fathers and early Puritans. This individualism emphasises the values of self-reliance and a mistrust of government. These factors combined with the traditional work ethic and entrepreneurial spirit have filtered down to the present day.

6. Not all politicians have disregarded the need for a nationalised system of healthcare. President Clinton devised a promising document for reform under which every individual would have access to some form of health insurance. His plan failed largely because of lack of support for the Bill. Since then a small number of commited individuals have continued the campaign for change.

7. There are tensions in the systems of Welfare and health. There is an imbalance which favours the rich and successful at the expense of the poor. This tension continues to form a platform for political debate.

References.

American Medical Association **Synopsis of Clinton Health Proposal,** 1993.

Bellah RN, Madsen R, Sullivan WM, Swindler A, Tipton S. **Habits of the Heart: Individualism and Commitment in American Life**, University of California Press 1996; pp46-8.

Eckholm E. (Ed). **Solving America's Health-Care Crisis, A Guide To Understanding the Greatest Threat To Your Family's Economic Security.** The Staff of the New York Times 1993;pp3,5,17-20, 37-9, 54.

Etzioni A. **The Spirit of Community Rights, Responsibilities and the Communitarian Agenda**, London:Fontana Press Harper Collins, 1995;pp228.

Health/Human Services 'Clinton's Health Care Plan Laid to Rest'. **Report 1994 Congressional Quarterly Almanac** 319-310.

Katz JL 'Long Awaited Welfare Proposals Would Make Gradual Changes', **Congressional Quarterly Fall,** 1994 Library of Congress, Washington DC.

Katz M. **In the Shadow of the Poor House**. New York: Basic Books, 1986.

Langdon S. 'Kennedy, Kassebaum Steer Insurance Safety'; **Congressional Quarterly Weekly Report**; 1996; vol. 54 no.31; August 3rd.

Mead L 'From Welfare to Work , Lessons from America'. **Choice in Welfare** no 39. IEA Health and Welfare Unit, Edited by Alan Deacon, London, 1997;xiii.

Marmor TR, Mashaw JL, Harvey PL **America's Misunderstood Welfare State,** Harper Collins, USA 1990;p5-6, 88-90, 182-3.

Navarro V. **Dangerous To Your Health: Capitalism In Health Care.** New York: Cornerstone Books, 1993;pp35.

Navarro V. **The Politics of Health Policy, The U.S. Reforms 1980-1994,** Cambridge, USA:Blackwell, 1994;pp198,202,209-210.

Orloff AS. 'The Political Origins of America's Belated Welfare State'. In: Weir M, Orloff AS, Skocpol T. (eds). **The Politics of Social Policy in the United States**, Princeton University Press, 1988; pp74-9.

Pierson C. **Beyond The Welfare State? The New Political Economy of Welfare**, Pennsylvania State University Press, 1991;pp120.

Quadagno J. **The Transformation of Old Age Security. Class and Politics in the American Welfare State**, University of Chicago Press, 1988;pp3-6.

Rector R. 'Wisconsin's Miracle. Policy Review'. **The Journal of American Citizenship**, March-April, 1997.

Rubin AJ, Connolly C. 'Clinton Delivers Health Bill, All 1,342 Pages Of It'. **Congressional Quarterly Fall**, Library of Congress, Washington D.C. 1994.

Starr P. **The Social Transformation of American Medicine.** New York:Basic Books, 1982;pp239-242, 380.

Thompson T, Bennett W. 'The Good News About Welfare Reform: Wisconsin's Success Story', **Heritage Lecture No. 593**, Sept. 29th, 1997.

Tocqueville A de 1835 **Democracy in America**. Translated by George Lawrence, Ed. J.P. Mayer, New York:Doubleday, Anchor Books, 1969;pp279.

Weir M, Orloff A, Skocpol T. **The Politics of Social Policy in the United States,** Princeton University Press 1988;pp426-7.

Chapter 8: Health and Welfare in the United Kingdom; A Critical Analysis.

8.1 The Background.

The origins of the British Welfare State go back at least as far as the seventeenth century although there is a widely held view that it was born on July the fifth nineteen forty eight (Marsh 1980). In reality the concept of 'Welfare State' was a gradual evolution. There are various theories as to why this label was applied and some of these are of interest (p6). One theory is that 'welfare' state was used to distinguish it from 'warfare' state which was consistent with the rise of totalitarian regimes (Oakley 1994). It is more likely to have come about as confirmation of the labour governments' promise to offer services such as social security which was a term also coined during the war. Social security meant the security of citizens against poverty (Lowe 1993). Whatever the reason for the label 'Welfare State' it has subsequently become synonymous with a caring state, at least in its early years.

In attempting to analyse the British system of welfare in a critical manner it is relevant to briefly consider the social and political background. Various changes in the late nineteenth century were significant in establishing the new system. Industrialisation changed communities both in terms of mobility and as a labour force. The kind of work undertaken in factories was directly related to industry. An urban working class evolved. The population increased and due to the public health measures there was a fall in infant mortality (Pierson 1991).

Economically, up until the middle of the nineteenth century it was the laissez-faire system which operated (p34). There then followed a period of discontent with the liberal capitalist system. This came about as a result of the many social changes resulting from industrialisation. Theories as to the precise reason for the Welfare State differ considerably. One theory at the time was that it was purely an extension of the widespread feeling of charity towards ones neighbour-the idea that we are all members one of another (Hall 1952).

I have already described the strength of charity in the alleviation of poverty (p100). However it is unlikely that this was the sole reason for change. The idea that industrialisation was a major factor was popular with many commentators. The various social changes resulting from industrialisation resulted in 'modernisation' provided scope for a changing perception of employment. Problems both social and medical, of the workforce called for some state action in terms of legislation. Modernisation also meant a growing appreciation of the idea of citizenship. Indeed another theory for the foundation of the Welfare State is that it came about because of the transition from subject to citizen. One of the greatest proponents of this view was Marshall who identified three stages and categories of rights: civil rights in the eighteenth century, political rights in the nineteenth century and social rights in the twentieth century (Marshall 1979).

Politically there were three main influences identifiable in the early years of the Welfare State. These were: The Reluctant collectivists Beveridge and Keynes, Social Democracy and Conservatism (1951-1964) (Lowe 1993).

Beveridge and Keynes have been referred to as reluctant collectivists (Lowe 1993, George and Wilding 1976). They were reluctant in that they were both commited to the market ideology and yet were aware of its defects and recognised the need for state intervention in matters of welfare. Beveridge showed foresight in seeing at an early stage the desirability and importance of input from not just the state and the market but also from the voluntary sector (Beveridge 1948). The market was seen by Beveridge as being vital for developing individual incentive and motivation. The state on the other hand held the key to the achievement of a more economically free society (Lowe 1993).

Democratic Socialism had a significant impact on the perception of British politics internationally. The aim of the Democratic Socialists was to have a more equal society where capitalism was replaced by socialism. Marshall and Titmuss were strong proponents of these views. Marshall saw social rights of citizenship as crucial to such an end. These rights would include health and welfare services shared by all men as equals. This in turn would enhance a sense of community.

Titmuss held similar views , also emphasising the necessity for community and altruism (Lowe 1993). Titmuss used the example of blood donation (p100) to show how altruism could work as gifts among strangers. The problem with this particular argument is that blood donation cannot serve as an example for other welfare benefits. In fact Titmuss offered little in the way of a possible solution to the problem of social security based on insurance and as a means tested benefit.

Conservatism in the context of the Welfare state is of interest. It is of interest in that the idea of 'change' in welfare and health is often associated with conservative governments, but it is arguable whether this was in fact the case. No major change was effected during the period up to 1964 (Timmins 1995). It was the New Right wing of the conservative party which took office in 1979 which was responsible for instigating reforms in welfare thus departing from the ethos of 'conserving' which is implicit in 'conservatism' (this is discussed in chapter 11 p226). There remained for some time a clear distinction between New Right and Old Right. Mrs Thatcher and Sir Keith Joseph were major proponents of New Right thinking (McLean 1996). Both were influenced by the work of the economist Hayek whose philosophy on the market became part of New Right policy (Hayek 1944). A particular view of the state is held by the New Right, one which rejects the 'giving' state.

The New Right have been critical of what they regard as the nanny state. In addition they make a strong and convincing case for the inclusion of market forces within the welfare sector. They use key terms such as choice and empowerment to highlight the lack of these elements in the traditional welfare state. The Welfare State is seen as inefficient,wasteful and ineffective depending as it does on a bureaucratic structure. It is also an infringement of liberty with its compulsory taxation and lack of public choice in services (Pierson 1991). These issues are taken up in the context of the discussion of the effects of Thatcherism (p149).

8.2 What Beveridge Envisaged.

The two people whose names are usually associated with the foundation of the Welfare State are Beveridge and Bevan. Beveridge was instrumental in formulating the plan for social security the details of which are found in The Beveridge Report (HMSO 1942). To Bevan is attributed the National Health Service. Housing and education were also key elements in this plan. For the purpose of this thesis however it is health and welfare with which I shall mainly be concerned.

The main contribution made by Beveridge was the organisation of a system of social security based on insurance contribution for times of need, that is when employment was not possible due to lack of jobs or sickness. The system was to provide a safety net and was a short term strategy only. Beveridge had based his plan on a similar system in operation in Germany (Glennerster 1995). The appeal of the crusading style of Beveridge was articulated in his focus on what he regarded as the five giants : want, ignorance, disease, squalor and idleness. The ambitious project of eradicating these evils in society received overwhelming support in post war Britain. In fact the war is seen by many as being instrumental in creating the climate of optimism which subscribed to the desire for a better future in terms of health and welfare. The other strongly appealing aspect of Beveridge's plan was the language in which his proposals were couched. The promise of a 'cradle to the grave' set of services embodied a feeling of a caring state. The other side of this coin was of course that in offering such a promise Beveridge also gave the state unlimited powers of intervention.

If we measure the progress and success of the Welfare State in terms of the original five giants we see that some giants fared better than others. I have already indicated (p102) that 'want' in Beveridge's terms was a synonym for 'need' and that the term 'want' only later became associated with 'preferences' to be satisfied by the market. Interestingly it has also been suggested that Beveridge used 'want' as a synonym for poverty and it is noted that he appeared to avoid reference to poverty (Timmins 1995). It was Beveridge's commitment to full employment which apart from social security was aimed at eradicating want. Employment was seen as crucial both to the economy and to the individual. Clearly , as time passed and unemployment became a major problem the

giant 'want' had clearly not been dealt with adequately. It is however recognised that for at least the first thirty years after the war the problem of poverty was stabilised by state welfare. This period has been regarded as the era of 'old' poverty whereas 'new' poverty is seen as a result of economic and social changes from the nineteen seventies (Dean & Taylor-Gooby 1992). This was the era of economic depression, increasing unemployment and changes in family patterns, in particular a rising number of single parent families.

Unemployment became a problem which the system of social security has done little to rectify and has led some conservative commentators to associate welfare recipients with a dependency culture. In one study carried out in Britain by an American political scientist, Charles Murray, it was confirmed that Britain was following America with the emergence of an underclass (Murray 1994). Idleness, lack of incentive to find work and one parent families were all seen as part of this destructive element associated with social security and poverty. Criticisms such as these have focused on the moral issues of welfare and questioned the morals of individuals who felt it was their right to 'take from' the system with no apparent feeling of a duty to pay back. This is certainly one aspect of welfare which clearly needs to be addressed if those in real need are not to be victimised because of deviance by a few. This moral argument was very much part of the Thatcher era with emphasis on old values of self-reliance and a traditional work ethic. But there is another problem which is more fundamental in importance. The issue of unemployment itself and in particular its effect on health and well-being has received relatively little attention and little has been done to investigate the problem (Bartley 1994).

The problem of idleness then, we can say has deteriorated since the Beveridge Report. Another of Beveridge's giants was ignorance. Although a detailed analysis of education and housing policy is beyond the scope of this discussion, nevertheless a brief review serves to complete the picture of welfare reforms. The question of education proved to be the most political of the issues in the post- war era and it was also the first to be reformed. In the period after the Industrial Revolution the situation was that education leading to university placement was available only to those who could afford. That excluded the majority of the population. In 1818 only seven percent of children

attended day school (Timmins 1995). Various institutions provided some basic form of schooling for those who did not attend school (Fraser 1984). The question of literacy was controversial with an implication in some circles that extension of education to the lower classes would not be in the best interests of anyone. There was a sense in which the division between classes had to be maintained so that a status quo prevailed and the so-called leisure class had education and knowledge which in the hand of the lower classes might produce rebellion and dissatisfaction. In my discussion of the work of Marx this becomes clearer in the overall context of class.

As we have seen in chapter 6 (p98) the charitable organisations were influential in helping the needy in the period. This help had extended to education. Because of the influence of Christianity, both Church of England and Roman Catholicism religion was a large component of education at the time. Religion also re-enforced the attitude of humility and charity so discouraging ordinary people from attempting to rise above their station. At the same time it was recognised that ignorance was also unacceptable so a degree of input was necessary. Victorians saw a free society as a literate society. The case was made for state intervention on these grounds, that is the good of society as much as the good of the individual (Marshall 1979). Elementary, compulsory free education was therefore introduced and legitimised in the 1870 Education. From the point of view of citizenship education was important. There were various debates as to what should and should not be taught in schools.

The problem of squalor is closely associated with poverty and poor public health services. Attempts to relieve this have been analysed as part of the public health sector (p86) and as part of the discussion on charity (p98).

In the immediate post-war period there was massive destruction of housing and as a result re-building necessitated the employment of planning officers and builders. The giant 'disease' had an effect on and was affected by the other four giants. While public health measures to improve disease were limited they were nevertheless highly effective in securing a clean water supply. As far as general health is concerned it was the National Health Service which was instrumental in improving all aspects of health

and more importantly the service was available to all free at the point of delivery. Let us analyse this in more detail.

8.3 The National Health Service.

While the social security system offered a minimum of provision, the National Health Service offered an optimum making medical care available to all free at the point of delivery. The service became the most popular aspect of the Welfare State. This popularity has been attributed to various factors. The war it seems had a significant part to play. The spirit of optimism and generally high morale in the post-war period together with the many new ideas and services which came about as a direct result of the war were also important. Services such as blood transfusion and improved surgical techniques paved the way for greater things especially in an atmosphere of growing interest in medical science. The social security system would, it was believed, alleviate poverty but poor health was still a problem. The National Health Service then, seemed to address this problem. New drugs were now available to treat various infections. What was needed was a system to make services available.

It is of interest to note the system of hospital and general practitioner services which existed before 1948. This is because it shows the improvements made over a very short period in the very early years of the National Health Service. It also serves to put subsequent criticisms into perspective. Just before the war there were 1334 voluntary hospitals which included many of the large London teaching hospitals. There were 1771 municipal hospitals many of which were extensions of the workhouses and certainly inferior to the voluntary hospitals. These were run by the local authorities. The school health service, health centres,and home-nursing were also the responsibility of the local authorities. General practitioner services took the form of 'panel doctors' which in 1938 covered 43 percent of the population. The system did however exclude women, children and the elderly (Timmins 1995).

Long before the health service evolved there was recognition of the need for reform. The British Medical Association in 1930 was asking for a more comprehensive system

by extending National Insurance to cover hospital care. This was clearly not the answer since the most vulnerable groups would still be excluded.

The actual form which the new health service was to take was documented in the 1946 in the National Health Service Act. The service was to be paid for from general taxes with a small income from the national insurance. Hospital and general practitioner services were free as were all medicines dental care and optician services. The reality of 'free' services made the National Health Service popular and this continued for a brief period. The first signs of budgetary problems were realised as early as 1949. Extra capital was needed for defence in the Korean war. This capital was taken from the health budget (Glennerester 1995). The two services to be affected were ophthalmic and dental care. The idea of a free service with equal treatment for all was an ideal which retrospectively can be seen as a promise which could not be kept. This breach of promise resulted in the forced resignation of Bevan (Lowe 1993).

From then on there followed a series of reports investigating the running of the health service. This continued up until the 1974 reorganisation. This reorganisation came about in response to the deficiencies highlighted in the various reports.

It appears that the main problems with the early health service was to do with resources, their management and allocation and the bureaucratic tiers of hierarchies involved in the use of these resources. Many critics are forceful in their portrayal of the perceived failure of the service even at its preliminary stage. But given the circumstances and problems which it inherited and a rapidly changing population soon after the war many of the subsequent shortcomings may not have been anticipated by the main architects. One of the shortcomings was the inability to keep the promise of providing health centres nationwide. By 1960 only ten had been constructed (Webster 1994). The pattern of lack of commitment to preventive services was set from the beginning.

The 1974 reorganisation of the health service aimed to achieve a unification of services to remedy the fragmentation already in existence. At that time hospital and domiciliary care were separate as were therapeutic and preventive services. In addition to improved co-ordination and administration of these services a three tier system was introduced :

regional, area and district health authorities each with a specific role and function. An important aspect of the reorganisation was the introduction of Community Health Councils which constituted the very first attempt at representing the views of patients (later to be called 'consumers'). As we shall see (p198) these councils had a limited impact on service delivery.

The problems in the health service did not end with the new structure. In fact there now emerged additional concerns relating to the new burcaucratic hierarchy. At the top of the hierarchical tree was the region and at the bottom was the patient. A struggle between the various layers began.

It could be argued that the history of welfare and certainly health care has, over time reflected the political views of the particular party in government at a given time. Rebuilding and dismantling have been, and still are, the basis of continuous tension within the services. A pattern has emerged showing peaks and troughs interspersed with constant change which usually coincided with a change of government.

With the new conservative government of 1979 came more changes. The 1979 White Paper Patients First recommended the removal of the 'area' level from the health service structure. Efficiency saving and accountability were areas targeted to reduce spending and create a more efficient and better quality of service. Doctors were also targeted and medical audits and performance indicators were the tools employed to investigate the role and performance of various professionals (HMSO 1979). Sir Roy Griffiths was called in to investigate and report on the health service. As a result of his report general managers were introduced at regional and district levels.

Griffiths diagnosed four main concerns in the service. These were:

1. A lack of management accountability,
2. No evidence of intention to implement plans,
3. Little in the way of performance and outcome evaluation
4. Poor consumer representation (Griffiths 1983).

Griffiths recommended mainly management changes with more accountability and review processes.

The proposed changes met with opposition from professionals initially . One major concern was that the new general managers and unit managers were not knowledgeable about patient care and the day to day running of such services.

In instigating the new management structure the conservative government under Mrs Thatcher had sought advice from The United States. The degree to which conservative policy has influenced the system of health care is of interest as it has proved to be the beginning of an American style service delivery with consumer choice and patient charters as the main selling points.

Let us now consider the impact of Thatcherism on the health and welfare.

8.4 The Influence of Thatcherism.

The New Right was opposed to the idea of the Welfare State (p142). By the time Mrs Thatcher came to power the idea of crisis had been popularised. The time was appropriate for the new government to take steps to dismantle what was considered the nanny state. A combination of a desire to return to old Victorian values and a belief that the Welfare State had created a dependency society were behind the reforms which came about during the Thatcher years.

According to the New Right doctrine the Welfare State was ineffective as far as alleviation of poverty was concerned (Gamble 1988). It created a bureaucratic system far removed from public opinion which was both wasteful and unwieldly. Most crucially the Welfare State led to a lack of liberty for the individual. This latter point is very much part of the thinking of Hayek who believed that any attempt to lay down a plan as to how resources are to be used for a specific cause amounts to a loss of liberty. The compulsory taxation system is equally inappropriate (Hayek 1944).

The importance of Thatcherism to the history of the Welfare State is that it brought into sharp focus the conservative desire for a move away from the 'giving state' to a more market-orientated system. The gradual introduction of quasi- markets was seen in most public services, but the effect was most profound in the health service. The driving force behind the reforms was based on what came to be known as consumerism (p226). This was based loosely on the American doctrine of consumer power and choice. It emphasised the idea of the law and order state. The Welfare State was seen as an institution which, via bureaucratic structures, intruded into the lives of citizens diminishing choice and negatively influencing economic growth (Glennerster & Midgley 1991).

Some of the changes instigated by the Thatcher government were popular. The sale of council houses for example gave long-standing tenants the opportunity to be property owners (Glennerster 1995). Other changes were less welcome. The budgetary changes in the health and welfare services as well as the management structures introduced in the early nineteen eighties had still not solved the financial problems. According to Mrs Thatcher neither had the reorganised services achieved the efficiency and quality of output which she had envisaged (Thatcher 1993). Again the health service was targeted for change.

Various proposals were made in a White Paper 'Working for Patients' 1989. These proposals included what came to be known as the purchaser provider split. Based on an American idea a competitive element was introduced. District Health Authorities were to become purchasers of services. Contracts would be issued to the hospitals which offered the best services even if this meant buying the services from another district or from the private sector. Very few guidelines were issued regarding the actual mechanism of this system. Therefore a individual districts had to learn by mistakes (Ham et al 1994). The main intention of this exercise, it seems was to make districts responsible for assessing the needs of their own populations and based on their assessment choosing that most appropriate services within the limits of a specific budget. This also involved setting priorities. The needs and views of the public were

also deemed important in prioritising services. Some of the experimental cases which followed were based on the Oregon Experiment (p202).

Another aspect of this scheme was liaison between various organisations such as the Voluntary Sector and Community Health Councils (Ch.11). The issues associated with public participation and the various organisations are taken up in chapter 11. The influence of the Thatcher years was also reflected in the area of community care with the passing of the 1990 Community Care Act. In order for this to be seen in relationship to other aspects of welfare it is relevant to trace the history of community services and care in the community.

8.5 Community and the Welfare State.

The question of community and the Welfare State does not appear to reflect the same degree of input and support from the State as other aspects such as the Health Service and social security systems.

Despite the notion of the Welfare State as nanny state, care in the community does not appear to be included under this label. Titmuss referred to the nostalgia associated with a caring community and concluded that this kind of commitment from the state involved substantial cost (Titmuss 1968). But cost does not appear to be the only obstacle to care in the community.

The lack of commitment to care outside of institutions is historical. Throughout the history of welfare no firm agreement has ever been reached regarding who or which department should take responsibility for community care. Thus this aspect of care has been passed from local authority to health authority and back again.

The concept of care in the community has recently re-emerged for a variety of reasons. With the restructuring of health and welfare services the community has come under scrutiny as a means of providing care for groups such as the elderly and mentally and physically handicapped. This trend is likely to continue. One reason for this is the

growing number of people over sixty which in 1991 was 11.6 million, that is 8 percent more than in 1981. This rise was mainly due to an increase in the number aged 95 and over; and particularly those aged 85 and over. In the latter category there were 50 per cent more in 1991 than in 1981 (OPCS 1991).

The history of community care policies in Britain is one of slow and reluctant progress. The romanticised idea of community as a place where people are cared for on discharge from institutional care is misplaced. In this sense 'community' and 'care' do not go together. The idea of taking people out of institutions and into the community first came into being in 1957 when the Royal Commission stated the desirability of community as opposed to hospital care for mentally ill and mentally retarded. Since that time governments have continued to promote this ideal (Lewis 1994).

While the idea of community care has connotations of a caring society the reality has not reflected this view. Part of the appeal of community care has been the pluralistic approach which it seems to embody. This is because it involves not just the State but the family, the voluntary sector and self-help groups as well as groups of professionals for each aspect of care. This was very much the line promoted by conservative governments since 1979. On the receiving end of community care are the most vulnerable groups in society: the elderly, the mentally and physically disabled. One reason why the whole issue was highlighted during the early Thatcher years was that the family and voluntary services were seen to be of paramount importance. The idea of people being cared for by relatives and neighbours was appealing to a government whose thinking was based on Victorian values. An analysis of the changes is appropriate in the light of these policies.

By 1985 little progress had been made and what services there were received criticism from the Audit Commissions report *Making a Reality of Community Care* (HMSO 1986). With the re-organisation of the health service in 1974 responsibility for community care moved from local authority to health authority. From that time attempts were made to cut costs in hospitals and it was envisaged that the community could meet the cost instead. The predicted increase in the elderly population was also a factor. A White Paper entitled *Growing Older* in 1981 had emphasised the desirability

of care by the community (HMSO 1981). Meanwhile moves were underway to try and encourage as many people as possible to go into private or voluntary care with the help of social security grants. The Report of the Commission led to the Griffiths enquiry in 1988 (Griffiths 1988). The first proposal of the Griffiths Report was to make local authorities once again responsible for community care. In keeping with his policy of introducing managers into services (p148). Griffiths recommended care managers to identify and assess need. These managers would be accountable to a minister for community. Local authorities were to become the organisers and not the providers of care.

In 1989 there followed a White Paper outlining the governments proposals for improved community services. Some of the Griffiths proposals were dropped. There were six proposals in the White Paper the most important of which were 1. Making carers a high priority and 2.making need-assessment crucial to a high standard of care. In these two proposals alone there are problems (Lewis 1994). Making the carers a priority served to acknowledge the problem of caring for female relatives. However the degree to which this problem has been addressed is unclear. What is clear is that when care is provided mainly by a friend or relative entitlement to social services is often removed or reduced.

The problem with the second proposal i.e assessment is one which I have already addressed (p105). That is the objective decision by professions in this case social workers as to who needs which service. From the consumerist aspect promoted by Griffiths of giving consumers a voice and a choice, the reality is different. In fact the consumer has limited choice as the final say is had by the local authority as to which service should be provided. In addition one person's needs may well be pitched against another's when scarce resources are at stake. Such small choice as may be offered is then in tension with the rationing process (Lewis 1994).

Changes in community care services have been difficult to implement. Two terms, new in this particular context have arisen These are 'enabling' and 'empowering'. According to the 1990 Act local authorities were to become 'enablers' rather than providers of services. This has caused a degree of discomfort among professionals who

ordinarily see themselves as 'doers' (p169). Confusion follows when roles are suddenly changed and this is sometimes manifested in poor quality of service. The various projects undertaken to show how the new system works on a daily basis are still in progress.

As far as empowerment is concerned, this is the language of consumerism (Ch 2.6, Ch.11, p223). The term often erroneously indicates that users have a degree of control over the service provision. It also implies choice which as I have already indicated is not actually the case in this instance. In 1993, two years after the Act, it would seem that fewer people were receiving a better service and that only high dependency needs were being considered. The Community Care Act is still in its implementary stage.

In spite of the uncertainty of the new plans there have been various recent initiatives throughout the country on an experimental basis. These mainly involve the concept of case management aimed at supporting the most vulnerable groups in the community. Some of these projects are; the Kent and Gateshead Schemes, the Darlington Project, the Epic Project and the Gloucester Project (Challis 1996). Each of these projects was based on recognition of the need for co-ordination of services so that the individual needs of clients are met. Other projects undertaken (some of which are still in progress) relate to services for the mentally ill (Simic 1996) and various housing projects using care assistance (Petch 1996).

Overall the implementation of the 1990 Community Care Act appears to have been taken on board more seriously by individual health authorities and local authorities than by the government. The concept of integration of services begun in the 1974 re-organisation has re-emerged as an issue of importance and the above projects bear this out. The idea that hospital care and community care should run in tandem as outlined in the Griffith's Report is an ideal yet to be aspired to. Whether general practitioner services or individual hospital trusts will take over responsibility for the running of community care services in the future remains to seen.

8.6 Tensions in the System.

Many of the tensions in the British systems of welfare and health are similar to those found in the American system. Since Britain is seen increasingly to emulate the American system this is not surprising. However, if we consider the basic intention of the Welfare State in Britain, as discussed in the context of the Beveridge Report, then a tension is immediately visible. This is between that original intention and the current situation. For the first three decades of the Welfare State there was apparent equilibrium. This, as we have seen, was gradually eroded to uncover flaws the discovery of which eventually led to the current changes. As in the United States the concept of health and welfare provide major platforms for political debate. The changes instigated largely reflect the policies and views of the government in power. Health and welfare challenged political leadership at each election. A tension can be seen here between Beveridge's intention to ensure a welfare state for all and the reality of a Welfare State which encountered financial problems soon after its arrival. Beveridge could not have predicted the vast changes in society which would come about in the post war era. The tension is ongoing between those who argue for maintenance of the original plan, and those who seek reform it via the Market. This tension dates back to Beveridge's own vision of welfare before he reluctantly agreed to more state intervention. He was previously a strong advocate of the market believing that it brought out the best in people when they were innovative and enterprising. However as we shall see (Ch.11) the presence of this tension can be a tool for a more integrated system in which no one element is dominant and the idea of the monolithic state proves unrealistic.

A further tension is seen between the idea of community care and the apparent reluctance of governments to fund this aspect of the Welfare State in a satisfactory manner. This tension is manifested in a struggle to provide care in the community for the elderly and other vulnerable groups. The idealistic view of the family as primary carers for old and disabled relatives is no longer a reality for many people living alone. The degree to which the Community Care Act will bring balance to this tension remains to be seen.

8.7 Conclusions.

1. The British Welfare State has served as a model to be aspired to by many countries since its inception. Contrary to popular belief the Welfare State did not emerge as a ready-made solution to the problems of the day in 1945. It was in fact a gradual transition which began at least a century earlier.

2. Beveridge was responsible for the design of the social security system which was intended to be a safety net, a temporary form of help for periods during which work was not possible for a variety of reasons. Bevan is credited with the foundation of the National Health Service which promised health care for all, free at the point of delivery and funded from central taxation.

3. The period up to 1975 has been described as the golden years of the Welfare State. The decline which followed this period was accompanied by a parallel decline in the economy generally. The governments in power from then until now have sought to improve rebuild or dismantle the Welfare State . The political left remained commited to welfare in the face of criticism from the right who saw the idea of a free welfare service as wasteful and inefficient. The main target of criticism was the National Health Service. The welfare aspect was regarded as encouraging idleness and creating an underclass and dependency culture.

4. Beveridge identified five social giants, the eradication of which would hopefully cure the evils of the time. These were: want, idleness, squalor, disease and ignorance. The subsequent failure to fullfil the promise of eradication of all the giants has become the means by which the Welfare State is judged by its critics. In the case of welfare, idleness and want are the giants used to demonstrate the failure to secure employment for all and to deal with the problem of poverty. The problem of disease eradication has been more successful although this cannot be entirely attributed to the Welfare State as the history of early public health shows. The National Health Service has done much to improve the general standard of health. It has also provided employment for vast numbers of professionals.

5. Recent reforms of the health service have introduced the concept of the market ideology into the service, immediately creating tension between free services as originally intended and the competitive force of the market. The idea of health as a commodity is incompatible with the history of British welfare. Although the markets only hold a quasi status there is evidence to suggest that a more Americanised system is envisaged for the future.

6. There has been a historical division between health in the community and care in institutions. Tension is visible between a high input of services in hospital and other institutions and the relatively few back-up services at community level. There is further tension between the States' perceived obligation to remedy this situation and at the same time its reluctance to support the primary carers which in many cases is the family.

7. The main tension which can be identified following this analysis is that between intention and reality; between the desire of some politicians and government agencies to maintain the basic structure of the Welfare State, and the desire of others to commercialise it in line with the new consumerism. Clearly Beveridge's vision is no longer viable given the changes in society since his time. The idea of a system in which all political stances are recognised is not impossible. There would however be ongoing tensions between the various factions ie the state, the market and the voluntary sector.

References

Audit Commission. **'Making a Reality of Community Care'** London:HMSO,. 1986.

Bartley M. 'The Relationship Between Research and Policy; The Case of Unemployment and Health'. In: Oakley A, Williams S. (eds). **The Politics of the Welfare State**. London:UCL Press, 1994.

Beveridge WI. **Full Employment in a Free Society.** London.:Allen & Unwin, 1944.

Beveridge WI. **Voluntary Action; A Report on Methods of Social Advance**, London: George Allen & Unwin, 1948.

Challis D. 'Case Management: A Review of U.K developments and Issues'. In: Titterton M. (ed) **Caring for People in the Community; The New Welfare**, London:J Kingsley, 1996.

Cm 849 **Caring For People: Community Care in the Next Decade and Beyond,** London: HMSO, 1989.

Cmnd 6404. **Social Security and Allied Services**; Report by Sir William Beveridge. London: HMSO, 1942.

Cmnd 8713. **Growing Older**. London:HMSO, 1981.

Department of Health and Social Security. **Patients First,** London:HMSO, 1979.

Dean H, Taylor-Gooby P. **Dependency Culture, The Explosion of a Myth,** London:Harverster Wheatsheaf, 1992;pp26.

Fraser D. **The Evolution of the Welfare State;** London:Macmillan,. 1984.

Gamble A. **The Free Economy and the Strong State; The Politics of Thatcherism;** London:Macmillan,. 1988.

George V, Wilding P. **Ideology and Social Welfare;** Routledge Kegan Paul, 1976.

Glennerester H. **British Social Policy Since 1945;** Oxford:Blackwell, 1995;pp163, 191.

Glennerster H, Midgley J. **The Radical Right and the Welfare State;** Barns & Noble, Herts. 1991.

Griffiths Sir R. **NHS Management Report (The Griffiths Report),** London: HMSO, 1983.

Griffiths Sir R. **Community Care: Agenda For Action,** London:HMSO, 1988.

Hall P. **The Social Services of Modern England,** London: Routledge & Kegan Paul, 1952;pp4-6.

Ham C, Honingsbaum F, Thompson D. 'Priority Setting for Health Gain'. In.: Oakley A, Williams S. (eds) **The Politics of the Welfare State,** London:UCL Press, 1994.

Hayek FA. **The Road To Serfdom,** 6th Edition 1993, London:Routledge,. 1944.

Lewis J. 'Choices, Needs and Enabling; the New Community Care'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State.** London:UCL Press,. 1994.

Lowe R. **The Welfare State in Britain Since 1945.** London: Macmillan, 1993.

Marsh DC. **The Welfare State; concept and development,** Routledge Kegan Paul, 1980.

Marshall TH. **Social Policy in the Twentieth Century.** London:Hutheison,. 1979.

McLean I. **The Concise Oxford Dictionary of Politics.** Oxford University Press, 1996.

Murray C. **Underclass: The Crisis Deepens.** IEA Health and Welfare Unit in association with the Sunday Times, London. 1994.

Oakley A, Williams S. (Eds) **The Politics of the Welfare State.** London:UCL Press, 1994;pp2-3.

OPCS. **Topic Monitor 1991 Census: People aged 60 and Over, Great Britain**, The Government Standard Services, 1991.

Petch A. 'The Best Move I've Made': The Role of Housing for People with Mental Health Problem. In: Titterton M. (ed) **Caring for People in the Community; The New Welfare**, London:J Kingsley, 1996.

Pierson C 1991 **Beyond the Welfare State? The New Political Economy of Welfare**, The Pennsylvania Press, Pennsylvania.

Simic P. 'Moving out of Hospital into the Community'. In: Titterton M. (ed) **Caring for People in the Community: The New Welfare**, London:J Kingsley, 1996.

Thatcher M. **The Downing Street Years**. London:Harper Collins, 1993.

Timmins N. **The Five Giants. A Biography of the Welfare State**, Fontana Press, Harper Collins. 1995.

Titmuss R. **Commitment to Welfare.** London: Allen & Unwin, 1968.

Titmuss R. **The Gift Relationship. From Human Blood to Social Policy**, Randomhouse, New York:Pantheon Books, 1970.

Webster C. 'Conservatives and Consensus: The Politics of the National Health Service, 1951-1964'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State**. London: UCL Press, 1994.

Chapter 9 : A Critique of the Systems by Ivan Illich.

9.1 Introduction.

This chapter uses the work of Ivan Illich as a critique of the systems discussed in chapters seven and eight. It will emerge that many of Illich's criticisms are particularly relevant to the American system. However since the British welfare state is moving towards an Americanised model, the same criticisms therefore apply.

The focus of Illich's argument relevant to this discussion is health care in particular. However he has been equally vociferous with regard to education and employment (Illich 1974, Illich 1978). It must be said at this point that Illich has himself been the focus of much criticism mainly for his apparent failure to acknowledge the many positive aspects of modern science. There are those who think that his criticisms are outdated and even nostalgic. However he has presented a powerful challenge to governments and professionals which questions the progress which we all take for granted. He vividly displays the ongoing tension between modernity and tradition and is persuasive in his view that 'new' does not always equal 'good.' He does not merely criticise economic systems such as capitalism. It is the effects of industrialisation which Illich sees as dangerous. This statement covers a wide range of topics, from technology to the professionals who work in the systems. At every level there is expertise. He points to a society of experts and clients rather than citizens.

Illich's views first became popular at a time in the nineteen seventies when there was a new consciousness about health. (It was also a time of flourishing of the welfare services, in Britain particularly). In the United States media attention was beginning to focus on the effects of lifestyle on health and questions were being asked as to the effectiveness of medical treatment (Starr 1982). Environmental issues were also topical. The effects on populations of unemployment were also being considered.

Medical nihilism, of which Illich was a proponent, was being discussed. The attack on the medical profession had actually begun a decade previously when criticism of the care

of the mentally ill was the focus of media attention. Writers such as Szasz and Goffman were particularly interested in the idea of labelling people as mentally ill and the resulting stigma borne by the sufferer (Szasz 1961, Goffman 1963). The film One Flew Over the Cuckoo's Nest highlighted many of their views. The idea of regarding as deviant people who would not or could not conform was now seen as a form of social oppression and control. From psychiatry this attitude spread to general medicine (Starr 1982).

This was the beginning of the critical era and the challenge to medical supremacy. It coincided with a strongly interventionist British welfare state (p143) and the Great Society projects in America when welfare almost became a right (p117). In the light of the discussions of two systems of health and welfare let us now consider how Illich views these systems.

9.2 Illich: The Central Argument.

Illich's argument against modernity was by no means confined to health care systems. However, since this thesis is mainly concerned with welfare and health it is necessary to draw some form of boundary around specific criticisms presented by Illich. Within this context Illich sees industrialisation as the root cause of the problems of modern life. Capitalist societies have become industrial, post-industrial and mixed economy societies. Capitalism according to this view is incidental. The main problem is the dominance of industry over society (Illich 1981). Productivity, efficiency and progress are the key words in this system. Within this system there are layers of organisation, all of which according to Illich are detrimental to society. These include the bureaucrats, technocrats, managers and professionals.

Managers, technocrats and professionals can be criticised independently but the bureaucracy is seen as instrumental in the harm inflicted by the latter. Far from seeing the bureaucratic structure of organisations as necessary for the smooth running of systems on an everyday basis, Illich sees the collective control held by such groups as responsible for the flaws of modern life. Illich's contention is that at the bottom of the

layers of the bureaucracy sits the individual. But he is not seen as an individual for he is a client, a consumer or a person who 'needs' some form of service from the system (Illich et al 1992).

Illich was critical of bureaucracies and did not agree with Weber's theory that the bureaucratic system was important in all organisations in order that some form of accountability could be measured. The bureaucracy according to Weber was the most technically superior structure (Weber 1946). Illich on the other hand seems to follow the Marxist view that these are secret organisations in which power can be held at the top of the structure. He does not express the more common shortcomings of the bureaucracy which are inefficiency and waste. Examples of both are evident in the British National Health Service.

When we apply these basic statements to the concepts of welfare and health we find that, according to Illich, health services, the bureaucracies which control them and the professionals who provide the services are actually doing more harm than good (Illich 1981). Iatrogenesis is the name Illich gives to the harm done by providers of services. He describes three types of iatrogenesis : **1.** Clinical iatrogenesis, **2.** Structural iatrogenesis and **3.** Social iatrogenesis.

Clinical iatrogenesis, according to Illich occurs when sickness and pain result from medical care. Structural or cultural iatrogenesis results from medically-sponsored behaviour which restricts individual autonomy by undermining competence and ability. Social iatrogenesis is the dependence which individuals develop on medical services instead of resolving problems by themselves or in the confines of the family or friend relationship. All three of these types of iatrogeneses are applicable to welfare and health systems. We could condense Illich's labelling further to say that the problems specific to health and welfare which produce tensions are; the system, the professionals and the consumers or users of services.

Illich did not speak of tensions in the systems, but of flaws - flaws which are perpetuated and endorsed by professionals. In a passionate and radical way Illich set out to show that ordinary life had become over-professionalised and he rightly predicted that this

would escalate as people began to believe that there was an expert for every ill. To reject the help of experts has become unacceptable and such rejection clearly points to a flawed personality (Illich et al 1992). Let us consider the concept of iatrogenesis more closely under a general heading which I shall call 'The price of progress'.

9.3 The Price of Progress.

Illich describes two watersheds in the history of modern medicine. The first occurred around the year 1913. Up to that point the shamans and herbalists had equal and often better results than doctors. Since then medicine has taken over.

The Westernised public learned to demand effective medical practice as defined by the progress of medical science.' This progress was due to a new perspective of the origins of some ancient scourges, water could be purified and infant mortality lowered, rat control could disarm the plague, treponemas could be made visible under the microscope;.....Paradoxically the simpler the tools became the more the medical profession insisted on a monopoly of their application, the longer became the training demanded before a medicine man was initiated into the legitimate use of the simplest tool, and the more the entire population felt dependent on the doctor (Illich 1990).

By the mid nineteen fifties medicine had reached its second watershed and had, according to Illich, created new forms of disease (Illich 1990). From then onwards we have the evolution of the expert, the disabling professionals and the concept of iatrogenesis. There are many uncertainties implicit in the arguments produced by Illich in his portrayal of the harm done by progress in the most general sense. One immediate observation is the lack of acknowledgement of any positive effects of modern accomplishments, scientifically or otherwise. Areas which concerned other historians and philosophers appear to be overlooked by Illich. I refer to economic systems in the post-industrial era. Illich blames industrialisation and yet ignores particular types of economy such as capitalism. In other words he is as scathing in his criticism of underdeveloped countries as he is of advanced capitalist countries. This is remarkable

since many of his cogent arguments against modernity lose some credibility when the actual governmental structure of countries is left undiscussed either positively or negatively. By this I mean that in taking particular aspects of progress or industrialisation and criticising them, Illich does not appear to discuss these in the context of particular cultures. He does not appear to acknowledge that there are degrees of capitalism and that not all westernised countries have the degree of affluence of the United States. This deficit will become clearer in the Marxist critique of the systems which on the whole is much more specific in terms of 'systems' and much less critical of individuals within those systems. Nevertheless, Illich has produced an indepth analysis of health care and the role of laypersons and professionals within them. He is critical of both. His analysis of cultural and social iatrogenesis highlight lucidly the shortcomings as well as the tensions in health and welfare systems.

9.3.1 Cultural Iatrogenesis.

According to Illich this is the notion of the removal of suffering and pain and the postponement of death by medical intervention and high technology. Illich's exploration of death through the ages shows how in early history death was something private to the individual. It usually occurred naturally and various sacred rituals marked the end of life. With the advent of medical intervention death has become a commodity and the medical postponement of death a cause for celebration (Illich 1981). This point is particularly relevant to modern health care systems in view of the longer lifespan and the growing number of people over eighty- five years (p152). The quality of life for many people may not be what they had hoped for. Given the previous discussion on care in the community (Ch.8.5) in Britain the final stage of life may well mean loneliness and institutionalisation. In the United States the situation is even more precarious since only the rich can afford a reasonable standard of care for themselves or their relatives (p119). Apart from the element of cost there also appears to be a regional variation as to whether elderly people die at home or in hospital. The Dartmouth Study found that dying patients often do not get what they want in terms of where they die. The study found that four out of five Americans say they would prefer to die at home. Another study carried out at the George Washington University recently showed that many patients

endure long painful deaths in which living wills and requests for 'no resuscitation ' are ignored (Editorial Washington Post 1997). These findings support Illich's view on the desirability of dying at home. By opting to die at home Illich argues people would avoid the exile, loneliness and indignity which awaits them 'in all but the most exceptional hospitals' (Illich 1981). This view assumes traditional family networks and communities. Unfortunately it does not apply to many elderly people who may have no choice but to be institutionalised. In large cities such as New York more elderly people live alone, without the support of families and the community support typical of the smaller town (Cassel 1997). The likelihood is that this trend will continue in both America and in Britain.

9.3.2 Clinical Iatrogenesis.

Clinical Iatrogenesis is, according to Illich, the result of inappropriate medical intervention. It has become part of the engineering approach of doctors who treat individuals as machines. In addition Illich says there is medical arrogance, incompetence and misunderstanding of what health is about. There is also the accusation of harm caused by this intervention, for example inappropriate surgery (Illich 1981). Here Illich uses the example of tonsillectomy which in many cases is unnecessary. In fact he is justified in this criticism and the number of tonsillectomies has decreased in recent years. Interestingly Illich confined his views on unnecessary intervention in surgery to these particular operations and yet did not pursue the issue of caesarian section births although at the time this was one of the most overused services. This may be because the question of intervention in the birth process was only recognised as a flaw at a later date by women's' groups and feminist organisations.

Clinical iatrogenesis was certainly the aspect of criticism which offended the medical profession most. At a time when saving lives via the various new technologies was widely regarded as heroic, such criticism was not welcome. In Britain and America the mid -nineteen seventies was the golden age of welfare and interventionist medical care. As we have seen in Part One (p58) there was a growing need for professionals of every

kind in health services. This need was perpetuated by professionals and with each new disease category came services manned by professionals.

In American society it is not just the medical professions which intervene in people's lives but also the manager and the therapist (p36). This is a growing area of the American culture and part of the world of bureaucratic consumer capitalism (Bellah et al 1996). In the British systems of welfare and health we saw the entrance into services of general and unit managers as a result of the Griffiths Report (p148) (Griffiths 1983). Illich was accurate in his description of the manager as being concerned with budgets, personnel, organisational structure and technology. In fact Griffiths had previously been a director of Sainsbury's Supermarkets (Harrison 1988).

These categories are part of what Illich labels 'the age of the expert' which will be considered presently.

9.3.3 Social Iatrogenesis.

The dependency which the public has developed towards professionals and the state is what Illich means by social iatrogenesis. It is of interest to note that this aspect of the argument differs fundamentally depending on the system under review. The British system of health and welfare, for example with its so-called 'nanny state mentality ' (at least until recently), can be seen to have created such dependence. The charge of dependency on welfare is well established. In America on the other hand the reluctance of the state to provide welfare beyond the bare minimum and the stigma which remains part of the welfare culture means that the charge of dependency is less applicable.

In terms of welfare generally, and health care particularly, it is the professional that Illich singles out as the source of most harm to the consumer (Illich et al 1992). Apart from the process of industrialisation and the bureaucratic structure of modern organisations it is the professional who perpetuates the need for services by convincing the public that they are needy. The welfare professionals which includes social workers, teachers and doctors are part of the system which strips people of the competence to make their own

decisions. The citizen is turned into a client to be saved by experts. This view was raised in Part One, Chapter 4 (p58) where I suggested that in relationship to professionals in welfare services there is indeed a case for supporting Illich's idea 'a society of experts'. This is based on the proliferation of professionals and experts since the beginning of the Welfare State. It is also based on the diversity of experts (often self-proclaimed) within these services. Illich takes the notion of the professional as expert to an extreme level, labelling them en masse as 'disabling'. To the extent that professionals can promote the view that their knowledge is superior to that of the client then there is justification to the claim by Illich that professionals are disabling.

Three disabling effects of professionals, in Illich's view, derive from the professional assumption of need. These are: **1.** The translation of a need into a deficiency. **2.** This perceived deficiency is often placed in the client as opposed to his particular circumstances. **3.** Needs are compartmentalised, that is there is different professional input for every aspect of life (Illich et al 1992).

The power which the professional holds over the client has already been noted (p74). I have referred to this undoubted power as control over clients. In Illich's view there is an assumption on the part of the professional that the client will not understand much of what is being done or said. This has certainly been the case with regard to welfare claims when many citizens failed to make legitimate claims because of the incomprehensible coded language on benefit forms. On the whole Illich's argument focuses on the concept of the client as needing professional services, and through conditioning being unable to recognise when he does not need any such service. 'A needless citizen would be highly suspicious; to be ignorant of one's own needs has become the unforgivable social act' (Illich et al 1992).

Two tensions are discernable from the last argument. The <u>first</u> has already been discussed (p69) which is the tension between controlling and caring on the part of the professional and the extent to which his role in the system is at odds with his own beliefs. The <u>second</u> tension emerges as relatively new. It concerns the role of the professional under the consumerist vision of care as opposed to the professionally dominated services. Within the context of consumerism the professional <u>cannot</u> be the

'disabler' which Illich describes, for the new ideology expects him to be an 'enabler'. There is a resulting tension between that which was part of the expectation of professionals and that which the new rights-based, choice orientated, informed clientele now demands. The 'enabling ' expectation is frequently cited in terms of health promotion and education and has become a buzz word together with the concept of empowerment (p223). This enabling role forces the professional to 'do' less, to stand back and provide a service based on knowledge and facts while allowing the patient/ client to make his own choices. This lack of 'doing' can be perceived by some professionals with unease, as removing their autonomy. It may also be seen as redressing the balance of power from the professional to the client/consumer. The presence of a tension here can be positively regarded if it (a) prompts the professional towards a higher standard of service delivery, (b) encourages the public to be in charge of their own welfare and (c) if it equalises the rift between professional and client.

9.4 Self-Care in the Age of the Expert.

The experts and the ethos of a society of experts has branched out beyond the boundaries of the professions. Health and welfare systems have created a need for counsellors and other advisors in keeping with new labels of disease both physical and mental. In all areas of life there are experts-

The new specialists who are usually the servicers of the human needs that their specialty has defined, tend to wear the mask of, and to provide some form of care .....They are more deeply entrenched than a Byzantine bureaucracy, more international than a world church, more stable than every labour union, endorsed with wider competencies than any shaman, and equipped with a tighter hold over those they claim than any mafia' (Illich et al 1992).

In spite of his view of the expert Illich does not favour what he calls 'the illusion of radical chic'- the self-helpers (Illich et al 1992). Illich, surprisingly does not see the idea of self-help as positive because, he argues it is an attempt to professionalise the public. As the discussion in Chapter 11 will show (p207) this fear may be unfounded since the

whole ethos of self-help is based on the desire of ordinary people, in particular circumstances not to engage the help of professionals. Clearly Illich has something else in mind. He has certainly criticised the idea of various health-related companies for promoting a do it yourself philosophy when this amounts to selling literature and home-diagnosis kits and over the counter medications. His objection seems to be focused on the production/consumption aspect of selling such information. To the extent that much of the self-help literature is produced by self-professed experts often with some background knowledge then the criticism is justified. There is indeed a ground for concern regarding the information published in some of the 'natural' and 'alternative therapies'. Over-use by the public of some vitamins is just one example. Self-treatment with homeopathy is another potentially dangerous exercise.

What Illich advocates is not self-help in the sense in which we regard it but self-care. This has as much to do with lay perceptions of health as to actual treatment. The underlying concept is that since medical professionals do more harm than good then the public ought to less willing to entrust themselves to professionals. Self-care based on the individual's knowledge of his own health in the context of the community is the vision held by Illich. Here Illich highlights an increasing tension between orthodox medicine and alternative and complementary therapies. At one time the 'pull' or 'force' of this tension was grounded in the medical side, now the opposite side is converging with a resulting conflict between professionals. It has been suggested that this change has come about due to the public's dissatisfaction with conventional medicine (Weatherall 1995). Such tension can be interpreted as public interest in health and a move away from the interventionist style of treatment found in health services. Part of the self- care philosophy advocated by Illich involves the need for suffering pain occasionally. Pain is part of life. It helps us recognise when something is wrong with the body. Historically people have dealt with various kinds of pain by self-medication, massage and acupuncture. Pain, according to Illich, has become a political issue and, a thriving industry for the manufacturers of pain killers. Treatment of pain is part of the medicalisation of life directly resulting from modernisation and industrialisation (Illich 1981).

Recently Illich appears to have altered his views on the 'medicalisation' of life. He states that if he were rewriting Medical Nemesis he would now change the term to 'systematisation'. It is the total system and the language of systems rather than the medical profession alone which is responsible for the fact that 'a person is now a life that emerges from a gene pool into ecology'. Death is now regarded as the irretrievable breakdown. Systems are used in many contexts. We now speak of human immune systems, management system and 'the state of one's system referring to health. Medicalisation has progressed and people are now managed by experts before they are born. (Illich 1995).

In choosing 'systematisation' rather than 'medicalisation', Illich appears to concede that medicine is only one system involved in the circle of life. In view of is theory of industrialisation as a regrettable state then seeing progress in terms of systems is more accurate and no doubt more palatable to many of his critics.

9.5 Predictions for the Future.

Interestingly, many of the predictions and the prescriptions recommended by Illich are being realised in both of the systems of health and welfare reviewed. One of these was the suggestion by Illich that consumers should force doctors to '*improve their wares*' (Illich 1981). Consumer satisfaction has been part of the American system for several decades. In Britain the introduction of quasi-markets into the health service is relatively recent. There is a move towards consumer participation (p204) and recognition of consumer views on the quality of care and services delivered. However the extent to which this has happened and with what effect has yet to be seen (Popay and Williams 1994). Various areas have been targeted for research of this kind (p205).

The suggestion by Illich that more attention ought to be paid to environmental issues is now receiving attention. Of the surveys so far carried out it seems that there is a wide gap between lay perceptions and those of professionals on these issues. The issues of public concern are related to poor housing, unsafe roads and pollution (Popay and Williams 1994). So far governments have been slow to act on these matters.

9.6 Conclusions.

1. A Critique of the American and British Health and Welfare Systems by Ivan Illich has provided an insight into tensions in the systems by highlighting the effects of progress on the modern perception of health and the mode of delivery of these services.

2. Though widely criticised for his views on the medicalisation of ordinary life Illich challenged professionals and institutions to question their own beliefs at a time when the whole ethos of medical intervention and technology was being celebrated.

3. The idea of a society of experts as Illich has shown has become a reality. There is now an expert for every ill and a dependency by the public on these experts. That many of these experts are self-proclaimed shows, in Illich's view, that as long as consumers are made to feel needy then more experts will emerge. This notion of expertise infiltrates all aspects of life from health to education.

4. Illich predicted a change which is gradually being realised. There is now a move away from the traditional, conventional medical care as the only option and a move towards a more holistic approach which involves self-care and self reliance. This change is part of the consumerist ideology where the users of services have choice and the confidence to exercise that choice.

5. The 'disabling' professionals described by Illich must now become 'enablers' which involves 'being' rather than 'doing'. This new role which is also part of the consumerist ideology is a prerequisite for effective health promotion and education. Here the professional role assumes updated knowledge and the ability to 'empower' people to take charge of their own health and welfare. A tension is visible in this role which is mainly positive since it leads to a more even distribution of power.

6. A further tension emerging from the critique by Illich is that between the idea of self-care and orthodox medicine.

7. The overriding tension illuminated by Illich involves all systems in industrial society. In a recent work Illich has substituted the label 'medicalisation' for 'systematisation', recognising that no one system is responsible for the problems of modern life. Although he did not refer directly to 'tensions' Illich was clearly aware of many imbalances. His work 'Tools of Conviviality ' seeks to find a balance for the defects of progress. Finding a balance between the tensions within health and welfare systems whereby a degree of equilibrium is achieved may be more realistic than radical change. The presence of tensions maintains a focus of attention on what Illich sees as flaws originating from industrialisation.

References

Bellah RN, Madsen R, Sullivan WM, Swindler A, Tipton S. **Habits of the Heart Individualism and Commitment in American Life**, University of California Press, 1996.

Cassel C. 'Pre-Death Health Care Varies Widely By Location' Dartmouth Study Shows. **Washington Post**, Wednesday October 15, 1997.

Editorial Cover Story. 'This is an Employee Benefit on the Wane', **USA Today**, Thursday October 16 1997.

Griffiths Sir R. **NHS Management Report** (The Griffiths Report), London:HMSO, 1983.

Goffman E. **Stigma: Notes on the Management of Spoiled Identity**, Englewood Cliffs, New Jersey:Spectrum, 1963.

Harrison S. **Managing the National Health Service,** Shifting the Frontier? London: Chapman and Hall, 1988.

Illich I. **Deschooling Society**, 6th Edition, London: Marion Boyars, 1974.

Illich I. **The Right to Useful Unemployment,** London:Marion Boyars, 1978.

Illich I. 'Limits to Medicine'. **Medical Nemesis: The Expropriation of Health** Fourth Edition, Penguin Books, 1981.

Illich I. **Tools for Conviviality**, 3rd Edition; London:Marion Boyars, 1990.

Illich I. 'Death Undefeated, from Medicalisation to Systematisation'. **British Medical Journal**, 1995;311: 23-30 Dec 1652-1653.

Illich I, Zola I.K, McKnight J, Caplan J, Shiken H. **Disabling Professions,** 4th Edition, London:Marion Boyars, 1992.

Popay J, Williams G. 'Local Voices in the National Health Service: needs, effectiveness and sufficiency'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State.** London:UCL Press, 1994.

Starr P. **The Social Transformation of American Medicine;** New York: Basic Books Inc. 1982.

Szasz T. **The Myth of Mental Illness.** New York:Harper & Row, 1961.

Weatherall D. **Science and the Quiet Art.** Medical Research and Patient Care, Oxford University Press, 1995.

Weber M. 'Bureaucracy', **Essays in Sociology**, Translated & Edited by H.H Gerth & C. Wright Mills, Oxford University Press, 1946.

Chapter 10 A Marxist Critique of the Systems.

10.1 Introduction.

The idea of a Marxist critique of the systems aims to reveal and to highlight tensions within the systems of health and welfare. As we have seen in chapter nine the work of Illich served to demonstate tensions which may be seen as particularly relevant to the American system although many of the points made are equally relevant to Britain. The Marxist view is also relevant to both systems though some would say to the British system in particular.

Whereas Illich is critical of the overall system and process of industrialisation, Marx singles out the capitalist system as one area to be criticised. The various flaws identified by Marx as the problems of capitalism can actually be regarded as tensions identifiable in the daily functioning of health and welfare systems. While it is true that Marx and his followers saw 'conflicts' and 'contradictions' in welfare systems I shall show that at least some of these conflicts are no more than tensions which, as I have suggested are not necessarily negative. For example, what Marxists see as conflict between workers and the owners of the means of production, may in fact be viewed as tensions which are necessary for the instigation of change. An example of this is seen in workers strikes to improve conditions or wages or safety aspects. Without this continuous tension positive change might not evolve and conditions would not improve.

In using the work of Marx to illustrate tensions in the systems it is appropriate to firstly to identify particular arguments by Marx and apply these to the health and welfare systems. If, for example, we take 'class' as a central problematic area in Marxism we can then see tensions relating to that particular aspect as being manifested in an inequality of health service allocation between classes (Black et al 1992). In Marxism the notion of class as we shall see, is not straightfoward and must be viewed as part of the perceived suppressive action of capitalism, that is to say the supremecy of a ruling class over a working class.

Some tensions have already been identified in the three models of citizenship. The problems of capitalism for instance are readily identifiable with a Consumerist Model of Citizenship. The area of Marxism which has particular relevance to health and welfare systems is his criticism of the economic system of capitalism. Clearly this is but one aspect of Marxism, but the perceived shortcomings of it will uncover other strands which in turn can be identified as tensions. This identification of tensions will involve consideration of what some commentators call contradictions in the Marxist view. Let us begin by considering the Welfare State from a Marxist perspective as a basis for drawing out the various tension-producing strands. Two of these strands will be discussed presently. They are: exploitation and alienation. Each of these can be seen to spring directly or indirectly from either class conflict or capitalism in general where class is one fraction of the total equation.

10.2 The Welfare State - A Marxist Perspective.

A Marxist view of the welfare state is underpinned by the relationship of the citizen to the state. It must be emphasised that Neo-marxist views may not reflect true marxism and that even between Neo-Marxists there are often conflicting opinions. However some general comments can be made based on the literature on the subject, which tend to demonstrate a Marxist view of the welfare state.

1. In general the welfare state is positively regarded to the extent that it is seen to have improved the lives of the working classes.

2. It has, however failed to deliver the degree of reform initially promised (Strachey 1957, Barratt Brown 1971).

3. The welfare state is criticised for creating a passive recipience of services with little in the way of participation on behalf of the users of services (Pierson 1991).

4. Specific services and benefits such as social security are seen as superficial attempts at public compliance with little effort being made to solve the real social problems (Barratt Brown 1971).

5. By keeping cash benefits at a bare minimum the status quo is maintained and working class revolt against the system is avoided. (Ginsburg 1979, Gough 1979).

6. The bureaucratic structures of the welfare state are negatively regarded as pandering to the interests and needs of the middle classes and may even be a means of controlling the poor (Piven and Cloward 1971).

7. Individual employees within the services i.e the professionals are seen as part of a system whose interests they are forced to serve and this may be in conflict with particular individual interests (Navarro 1976).

8. The various services provided via the National Health Service, while ultimately improving health and therefore quality of life, are in fact mainly aimed at maintaining a stable, healthy workforce whose labour serves the interests of the capitalist system (Gough 1979, Hugman 1991).

9. Finally the Welfare State is often seen as the caring face of capitalism. While the positive effects of this are incidental there cannot be harmony between capitalism and genuine social welfare (Doyal and Pennel 1979).

10.2 Marx on Welfare, Rights and Need.

Marx would clearly be suspicious of the modern Wefare State. The Neo-Marxists also hold the view that the Welfare State serves the interests of the capitalist system. In spite of his strong feelings regarding employment conditions Marx was sceptical about the idea of rights - human rights in particular. He takes issue with the concept of a difference between the 'Rights of Man' as listed in the Declaration of Human Rights, and the rights of a citizen. '*Who is this man who is distinct from the citizen*?' The isolation of the

term citizen means that there is a lesser and a higher being and that man in his capacity as citizen is less important than the man on which the Rights of man is based (Marx 1843). It might be concluded from this that rights to welfare in the Marxist doctrine were regared as ambiguous and this appears to be borne out by the relative lack of commentary on this particular issue even by the Neo- Marxists. The latter seem to be of the opinion that services such as social services, health services and education are in tension with the more coercive aspects of the state. This has led some writers to speak of contradictions which have ultimately led to crises in the the Welfare State (Offe 1984).

Marx takes each of the rights listed in the Declaration of Human Rights and appears to conclude that what is written in the various constitutions and declarations differs from the practical application of these rights. The whole idea of rights seemed to him to be a condition for the accumulation of wealth by those who flourished most during industrialisation. Membership of a community should not depend on rights but should be a condition of those elements of life actually enjoyed by the citizens (Marx 1843). Marx's view on structure of labour and its alienating potential substantiates this idea of citizenship.

The right to paid employment should be such that a man could change his job if he wished and should go beyond the fact that no man should be barred from employment on the grounds of race or sex. Employment should actually be available to any right-holder

The question of 'need' in Marxist doctrine is more complex. Some writers have focused on the confusion in Marxist texts due to particular uses of words. 'Need' is one of the terms subject to this criticism. According to Marx need is synonyomous with want and drive. The fact of having needs is never lost although people do not always realise all their implications, and learning how to satisfy them most efficiently requires intellectual skill (Marx 1844). Need in Marixism is always attached to power. A power is whatever is used to fulfill a need. To know any power is therefore to know its corresponding need and vice versa (Ollman 1971). Each stage in history creates its own distinctive needs in man, and with the passing to the next stage these needs disappear

along with their owners, to be replaced by new people and new needs. In primitive society man's needs were poor, few in number and only capable of meagre satisfaction. Communism on the other hand is rich because it assumes that man's needs are based on the totality of life's activities (Marx 1844).

Capitalism has a major effect on need according to Marx. It transforms 'whims' and 'caprices' into needs (Marx 1844). Meanwhile under the consumerist system the needs of the workers are ignored.

Rights and need then, in the context of a Marixist view of welfare would seem to substantiate the idea that welfare and capitalism are incompatible. Being a member of a community should guarantee the use of all services to all citizens regardless of any other criteria.

10.3 The Idea of Class in Marxism.

The idea of class permeates the whole philosophy of Marx. It is central to the Marxist perspective of welfare under capitalism and it appears as a focal point wherever there are discussions by Marxists on actual public services and on the professionals who operate those services. Wherever the notion of class seems to be ignored, as in America, a major tension emerges since all of the factors which create the conditions for domination of one class over another are nonetheless present. The absence of the use of the class label therefore highlights its covert presence even more. Conflict between workers and the capitalist class was present intermittently during the ninteen sixties and seventies in America (Navarro 1994).

The struggle to secure a National Health Programme in America is also class-linked. We have already seen evidence of the social divide in terms of rich and poor (Ch.7). The 1988 Jesse Jackson Campaign tried to introduce the idea of class awareness. The purpose of the campaign was to empower working people and to help them question how the powers such as class, race and gender had control over their lives. The campaign was unsuccessful (Navarro 1994).

A class system is present in American society in spite of the use, in ordinary discourse, of vague terms such as 'middle America', 'the rich' and 'the poor'.

10.3.1 Class Divisions in Marxism.

Undoubtedly the two classes which feature most prominently in Marxism are the ruling class and the proletariat or working class. However it appears that Marx's perception of a working class meant more than 'workers'. In fact in order to be a member of a working class (according to Marx) there were two conditions. One was the subjective view which required that the workers had to be capable of organising themselves politically. Without this capability they were just a mass of individuals. The other view - the objective view - was related to the actual work done. The worker must be productive, that is he must produce enough to generate capital. In this way surplus value is created which in turn maintains the capitalist system of production (Miliband 1979). Productivity is not seen as necessarily the result of individual effort for there can also be a collective sense of labour. This collective labour can include service workers of all kinds. However the lowest status is that of the factory worker. At another level there is the class which includes business owners, shop-keepers and the self-employed and state employees such as police and the military (Miliband 1979).

As far as the capitalist class is concerned it is not clear where this category ends and the self-employed begins. In any case the capitalist class includes the owners and controllers of the means of production. There is also another class which in the Marxist literature is a level below government officials but above the professionals. This class is frequently referred to as the power elite (Navarro 1976). This comprises the owners of large business and corporate organisations. In the United States particularly this group can exert pressure on the government to influence various campaigns either negatively or positively. A example of negative pressure was seen during the Clinton Health Bill campaign (p119) when many influential and wealthy organisations (such as the American Medical Association) were able to apply negative pressure against the Health Bill in spite of the presidential campaign.

The significance of class divisions in Marxism is that the now outmoded notion of class was used in the early part of the twentieth century in the period before the war and again in the nineteen -sixties to highlight the plight of the working class. The idea of class was therefore central to the argument surrounding suppression of one class by another. The formation of a strong working class in Britain was also put foward as a reason for the development of the Welfare State (Ginsburg 1979, Gough 1979, Jessop 1983). This argument was further supported by the absence of such a structure in the United States where a welfare system as we know it in Britain did not emerge.

In Marx's ideal society, that is one in which capitalism has been overthrown, there would be no class system. In the gradual transition from socialism to communism all members would live on income from the same source.

Whether or not we accept the theory of suppression of one class by another there is certainly a class- linked basis to disease patterns, to uptake of services and to allocation of services. It is, for example, frequently argued that it is the middle classes who have gained most from the National Health Service. Whether this is because this group are more aware of the right to certain services, or whether they are more motivated to use them, whether the services themselves are more available to the middle class population is not clear. What is clear is that mortality rates as a result of particular diseases are higher in the lower socio-economic groups (Black et al 1992). Where the Marxist view of health services may have particular relevance is in terms of occupations held by lower socio-economic groups. There is evidence to suggest that boring repetitive work as found among factory workers is associated with several stress -related illnesses. These illnesses can be physical, mental, or both (Navarro 1986).

10.4 Marx on Capitalism

In order to understand the class difference described by Marx it is necessary to consider his view of the state and the individual's place in the system. There are at least two strands to the relationship between classes and the state which can be identified. The first is that the state holds a degree of power independent of class forces. The second is

the view that the state is merely a superstructure serving the interests of the dominant class (Held 1989). The first point comes from Marx's confrontation with Hegel, for whom the bureauracy of the state was vitally important. Marx was critical of the bureaucracy by which he meant all state officials. It was the closed shop mentality and the secrecy that Marx objected to.

As for the individual bureaucrat, the purpose of the state becomes his purpose, a hunt for promotion and careerism (Marx 1844).

Marx's theory of class divisions must be seen as part of his overall critique of capitalism. This critique challenges the basis of the process of production, consumption and the whole labour process. The work relationship between capitalist and worker is compared with older systems such as the slave and the serf to their masters. While the slave was in effect owned by the master, the serf was forced to pay an agreed sum to the master in lieu of his labour. These arrangements were clearly unsatisfactory but so, according to Marx, is the relationship between the capitalist and the worker. In order to explain this further Marx produced a detailed account of this process surrounding work and workers in Capital Vol. 1. According to Marx the basis of any society is what is produced and how it is distributed. The commodity which is produced has a value and a specific relationship to human labour.

'A commodity is, in the first place, an object outside us, a thing that by its properties satisfies human wants of some sort or another. The nature of such wants, whether, for instance, they spring from the stomach or from fancy, makes no difference' (Marx 1867).

Whatever the nature of the commodity it is at the heart of the cycle of production and consumption. In setting out the nature of this commodity production and its effect on workers, it will emerge that according to Marx's view there will always be a tension between those who work and those who gain from that work. The central tennet of this process is what Marx sees as exploitation. Let us examine this theory more closely.

Under capitalism the price of a commodity equals approximately the work time taken to produce it. This approximate work time is what is known as the value of the

commodity. The capitalist will then sell the products, machinery etc. at these values and then retain the surplus for himself. The surplus value in terms of labour power can be increased in two ways to the detriment of the worker. **Firstly** working time can be extended. Marx calls this 'absolute surplus value'. **Secondly,** the actual work can be intensified so more output is expected in a given time thus creating physical fatigue and mental stress. This is clearly the pattern under capitalism. The motivation to achieve more or better output is often accomplished by bonus payments for a given target in a day or a week. The competitive aspect of this method may also affect relationships in the workplace and create 'bad feelings' between workers. The end result of this relationship is exploitation of the worker (Marx 1867).

The idea of the capitalist/ worker relationship as one of exploitation is just one aspect of the Marxist view. In the context of the Welfare State it has been suggested by some Marxists that the Welfare State itself is necessary for the perpetuation of the capitalist system. Any changes or reforms are seen as strenghthening capitalism. Again this argument centres round the notion of work and production. There are in fact a number of ways in which the Welfare State has influenced the work process:

1. It has created employment for large numbers of professionals, semi-professionals and skilled and unskilled workers.

2. The trend for introducing new jobs, most notably counsellors is continuous so that there is a reciprocal dependency between the state and its employees.

3 If we apply the Marxist critique of exploitation of workers then the National Health Service again reveals a division of labour reminiscent of such a theory. Ancillary workers might constitute one group which has been exploited insofar as they have been concentrated in the lower pay sector. In 1976 seventy five percent of these were women (Doyal and Pennel 1979).

Marx highlights the tension inherent in the apparent necessity for capitalism to maintain a system in which one group exploits another. At another level this exploitation occurs in the workplace. If we consider levels of pay and entitlements for part- time workers

and full-time workers, the former have relatively less benefit and status in terms of prospects for promotion (Employment Dept. Group 1993).

It is of interest to note that the Marxist theory of exploitation does not include professionals. It appears that it is the use value of professional work which is important here. This means that professionals, by virtue of their skill and expertise, create productive labour. Since the product of this labour is necessary to help others achieve similar skills, the professionals therefore are not exploited (Larson 1977).

As far as welfare professionals are concerned it is the overall structure, and particularly the bureaucracy which is criticised. In other words it is the system which controls the professionals rather than individual professionals. This view differs from later Marxists such as Gramsci who saw professionals as intellectual and therefore of great importance to the ruling class. Gramsci described professionals as appearing like caste members all fighting to defend their autonomy (Gramsci 1971).

10.5 The Concept of Alienation.

The idea of alienation is a recurring theme in the work of Marx. Alienation as a general term refers to a condition where a person finds himself separated from some feature of his context (Miller 1989). For Marx alienation arises only under specific social conditions. It is not a human condition but rather an objective concept which always arises as a result of something and always means estrangement from something (Marx 1844).

Marx's use of the term alienation related mainly to work, and the individual worker's relationship to it. Under capitalism private property is the result of alienated labour. Alienation occurs for several reasons. The worker is alienated from his work, he may well be in employment which he does not enjoy. The work is not voluntary, for it is enforced or done out of economic necessity. There is therefore little job satisfaction. Not only is the actual work alienating but also it is work done for somebody else. He

therefore becomes alienated from the source of employment (Marx 1844). The individual then becomes alienated from other workers and finally from himself.

The alienating character of work described by Marx is readily identifiable in many kinds of low paid employment. There is also another aspect of alienation seen particularly in the American workforce. This is what I have already described as the 'job lock' situation where workers are forced to remain in the same dissatisfying employment in order not to lose insurance benefit (p130). The consequences for health are that there are high turnover rates, absenteeism and hostility to management. Part of this hostility is directed towards the bureaucrats who are usually distant both physically and emotionally from the workers. A tension exists between the necessity under capitalism to keep certain grades of worker supressed in terms of work conditions, and the necessity for the worker of having to remain in such circumstances. The capitalist system therefore highlights the ongoing tension between economic affluence and the poverty line.

While Marx confined the concept of alienation to work situations Hegel (with whose view Marx disagreed) argued that alienation was something which came from within the individual. It was therefore not to do with the material conditions of existence as suggested by Marx. In Hegel's view each person can rid himself of alienation by his will. Marx saw the end of alienation as happening only with the overthrow of capitalism (Marx 1843). The significance of the concept of alienation can be observed most clearly in capitalist systems.

10.6 Conclusions.

1. A Marxist critique of systems of health and welfare has been usefully employed to show various tensions within these systems. This critique differs from that of Illich in so far as one aspect i.e capitalism has been singled out. According to the Marxist view the Welfare State emerges as a system which is incompatible with capitalism. The idea of the Welfare State as the caring face of capitalism is misplaced and the reality is that welfare serves the interests of the capitalist system.

2. Welfare serves the interests of capitalism in a number of ways. Capitalism depends on the labour of a fit and healthy workforce. The workforce is essential for production which is essential for creation of the commodity , which in turn is essential to consumer needs.

3. Within the capitalist system the element of class is a prominent force. Whether class divisions are visible as in Britain, or invisible as in America, the idea of class remains significant. There is domination of one class by another under capitalism and again this is more obvious in systems which tend to deny the importance of class.

4. As far as health and welfare services are concerned there is clear evidence that services and their uptake and distribution favour the middle classes. Statistics show higher mortality rates and a greater prevalence of certain diseases among lower income groups.

5. Two strands have been identified within the Marxist Critique as tension-producing. One of these is the concept of exploitation. This exploitation refers mainly to low paid workers in low status jobs. Both of these are evident in Welfare State employees. Professionals, according to a Marxist view escape exploitation since the product of their labour is useful to other trainee professionals.

6. The second tension-producing strand is alienation. The Marxist perception of alienation relates mainly to employment. It is suggested that workers in boring reptitive jobs in a capitalist system result in three types of alienation; the worker becomes alienated from the source of work, from his co-workers, and finally from himself. The result is manifested in poor health both mental and physical.

7 The overriding tension which emerges is that between capitalism and those ruled by the system; between the workers and those who gain from that work. As far as the Welfare State is concerned there is tension between the necessity for capitalism of maintaining a system of welfare and the consequences of this which in Britain in particular, has produced a dependency culture.

References

Barratt Brown M. **The Welfare State in Britain,** Socialist Register, Merlin Press, 1971;pp 202-3.

Black D, Morris C, Townsend P. 'Towards an explanation of health inequalities'. In: Townsend P, Davidson N and Whitehead M. (eds). **Inequalities in Health. The Black Report. The Health Divide.** Penguin Books, 1992;p111.

Doyal L, Pennell I. **The Political Economy of Health,** Southend Press. 1979.

Employment Department Group **Labour Market Quarterly,** Report: Employment Department, London, 1993.

Ginsburg N. **Class, Capital and Social Policy.** London:MacMillan, 1979.

Gough I. **The Political Economy of the Welfare State.** London:MacMillan, 1979.

Gramsci A. **Prison Notebooks.** Hoare Q, Smith N. (eds). New York:International Publishers, 1971.

Held D. **Political Theory and the Modern State,** California:Stanford University Press, 1989.

Hugman R. **Power n the Caring Professions,** London:Macmillan Press, 1991.

Jessop B. **The Capitalist State. Marxist Theories and Methods,** 1983.

Larson MS. **The Rise of Professionalism. A Sociological Analysis,** University of California Press 1977;pp11.

Marx K. 1843 'Critique of Hegel's Doctrine of the State', in **Early Writings** Penguin Classics, 1990;pp112-113.

Marx K. 1843 'On the Jewish Question', in **Early Writings.** Translated by Rodney Livingstone, Penguin Classics, 1990;pp 136.

Marx K. 1844 'Economic and Philosophical Manuscripts', in **Early Writings**, Penguin Classics, 1990.

Marx K. 1867 **Capital.** A Critique of Political Economy' Vol. 1 The Process of Capitalist Production; New York:International Publishers Sixth Edition, Translated by Moore & Aveling 1967;pp139.

Miliband R. **The State in Capitalist Society.** London:Coronet Books, 1979;pp14-16, 35-37, 46-7.

Miller D. **Market, State and Community. Theoretical Foundations of Market Socialism**, Oxford:Clarendon Press, 1989;p203.

Navarro V. **Medicine Under Capitalism.** New York:Prodist, 1976;p189.

Navarro V. **The Politics of Health Policy. The US Reforms 1980-1994** Cambridge, USA:Blackwell, 1994;p137.

Navarro V. **Crisis, Health and Medicine**. New York and London: Tavistock, 1986.

Offe C. **Contradictions of the Welfare State.** London:Hutchinson Education, 1984;pp5Ol.

Ollman B. **Alienation. Marx's Conception of Capitalist Society**, Cambridge Unversity Press, 1971.

Pierson C. **Beyond the Welfare State? The New Political Economy of Welfare**. The Pennsylvania:Pennsylvania Press, 1991.

Piven F, Cloward R. **Regulating the Poor: The Functions of Public Welfare**. New York: Pantheon Books, 1971.

Strachey J. **Contemporary Capitalism**, New York:Gollanez, 1957.

PART FOUR:

CITIZENSHIP AND TENSIONS

PART FOUR: CITIZENSHIP AND TENSIONS

Introduction to Part Four.

This final part of the thesis returns to the idea of citizenship. Two main strands will be discussed. One is the concept of participation and the other is the concept of tensions. The concept of participation will be analysed with reference to various studies currently in progress in health and social services. The aim will be to draw together the main outcomes of discussions so far, and from them to propose a system which will be based mainly on the Neighbour-Centred Model described in chapter 3. The Neighbour-Centred Model was the one chosen as the most appealing and practical for the practice of citizenship.

The analysis in chapter 3 of the Neighbour-Centred Model concluded that the idea of community, while recognised as a positive goal, had nevertheless an element of exclusivity which was considered inappropriate for the practice of citizenship. It was further concluded that a traditionally strong element of the notion of community, that is fraternity, was no longer seen as relevant in terms of the label 'fraternity'. An alternative was suggested ie 'neighbourly solidarity' which seemed to overcome the problems identified, while at the same time emphasising the idea of neighbour relationships p(49).

The concept of neighbour as opposed to other terms such as stranger or brother was chosen as the most applicable for citizenship. This was because the concept of neighbour assumes the possibility and reality of relationships without the emotional ties of the old community and without the pressure of the brotherly bond. This would offer a more modern vision of citizenship, one which is compatible with other roles. The concept of neighbour allows for the fact that the individual qua neighbour is primarily and most significantly a member of his community but with the ability to be a client and a consumer. These other roles may be intermittent during the course of a lifetime but the neighbour relationship outlives both.

The main conclusion therefore from an analysis of A Neighbour-Centred Model was, that in spite of various restrictions, this model could be used as a basis for participatory citizenship.

In speaking of the practice of citizenship in the context of this thesis, it is citizenship associated with welfare and health with which I am mainly concerned. These two elements will therefore be recurring features throughout. As we have seen welfare and health are two of the ways in which particular styles of citizenship are manifested. The differences in two systems were illuminated in the analyses of the American and British Health and Welfare systems (Chps 7,8).

In returning to the notion citizenship (Ch.11), I shall be concerned with the idea of the active citizen. This term has recently become popular. Its meaning will be explored in the light of various government manifestos, proposals and charters.

A discussion of the active citizen involves the exploration of the idea of participation. There are a variety of ways in which this can appear but I shall concentrate mainly on public participation in welfare and health-related services. A detailed discussion of citizen participation in government as part of a democracy is beyond the scope of this thesis. However some elements of this will appear in the context of specific services. Local government for example, is envisaged as being a strong component in the way in which actual public services are delivered. In fact the liaison between health authorities, social services and local government bodies is crucial to the type of citizenship envisaged.

Various tensions in the systems have been identified throughout previous chapters. The question of how these tensions can be reconciled as an ongoing and inevitable part of the system will be explored. This will involve a discussion of the roles of various institutions including the state, the market,and the intermediary body. It is envisaged that no one element will be dominant and that citizenship will include input from all factions discussed. The roles of the state and the market are important and it is suggested that a balance is possible between these two traditionally rival forces. The idea of the 'nanny state' should not be replaced by the 'night-watchman state'. Neither

would be appropriate in the context of modern citizenship. The positive aspects of the market are frequently cast aside in the health and welfare debates. Yet, to the extent that the market represents consumer interests, and offers choice, it is important to the practice of citizenship. The market also offers the possibility of a rejection of the notion of dependency and its competitive element can trigger positive action by enterprising individuals.

Chapter 11: Citizenship and Tensions in the Progressive Society.

11.1 Introduction.

The idea of 'the active citizen' has recently become popular. Each of the political parties have at various times put forward the view that the individual should be part of the decision-making process in matters of interest at local level. On the whole the reality has been disappointing and the notion of 'active citizen' has been vague and superficial. It would appear that the public perception of participation differs from that of politicians although this situation is gradually changing particularly in the field of health care.

There are various ways of approaching the idea of participatory citizenship and in the context of this discussion the concepts of participation in health and welfare is relevant. The idea of participation will therefore be considered as part of the notion of the 'active citizen'.

The notion of participation in health service decisions is relatively new. It will be re-called from chapter 8 (p148) that the Griffiths Report diagnosed among other factors, a lack of consumer power within the National Health Service. Up to that time the only groups representing the consumer were the Community Health Councils. These mainly dealt with complaints against the service providers or about the quality of care. This arrangement was far from satisfactory.

The idea of participation in relationship to health and welfare services can be placed in three categories:

1. The most recent manifestations of this are seen in the charters which evolved as a branch of the new consumerism. This encompasses the many projects in progress in health and social services where client /consumer participation is encouraged. This can involve decisions as diverse as resource allocation to the type of services to which priority ought to be given in the healthcare field. In other public services it can involve

community projects ranging from neighbourhood watch schemes to social service projects at community /local government level.

2. The more traditional forms of participatory citizenship include self-help and voluntarism and the University settlement. As a philosophical concept self-help is not confined to the Self-help Movement which became popular in the nineteen sixties. It in fact belongs to the Victorian idea of character-building in which self-reliance and mutual support were rooted in the individualism of the period. The concept of Voluntarism has been a vital complementary element of welfare which predates the Welfare State. The University Settlement played a vital role not only in encouraging public participation, but also it was instrumental in the development of some of the state -run services taken over by the Welfare State. The University Settlement and the Self-Help Movement aimed to build character. The emphasis was on bringing to the surface the individual inborn ability to look after oneself with the aid of communal support of one form or another.

3. The third element, Health Promotion, does not fit neatly into either of the above categories. However, in terms of individual health and individual responsibility for health it is the main vehicle via which the public can be educated and at the same time have a voice in particular policies. That at least was the intention. The reality may be otherwise as we shall see.

Before discussing each of these elements in turn let us begin by analysing the idea of the active citizen.

11.1.1 The Active Citizen.

The concept of the active citizen has become a catch phrase among politicians of all parties. However a variety of interpretations can be drawn from it. From the point of view of right wing politicians it has a definite implication of 'putting something back' into society in the form of some kind of voluntary action or charity. The citizen according to this view is to see his relationship to the state and society as one which

implies responsibility as well as certain rights. This meaning is restrictive and aims to keep the notion of 'activity ' low key and local. Therefore when Douglas Hurd spoke at the speakers Commission on Citizenship he emphasised the importance of neighbour and family. Quoting Burke he said ---

to love the little platoon we belong to in society, is the first principle, the germ as it were of public affections. It is the first link by which we proceed towards the love of our country, and of mankind (Hurd 1988).

It is not clear what Burke meant by 'platoons' but according to Douglas Hurd it was the small neighbourhood acting in conjunction with intermediary bodies. Here certain established committees or groups would act as representatives on behalf of other citizens. This would allow the less vocal members of the community to express opinions via a third party. This view has been criticised for its narrowness and for the lack of power which it gave to the public (Barnett 1989, Norman 1992). This criticism may be unjustified because although it clearly implies limited scope for active citizenship, it does however recognise the possibilities that a) not all citizens wish to be active, and b) some people prefer to have a close link with local community rather than have an interest in a more distant bureaucratic structure such as central government.

Schumpeter argued that the idea of the non active non participating citizen was desirable in view of the general state of ignorance of the ordinary citizen (Schumpeter 1976). If we accept this view then the inactive citizen is performing a useful role by virtue of his silence. This argument of course goes against that put forward by Mill who insisted that the real reason for the active citizen was to avoid a situation of the tyranny of the majority (Mill 1859). But Schumpeter's argument does serve to illustrate the problem of vagueness of the idea of participation such that it is associated only with political issues of national or international importance. Modern views of citizenship on the other hand seek to extend the participatory role of citizens to a more local level.

If the Conservative view of the active citizen is seen as restrictive the same cannot be said for the Liberal Democrats. In 1989 Paddy Ashdown spoke of a new concept of

citizenship which emphasised the necessity for rights and responsibilities. Criticising the Conservatives he said;

Instead of rolling back the frontiers of the state the Conservatives have rolled over the safeguards which protect the citizen. They proclaim the enterprise culture, yet their policies trap people in dependency.....Above all they claim to uphold freedom, yet they rely increasingly on coercion
A new deal for citizens will establish citizens rights, define their social entitlements and clarify their responsibilities to each other.....It will include all our citizens in the benefits of progress and prosperity. This is the way to bring out their best contributions to our society (Ashdown 1989).

This view seems to allow for all sides to benefit but could be seen as too optimistic. If for example we agree with the existence of a dependency culture, a situation which evolved over several decades of welfare, then the idea of a society transformed into one where there was adequate employment, less poverty and a will to take responsibility by all citizens then this would constitute a utopia.

The views of the Labour Party must be seen in two distinctly different eras -- old Labour and new Labour. While the more traditional philosophy of the Labour Party was towards the idea of community and fraternity new Labour preaches a message of partnership between public and private sectors. The new view of citizenship recognises the value of all sectors including the voluntary sector. Tony Blair speaks of a new vision of citizenship as strengthening and reviving a sense of community ---

we need a collective action that advances individual freedom and is not at the expense of it-a fusion of cooperative action and individual expertise (Blair 1996).
He also underlines the importance of local government and its links with local communities so that decision making is closer to the people.

Clearly the idea of the active citizen from all political stances implies participation of some kind. Several degrees of participation are possible. Let us look more closely at the idea of participation.

11.1.2 The Idea of Participation.

The idea of participation is difficult to define. The question immediately arising is participation in what? There is an inherent assumption that to participate in something is to contribute to a specific cause in some way. In chapter 1 I discussed the problem of defining some words and suggested that the idea of mapwork would solve the problem of terms in which the context was crucial to the use of the word. 'Community' was taken as an example (p4). Mapping is also necessary in the case of 'participation.' In the context of this discussion participation is located in relationship to concepts such as democracy, the State and government-run institutions.

When we speak of participation by the public in matters relating to health and welfare services then it appears that in Britain at least this concept is relatively new. Unlike other state institutions there was no consumer body created for the National Health Service. As discussed in chapter 2 (2.6) the idea of 'consumerism' became associated with public services in the last two decades. In view of the history of the Welfare State in its early stages (Ch. 8) it is clear that the concept of consumerism would not have been compatible with what was then a predominantly 'giving' state with its cradle to the grave philosophy. The paternalistic aspect of service provision, particularly with regard to social security handouts, left little room for complaint by users of services.

The idea of representation is of course indirectly linked to participation. Although 'consumerism' arrived relatively recently, there has been some form of representation of patients since the Welfare State began. In the early stages this took the form of patient representation on committees at regional and local level (Day 1990). With the first re-organisation of the health service Community Health Councils were created in 1973. These were intended to represent patients and form a link between users and providers of services. Since that time there has been a degree of confusion as to the precise role of these councils and an apparent diversity between different health authorities as to their actual remit. It is of interest to consider these councils in more detail since the most recent reforms have focused on their importance for the future of the health service.

11.1.3 Community Health Councils.

The confusion regarding the role of CHCs has been the subject of investigation in recent years. This would appear to be the result of the lack of any universal standards or nationwide criteria. One study of CHCs found that there was indecision due to conflicting views among members as to what should be their real purpose. Some members for example might see their role as providing patient information , others might wish to be more actively involved in priority setting based on information gleaned from patients (Hogg 1986).

This idea of role confusion is supported by Klein who sees members as being torn between meeting the demands of participation on behalf of the patient and the demands of consumerism in line with market ideologies (Klein 1983).

It would appear that the diversity in role perception until now has been accepted and four types of council have been identified. **1.** The bureaucratic type which is largely concerned with hierarchies within the system and has a liaison position. **2.** Those whose main focus is health education. **3.** Those whose main concern is complaints by patients against the care and service received. **4.** Those commited to changing policy in conjunction with various pressure groups (Winkler 1986).

A recent document published by the Association of Community Health Councils for England and Wales set out what it considered to be a realistic proposal for the inclusion of CHCs within the new structure of the health service (ACHCEW 1994). The Association recognised all of the ambiguities already outlined including the variety of mission statements produced by individual councils. The Association proposed the following statement taking into account the previously wide remit accorded to the councils:

1. The CHC is a statutory authority which represents the interests of local public in the health services; and its patients' voice in relation to those services

2. The main purpose of the CHC is to influence the nature of health care provision and monitor its quality on behalf of the local population

3. The CHC works by empowering users of health services and it acts as an advocate for those unable to represent themselves (ASCHCEW 1994).

It was also recognised that in order to be effective and to reduce conflict between members, professionals and management the following points should apply;

CHCs should be independent of local health service management

Work closely with all purchasers, providers and the community

listen to the views of service users

be open to public scrutiny

visibly participate in community activities

provide user-responsive information and advice (ACHCEW 1994).

The Community Health Councils have a clearer structure since the recent reform of the health service and have a vital role to play in the quest for participatory citizenship within the National Health Service.

In Scotland CHCs are now actively involved in assessing the quality of care in institutions and make frequent visits to nursing homes and hospitals in the community. The Greater Glasgow Health Council hold weekly meetings to which the public are invited. A series of 10 leaflets are available to the public ranging from complaints procedures to the patient's right to read his medical record (Beacom 1997).

The next wave of emphasis on citizen participation and consumer voice came with the Citizen's Charter Unit initiative launched by John Major in 1991. By 1993 there were

thirty three charters. The Patients Charter set out standards to be expected within the health service by users (HMSO 1991).

11.1.4 The Patient's Charter.

The charters which have emerged in recent years are an expression of consumerism. They embody a philosophy of public services run by management and as such they embrace the market ideology. This represents a move away from professional domination of services which have been criticised for being part of a distant bureaucratic system which was unaccountable to any source and which was wasteful and not user friendly. The role of the state, according to this view, should be that of an enabler with responsibility for creating the conditions necessary for effective delivery of services. The White Paper, 'Working for Patients' made a distinction between purchasers and providers of care (HMSO 1989). This in turn led to the need for priority setting. Purchasers, ie districts would have to decide what services they wanted and from whom they should be bought. Concepts such as cost, quality and priorities became important. Providers of hospital and community services had to estimate costs creating a situation in which they were competing with each other as well as with the private sector. If after one year providers failed to attract sufficient contracts they would have to withdraw and possibly close down.

Districts as purchasers now receive a budget. They draw up contracts annually to meet the health needs of their populations. Some general practitioner groups also became fund holders in order to buy services from the hospital or community. The idea of the primary health care team involvement in the purchaser-provider split arrangement was seen as positive because it would strengthen the bond between it and other community services. General Practitioners were also seen to be in the front line in terms of patient/ professional interaction thus creating the conditions for health education and disease prevention (Gladstone 1995).

The charter movement produces a feeling of safety and a degree of control for the consumer in so far as he is now given a limited choice as opposed to no choice in

services and treatment. The element of choice must be necessarily limited by factors such as location and availability of services. Nevertheless the element of choice has been a major selling point of the new consumerist ideology (p239).

The charters, in particular the Patient's Charter is in fact elusive and vague. The rights which it claims to portray are in reality superficial attempts at outlining such rights. It could be argued that stating the various expectations which ought to be satisfied is of little use if they cannot be implemented. Stating, for example, that patients can expect to be seen immediately upon arrival in hospital is a promise which can rarely be kept. The value of the Patient's Charter seems to lie in its ability to alert the public to alternatives in care. It has also served to raise public expectations with regard to services generally (Winkler 1996).

As far as actual participation by the public is concerned there is substantial evidence that this is currently occurring as the following discussion shows.

11.2 Experiments in Participation in Health and Welfare .

The idea of participation by the public in health and welfare service delivery is a fairly recent factor in the British system. The idea stemmed from the suggestion of the desirability of public input as documented in the Patients' Charter and also based on particular trials in America.

In America the idea had long been part of the consumerist orientation of service provision. The elements of choice, competition and quality were all part of this consumerism. However in terms of rationing and cost-cutting a different approach was taken by the federal government. This involved a system of prioritising services in a ranked order so that a certain degree of priority would be attached to some medical services but not to others. Certain states were chosen for these experiments. The most frequently cited experiment is Oregon which has provided a basis for studies in Britain. Both the Oregon experiment and some of the British studies will be considered presently.

There is evidence that positive action has been taken by several Health Authorities in Britain to implement a strategy whereby patients are actively involved in planning procedures, in their own care and in a representative capacity on behalf of their communities. This appears to be most promising at the Primary Health Care level. The idea of projects involving General Practitioner populations is particularly relevant since patients are in direct contact with a particular group of professionals so there is scope for ongoing commitment. The hospital situation is more difficult in view of the transient relationships between patients and professionals. Let us now consider a variety of projects in both the United States and the United Kingdom which are underway with varying degrees of success.

11.2.1 The Oregon Experiment.

The Oregon Experiment has gained popularity in Britain as a model to be followed where the aim is to increase services for the most vulnerable groups while at the same time prioritising services according to need. It would appear that the appeal of such a scheme for Britain has been the relatively new concept of rationing services while at the same time involving the public in the decision-making process. It can therefore be seen as an attempt to implement a degree of citizen participation in health care and its distribution.

The discussion of American health systems in chapter 8 outlined the basic orientation of the delivery of services and the rift between those who could and those who could not afford medical insurance. The number who could not afford health care insurance was quoted as 43 million Americans (p134). The discussion also explained the limited state assistance for the poor and elderly and how the Medicaid and Medicare systems operated (p128).

Under the Oregon plan all poor people in Oregon were to receive Medicaid. The experiment was to continue for five years (from 1993) at which point the situation would be reassessed. The aim of the plan was to force the state of Oregon to choose which medical services it would be prepared to pay for from a list of procedures related to

specific illnesses. The cost of these procedures was also listed. This was to be an experimental model in designing an insurance scheme to provide cover for all (Klein 1992). The plan was similar to what President Clinton proposed for the whole of America.

The actual plan is detailed and at some points confusing . What is clear is that the implementation of the plan was not straightforward but fraught with difficulties as arguments arose as to who should be eligible for which service. One of the areas of concern was the possible discrimination against disabled groups (Eckholm 1993). Other objections were directly related to the system of ranking medical conditions since not everyone placed the same degree of priority on the same illnesses (Fox and Leichter 1993).

The final number of procedures ranked alongside their costs was 688. The state agreed to pay via Medicaid for procedures up to 568 but not those below this number. The procedures at the bottom of the list were assumed to take less priority. It was not just aspects of intervention such as cosmetic surgery which were given low priority. Fertility problems, chronic back pain and liver cancer among others were seen as low on the scale of priority (Eckholm 1993). It is unclear whether individual circumstances were taken into account and why some cancers took priority over others.

The plan involved long and detailed interaction between the lay public and professionals. At one point the whole idea was abandoned because more than half the members involved in devising the priority list were healthcare professionals (Eckholm 1993).

Given that the Oregon Experiment was geared towards an American system of health care it is difficult to see the value of similar plans in Britain. However it appears that the idea of rationing and prioritising services has been of interest to the purchasing authorities within the National Health Service. Certainly in the early stages of the plan the feedback appeared mainly negative. Questions were raised about the ethics of rationing the poor in society (Klein 1992). Other critics argue that the Oregon Plan proves that the idea of participatory citizenship in matters of decision making and

priorities in health -care is flawed (Fox and Leichter 1993). This charge may be justified on the ground that no other state appears to have followed the Oregon Plan.

It is of interest to note that while the Oregon Experiment was not emulated in America it was seen as a blueprint for change in the British system. Rationing appears to have been the element identified as a potential model to follow in Britain. In view of the purchaser/provider split already described (p240) experiments on similar lines to Oregon began.

11.2.2 British Studies based on Oregon.

A number of studies are currently in progress in Britain based loosely on the Oregon Experiment. These vary in format since there is no standardised initiative by the government to outline how priorities should be set. This means that individual districts set their own plans based on the needs of the population in question.

Ham, Honingsbawm and Thompson cite six studies whose outcomes are as yet incomplete (Ham et al 1994). One of these is in an inner city area in London. Here a list of health needs are ranked in order of priority and research is in progress to assess the priority which ought to be accorded to sixteen services in the views of the public, consultants, general practioners and public health personnel.

Other studies are in progress in Oxfordshire, Southampton. Wandsworth, Mid-Essex and Solihull. Setting priorities was just one of the aspects for investigation. Much attention is also give to need assessment and public participation.

In terms of measuring needs, in the case of all six locations a list of areas was identified where changes could be made. These included: *The cost of care (the number of cases requiring expensive treatment would be limited), the care -setting (more day care and less hospital care is required), professional responsibility (some procedures could be carried out by nurses rather than doctor) and equity in access to care could be improved* (Ham et al 1994).

Strong emphasis was placed on the idea of public participation. The researchers found that the most structured approach to this came from Solihull where a postal questionnaire was used to ask 600 adults chosen at random how they viewed the service in their area and in particular how they viewed 11 separate priorities for service development.

The Mid-Essex study used a different approach to elicit public views. Here the district joined forces with the local Community Health Council and Voluntary Organisations. Priorities were ranked on the basis of information collected from the public and the results transmitted to the relevant health authority (Ham et al 1994).

11.2.3 Public Participation in Primary Care.

In the area of Primary Care ie General Practices various initiatives have begun in which patients play an active role in the running of the service. This is in keeping with the recommendations of the Patients First Document. The 1997 publication 'Involving Patients', by the NHS Executive outlines the various projects under way. It stresses that the first most crucial step is to inform the public about how the service operates and how the National Health Service as a whole is run. From this basis the public can begin to make informed decisions regarding policies. The main aim is to allow ordinary citizens to gain the best service based on knowledge and participation (CanagaRetna 1997).

A wide variety of tools are in use to inform the public. Some surgeries have introduced a computerised system of information about many health -related topics including medical conditions, surgical operations, self-help groups and many others. Other districts hold 'awareness' evenings to which members of the public are invited and the topics are chosen by the patients. Yet other areas use walk-in centres with personnel available to answer questions and supply information.

Patient participation is encouraged at staff meetings and input from the public is used to prioritise and assess needs in specific communities. There are also close links between

patients and Community Health Councils. Again this was a recommendation of the White Paper 'Patients First' (CanagaRetna 1997). It seems that the success and availability of experiments in public participation with General Practitioner services depends on the enthusiasm of individual practioners.

11.3 Self-Help, Mutual Aid, and Voluntarism.

11.3. 1 The concept of Self-Help.

The spirit of self-help is at the root of all genuine growth in the individual; and, exhibited in the lives of many, it constitutes the true source of national vigour and strength. Help from without is often enfeebling in its effects but help from within invariably invigorates. Whatever is done ***for*** *men or classes, to a certain extent takes away the stimulus and necessity for doing for themselves: and where men are subjected to over-guidance and over-government, the inevitable tendency is to render them comparatively helpless.* (Smiles 1866).

The above statement summarises the Victorian vision of the importance of character building and self-reliance. Since that time it has become eroded as the necessity to fend for oneself was gradually replaced by the interventionist state. Today the whole concept of self-help takes on a new meaning but is no less important in terms of the health and welfare of the individual as we shall see.

The significance of the idea of self-help as public participation cannot be over emphasised. In many ways it draws together key elements from previous chapters. It arises for example in the history of welfare in Britain (Ch.8) where it ran alongside the concept of charity and altruism. Many organisations encouraged self help including the Friendly Societies and the various religious organisations. Prior to the Welfare State it was very much part of the community aspect of life in which the states' role was minimal. It is also part of the deeply entrenched philosophy of American Individualism where self help is seen as more desirable than any help from the state however meagre.

In its broadest interpretation self- help is enshrined in the Marxist and certainly the communist philosophy where the element of participation at every level is seen as the only means of achieving the *'withering away of the state'* (Marx and Engels 1848). The idea of self-help also appears in the work of Illich (p169). Illich saw this as a natural inclination based on man's inborn knowledge and common sense in matters regarding his own health. This natural ability has, according to Illich, been eroded by professionals.

The idea of self-help arose again during the Thatcher administration in keeping with the government's recommendation of a return to Victorian values which included self-help and self-reliance. A similar view existed in the United States under President Reagan (p122). More recently self-help has become popular and necessary in view of the changes in the structure of the health service. Earlier discharge from hospital has meant that patients must rely on their own resources alongside that provided by professionals at certain periods of vulnerability.

A distinction can be drawn between the concept of self-help and self-care. This distinction is important in demonstrating individual roles. Recognising the confusion between the two labels, the health education programme of the WHO Regional Offices has formulated a guide to various terms of reference. The first distinction is between self-help and self-care. Self-care refers to help supplied by unorganised individuals; families, friends or neighbours. It involves self-medication, self treatment and social support in illness, all within the context of everyday living. Self-help on the other hand has a wider scope. It includes self-help groups, self-help organisations and alternative care. The most widely used category is the self-help group which tend to be small local groups of people often drawn together for `a specific purpose (Kickbusch and Hatch 1983).

If we are to consider the idea of self-help as a way in which the public can help themselves and each other, then there are some potential obstacles which must be addressed. These obstacles cause tension the usefulness of which is minimal in this case. The first obstacle is professional interference. This is where the distinction between self-help and self-care is vital. The latter depends to a degree of professional

guidance and in some cases practical input. The practical input element is not only desirable but necessary in cases where patients are administering their own medication. This is particularly important in cases of childhood diseases such as asthma where the dosage of certain drugs requires alteration at specific times. Services provided by professionals in these cases is supplementary to conventional medicine (Tountas 1990).

There are other cases where the concept of self-care and professional input are in opposition to each other. This is particularly true in the move towards alternative therapies. Until recently professionals in orthodox medicine tended to dissociate themselves from disciplines such as homeopathy. Patients wishing to pursue this line of treatment were forced either to seek a specialist or self-medicate. This situation is gradually changing within the National Health Service. A similar trend is evident in the United States where it is estimated that Americans now spend approximately twelve billion dollars per year on alternative therapies (Weatherall 1995). Where professionals are involved in alternative therapies there tends to be a relationship of reciprocity with the client/patient since feedback about the effectiveness of treatment is crucial to success.

Another reason for the importance of professional input is the economic factor; that is the idea that resources are saved when institutional care is replaced by self-care. In the case of the elderly, for instance, where there is a combination of self-care and professional help together with input from other agencies including family, the cost to the system is lessened. This is especially relevant in the case of chronic conditions and mental illness (Tountas 1990).

The other aspect of interest within the concept of self-care is the potential for health education which again may involve the professional. However this may not necessarily be an ongoing commitment since one to one education is frequently called for. After the initial session of demonstration and explanation the professional can monitor the individual situation. In many respects the idea of self-care can be highly beneficial since it allows patients to participate in their own care not just in the physical sense but also in the decision -making process. The control or ownership of the disease is therefore placed with the patient.

As far as the concept of the self-help group is concerned the professional presence is not encouraged. The professional role is limited to that of an outside advice resource. This limited role for the professional is not surprising since many self-help groups emerge precisely because professional services have failed to fulfill a particular need. While it is not unusual for groups to elect a leader or spokesperson the main emphasis is on sharing information. The idea of participation is implicit since each member voluntarily elects to join the group because of a problem common to all the members. Self -help groups are by no means confined to health-related problems and often they evolve in order to gain government support for a particular cause such as environmental issues on the grounds that many voices are more effective than a few.

In conclusion it can be said that the concept of self-help may not run as deeply in terms of its character building philosophy as it did in Victorian times, but as a means of public participation in local affairs including health care it remains a vital resource whether seen as separate from or supplementary to state action.

11.3.2 The Concept of Mutual Aid.

In chapter six the idea of charity as a moral basis for welfare was discussed and it was observed that charity was a major form of welfare prior to the Welfare State. It also provided a means for citizenship participation since it was frequently religious organisations which were engaged in charitable work. A distinction must however be drawn between philanthrophy as discussed in chapter 6 and an allied source of help which is mutual aid. While both mutual aid and philanthrophy came under the umbrella of voluntary action the difference is important in terms of subsequent legislation and its consequences. This distinction was emphasised by Beveridge (Beveridge 1948).

Philanthrophy was usually help given by one person or group to another, usually acts of benevolence by the well -off to the less well -off. Mutual Aid on the other hand was characterised by a group of people helping each other. The concept of mutual aid draws together a number of elements of life prior to the Welfare State which many would wish

to see re-established in the cause of participatory citizenship. These elements include the idea of self-help, community involvement, voluntarism and a sense of solidarity within the group. Most crucially the mutual aid movement demonstrates the willingness of members to fend for themselves and to shun the idea of state help to individuals whose aim was to work hard and be self-sufficient.

The organisation most frequently associated with mutual aid is the Friendly Society. This was based on groups of workers whose aim it was to help themselves and their co-workers in times of hardship. The question of charity was not applicable to the recipient of aid since each member contributed to a communal fund on a regular basis both for himself and for any other person who could not contribute due to illness. The money drawn out in times of need was seen as an entitlement (an early form of self-insurance). Benefits which could be claimed included cash payments in times of illness, funeral expenses and medical care (Green 1993).

The Friendly Societies go back as far as 1555 to Leith in Scotland where the first organisations developed. The most attractive aspect of this scheme for the members was its autonomy and ability to change the rules as needs demanded. These societies had a substantial membership which was still escalating when in 1911 the state intervened to make insurance compulsory (Green 1993). The whole idea of mutual aid shows the ability of individuals to create the best conditions for themselves when left to their own devices.

11.3.3 Voluntary Organisations.

The third strand under the umbrella of voluntarism is the Voluntary Organisation. This constitutes one of the oldest forms of participatory citizenship (Marshall 1979). Voluntarism has had a history of activity and apparent inactivity over several decades. Recently there has been a new role envisaged for the voluntary sector which in effect means that its contribution to the changing Welfare State will increase in the future. The changes which have occurred have been accompanied by parallel changes in the organisation of health services and the Community Care Act in particular. The renewed

interest in voluntary action has been taken up by politicians from all parties. The current government sees it as part of the way ahead for citizenship where the idea of duty is acknowledged as well as the idea of rights to services. This duty to the community calls for young people to voluntarily offer support as an expression of caring for fellow citizens. In short it is seen as part of the notion of the 'active citizen' already discussed (p194). Let us consider the voluntary organisation in more detail.

The idea of the voluntary organisation as working alongside other welfare services has long been acknowledged. At times its role has been one of providing specific services into which the state had little input. Voluntary organisations also worked alongside the Poor Laws in areas such as poverty and child welfare.

Six phases can be identified in the development of the voluntary sector in relationship to the Welfare State.

1. The early development of the Voluntary Movement prior to the Welfare State.

2. In the immediate post war period there was a phase in which the voluntary sector was relatively inactive.

3. From the nineteen fifties and particularly in the early nineteen seventies many new community campaigns and initiatives were formed both in Britain and America. These provided a new wave of activity for voluntary organisations.

4. With the perceived failure of the Welfare State in the mid nineteen- seventies the voluntary sector called for a more pluralistic approach. This was endorsed by the Conservative party (Taylor 1995).

5. With the new conservative government of 1979 changes in legislation directly affected the voluntary sector (Taylor 1995).

6. The recent reorganisation of the health service and the 1990 Community Care Act have expanded the role of the Voluntary Organisation.

11.3.4 The Early History of Voluntary Organisations.

The influence of the Voluntary Sector is most clearly seen in the nineteenth century. Prior to this it worked separately from other forms of assistance such as the Poor Laws. In the eighteenth century it became influential in providing help to hospitals, orphanages and other institutions (Rooff 1957). By the nineteenth century there was a closer partnership between private and public sectors. Nevertheless the role of the voluntary sector must be seen as running alongside that of other services. Together with the philanthrophy and mutual aid already discussed and the University Settlement (p216) the voluntary sector was instrumental in the setting up of state -run services which later became part of the Welfare State. These services included maternity and child-care services, services for the blind and voluntary youth organisations.

With the arrival of state welfare the voluntary sector appeared to have an uncertain role as the whole emphasis was now on free services to all. There was therefore a period during which the main role of voluntarism was seen in terms of providing useful tasks for those interested in charity work. The Voluntary hospitals now came under the auspices of the state. This applied to all but two hundred hospitals whose campaigns to remain independent were realised (Taylor 1995).

With the change from a Labour to a Conservative government in the nineteen -fifties the voluntary sector received more recognition. The 1960 Charities Act which resulted from the report of the Nathan Committee extended the power of charities. The role of voluntary organisations in education was seen as important as were the various schemes to work on the problem of poverty.

The idea of public participation via the voluntary sector came about in the late sixties and early seventies. This was directly linked to the perceived failure of the Welfare State to deal adequately with a long list of social problems such as drug abuse, homelessness and single parent families. Other influential factors were the spread of middle classes into working class areas during this period of community development. There was a temporary revival of the Settlement Movement at this time.

The Seebohm Report and the Skeffington Report on participation in planning both underlined the importance of the voluntary sector. As a result of these reports many organisations were given government grants to improve communities. The first signs of active citizen participation was seen in the issues surrounding housing. People joined together to complain about tenancy and conditions and lack of facilities for children. As a result of this new 'voice' of the people welfare rights centres were established. These were located particularly in multi-racial areas where the lack of knowledge regarding welfare rights led to gross underclaiming (Younghusband 1978)

Central government responded to the growing power of the voluntary sector and its apparent effectiveness by appointing a minister responsible for voluntarism in 1972. At the same time a Voluntary Services Unit was set up in the Home Office.

11.3.5 The Wolfenden Report.

In 1978 the Wolfenden Report argued for a more active role for voluntary organisations. The report is of importance for the detail of its general analysis of voluntary organisations and n particular for its clarification of what is a confusing issue. The report recognises this confusion and the way in which some services overlap. The state and commercial sector may merge with the voluntary sector in certain instances. The report also provides insight into the whole meaning of the idea of voluntarism and stresses that not all voluntary organisations are charities, and likewise not all charities are voluntary organisations. It is suggested that 'non -statutory ' might replace 'voluntary 'in the future (Wolfenden 1978).

The Wolfenden Report deals mainly with the personal services in order to create boundaries for their research. The report found a widespread lack of knowledge among the public professionals as to how voluntary organisations work and a lack of documented research on the subject. It identified four useful categories of organisation based on the type of beneficiaries involved. These are:

1. Organisations which help people with special needs such as the elderly and the homeless. Traditionally these have obtained the most input in terms of volunteering from local citizens.

2. Organisations which are mainly concerned with a specific cause. These might range from issues such as human rights to environmental issues.

3. Organisations in which the members are the main beneficiaries. These include organisations for people with a common problem such as deafness or blindness.

4. Organisations where the beneficiary is not the individual member but another organisation. An example of this category is Age Concern whose efforts help other organisations (Wolfenden 1978). The Wolfenden Report was cast aside when the Conservatives came to power in 1979. It had aimed to predict the role of voluntary organisations in the future in line with social trends. The Thatcher administration had its own agenda and plan for voluntary services. As discussed in chapter 8.4 the new government's main aim was to take service delivery away from the state and to encourage the individual and the family to take more responsibility, to be more self-reliant and to be supported by the voluntary sector. The Conservatives envisaged a prominent role for voluntary organisations. The voluntary sector therefore became involved in the government schemes to privatise public services whereby delivery of some services was transferred from the state to the voluntary and commercial sectors. In order to facilitate this new role grants were made available from central government and other donors such as the commercial sector to fund the schemes. Fund raising also became a major issue and hospitals and schools were encouraged to pursue this on an individual basis.

11.3.6 Voluntary Action and the Community.

Organisations within the voluntary sector have been particularly influential within the community setting even prior to the Welfare State. More recently this role has been

extended with significant success. Several projects incorporating care and support in the community have been in progress recently. One of these which shows the success of voluntary service aid in community care was the Care in the Community Initiative in progress between 1985 and 1988. This was funded by the Social Work Services Group from the Scottish Office. This and many other similar projects aimed to encourage community services to be developed by voluntary organisations to meet the needs of various groups including people suffering with dementia, elderly people,and younger age groups with learning disabilities and adults with mental disabilities (Connor 1996).

The 1990 Community Care Act may well require the input of other projects similar to that described. The voluntary sector is therefore seen as crucial within the framework of the latest legislation. Under this new structure there is potential for an extended role for voluntary organisations, one which involves both active running of certain services and co-ordination between itself and other bodies such as health authorities, housing departments and local authorities. This role will constitute a partnership rather than a supplementary role.

A less positive alternative for the predicted future of voluntary organisations is that in the new competitive, market- orientated system of service delivery only the large organisations will thrive. The small local groups which in the past played a vital role at local community level may be eased out due to lack of funds.

The conclusion to be drawn from this discussion is that the idea of voluntarism running alongside other forces such as the state and the market is appropriate in line with a participatory model of citizenship. The resilience and usefulness displayed by the voluntary sector over the last fifty years confirms that type of organisation must always be part of service provision. Not only does it offer particular services but it also incorporates the potential for active citizenship by encouraging voluntary action by all age groups. By focusing predominantly on community based services it portrays a vision of neighbourliness even when the projects undertaken are on a large scale.

11.4 The University Settlement.

The University Settlement provides evidence of a kind of citizen participation which is at least one hundred years old. Its history provides hope for the future in the sense that it confirms the capability of people and communities to be active in working towards the common good and in helping each other. There is scope for a similar trend to evolve at the present time.

Focusing again on the idea of citizen participation, the Settlement movement demonstrates the neighbour relationship in addition to a spirit of altruism and a willingness to share education and knowledge among all classes.

The Settlement was based on aspects of the philosophy of some of the English idealists, most notably T.H Green who in turn had been influenced by Matthew Arnold who had preached the need for reform of the stifling effects of class divisions in society. Arnold advocated the idea of a total community . Arnold's idea of reform called for active participation, hierarchy and community. Green followed a similar trend and was commited to the notion of bringing out the 'best self' in the individual. (Green 1937). This would be achieved only in the context of a community. The idea of the isolated abstract individual was not part of this philosophy. There was a strong element of Christian belief in the thinking of Green with its emphasis on duty to the community and ones' fellow man. According to this idea of community the highest form of human association came about when each member was equal to the other and the force which held this community together was the loyalty of the members (Sabine 1952). The idea of intervention by the state was justified if this intervention helped men find their higher selves but voluntary help was preferable.

Arnold Toynbee was a graduate of Balliol college when Green was a tutor (Meachan 1987). He became a social reformer having been influenced by Green. He lectured in working mens' clubs and lived among working class people with the objective of uniting the educated and the ordinary worker. After his early death his crusade was carried on by others such as the philosopher Edward Caird. It was he who urged students at Balliol

to go out into the world and take up their responsibilities towards the poor in society (Meachan 1987).

Such was the basic philosophy taken on by the founders of the first Settlement house founded by Samuel Barnett.

The first settlement residence was Toynbee Hall founded in 1884 in the east end of London by Samuel Barnett. Hull House in Chicago was the American equivalent. The movement embodied a type of social reform which came about as a means of addressing the increasingly complex social problems generated by capitalism. Chronic unemployment, technological change and urban decay as well as international competition were forcing social reformers to rethink old attitudes and offer new solutions. Politicians were beginning to recognise the need for state involvement. Schemes initiated by Churchill and Chamberlain and the Fabian Society were a response to a realisation that public health and sanitation, factory regulation and slum clearance were the specific business of governments (Meachan 1987).

Toynbee Hall was founded as an expression of the belief that before change could be effected the basic question of social organisation had to be addressed. The concepts of community and self-help were important. The goal of the Settlement was social re-integration in the face of the negative effects of industrialisation and laissez-faire capitalism. The educators would provide enlightened authority and hierarchy to achieve a community of which they would be both teachers and governors. This teaching would help the working class to realise their best selves in addition to benefiting the whole nation (Meachan 1987).

Toynbee Hall provided a base from which emanated a spirit of community engendering the idea of self-help and education. Barnett drew a distinction between the settlement and a mission which usually embodied the beliefs of a particular religion or sect. The settlement workers' task was to restore the community. He adopted a policy of one to one teaching.

Gradually the settlement house became the settlement movement as wiling students joined from all over the country. The movement also spread to America. From about 1889 to 1914, the period when settlement houses were being established, there was a huge influx of immigrants into all cities. The poor were largely ignored and it was the organisers of the settlements who provided basic education for the residents. Just as in Britain the concept of community was a strong element, and the neighbour relationship was encouraged. (Trolander 1975).

In Britain the settlement was responsible for setting up of the state system of social work and services for handicapped children. Given the professional mix of the pioneers it appears that a wide range of skills were taught and topics explored. In some cases there was direct health education to groups from women settlers who offered classes in child care and nutrition. These were later to be seen as the basis of welfare services run by the state under the heading of maternal welfare (Rowbotham 1994).

So far all of the examples of participatory citizenship have involved the concept of 'neighbour'. All but the voluntary organisations and self-help movement belong to the past. The potential for their revival is nevertheless possible in the context of A Neighbour-Centred Model of Citizenship. This idea will be expanded in the discussion of the role of the state (p228).

The final aspect of participation, to which I now turn is the idea of health promotion. The discussion will focus largely on the idea of health promotion within the context of public participation.

11.5 The Health Promotion Movement.

Much has already been said about the delivery of health services and the political structures which determine the mode of delivery of such services. But as far as the ordinary citizen is concerned, factors other than availability and cost are important. We have seen how two particular systems set about delivering services to the public. One (Britain) operates a service free at the source of uptake. The other (America) offers little

in the way of free services and tends to regard health as a commodity to be bought like any other good subject to ability to pay. Yet both these systems are involved at different levels at promoting health as a goal to be aimed for. The fact that one group pays while the other does not may have little effect on how health is perceived by individuals. When we speak of the idea of the 'promotion ' of health we must take into account, therefore, particular cultures, political structures and economic systems. These may, to a large extent influence the individual perception of health. For example, affluent societies may in effect be less healthy due to modern processed diets than less affluent societies where these factors may not apply.

For the purpose of this discussion I shall be concerned with the association between health promotion and the idea of participation by the public in health care and health education. If we accept the suggestion that one of the aims of health promotion, as opposed to health education, was to lessen professional dominance and encourage input, complaints and feed back on services by the public, then there is evidence that the intention has not been successful. In order to analyse the concept of professional dominance and public participation we must first explore the origin of the idea of health promotion and how it has developed. This can best be achieved by asking three key questions, which are:

1. What do we mean by health promotion?

2. How does health promotion differ from health education.

3. How successful has this initiative been to date?

Let us begin by attempting to define health promotion.

In many ways the linking of the term 'promotion' to the concept of health is unfortunate, having as it does connotations of a promotion of some kind where the intention is to sell something. This in a sense is precisely what the health promoters are trying to achieve ie to sell the idea of health as a positive element of life which is to be protected, preserved and prevented from disease and injury. The question arises, however, as to why health

needs to be promoted. Clearly the answer is because other approaches have failed because they tended to focus on disease and the negative side of health. The idea of promoting health avoids this problem or so it is assumed. Another possible reason for the idea of health promotion is that it is part of the socio/political ideology which embodies consumerism in which citizens are encouraged to take control of their health and be in a position to take part in matters affecting their health. In that sense health promotion has a wide range since matters affecting individual health are infinite. The degree to which citizens can actually participate is obviously dependent upon a number of factors all of which can vary between one area and another. These include: political will, availability of existing facilities, success or failure of previous projects, the type of community involved, individual motivation to accept new initiatives and lastly the degree of professional commitment and ability to enable rather than take over particular projects.

There are so many facets emanating from the idea of health promotion that it is more relevant to speak of it in terms of a set of principles rather than a concise definition. WHO (1984) sets out five principles which it sees as the basis of health promotion.

1. Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases.

2. Health promotion is directed towards action on the causes or determinants of health.

3. Health promotion combines diverse but complementary methods or approaches including communication, education,legislation, fiscal measures, organisational change, community development and spontaneous local activities, against health hazards.

4. Health promotion aims particularly at effective and concrete public participation.

5. While health promotion is basically an activity in the health and social fields, and not a medical service, health professionals- particularly in primary health care have an important role in nurturing and enabling health promotion.

These statements acknowledge the wide range of possibilities for promoting health including the importance of public participation. There is also the implication that health education remains a firm basis of health promotion and that this relabelling of health education is somehow more wide-ranging.

11.5.1 Objections to Health Promotion.

Not everyone may agree with this new concept of promoting health as opposed to offering health education. In fact several objections to this trend have been identified. The most obvious objection concerns the degree of professional input into individual projects. According to this view there may be little difference between professionals 'promoting' health and professional indoctrination as in health education. If the primary aim of changing from health education to health promotion was to extend public involvement then there is a case for saying that this involvement continues to be overshadowed by professionals. Evidence of this is visible in the fact that at a very early stage of the change to health promotion professionals themselves were re-named 'health promotion officers,' thus ensuring an ongoing role for the professions. Clearly there is and must be a role for the professional but this role must change from activity to relative inactivity. It is accepted that professional knowledge can be used to enable and empower people to **a)** use the systems to their best advantage and **b)** encourage people to share in the quest for better health. This means more than asking for opinions, for it also involves attitudinal changes on the part of professionals. It must also be accepted that health advice, both negative and positive, is received by the public from additional sources some of which have a powerful effect. The media for example can influence the young in particular by portraying certain types of behaviour in a particular light. Advertisements for cigarettes and alcohol demonstrate this fact.

The commercial aspect of health promotion is another cause for concern. There are several strands to this not least the profit made by the 'fitness industry' who could be seen as cashing in on peoples' vulnerability. The idea that good health can be bought is the message delivered by suppliers of nutritional supplements and health foods the implication being that only certain foods are good enough for health. Finally there is the growing market in 'do it yourself diagnosis'. The idea here is that the public can measure their own blood levels as a diagnostic aid to certain diseases. An example of the ineffectiveness of these is seen in the measurement of blood cholesterol. Having found a high level on the home diagnosis kit the consumer must then seek professional advice to ascertain which of the many blood constituents of cholesterol is high and which is harmful. Not only has the consumer wasted his money but the result has caused additional anxiety and a visit to a doctor becomes necessary.

11.5.2 Health Promotion in Practice.

What then do we mean by 'health promotion in the practical sense?. The model of health promotion referred to by Downie et al encompasses three spheres of activity which overlap. These are: health education, prevention and health protection (Downie et al, 1996). This clearly has a much wider scope than health education. A comparison with health education may serve to illuminate the concept of health promotion.

Bearing in mind that the main focus of this discussion is on participation by the public, an immediate distinction is evident in that health education was mainly aimed at prevention of disease rather than the idea of positive health. There was also a sense of information being transmitted by experts to a passive public who could choose to ignore or accept the information given, assuming that it was delivered in a manner appropriate to understanding by lay people. Two points are crucial to a move away from this type of strategy. **The first point** is that health education, whether to schools or adult audiences, tended to run according to a set plan, that is to say topics of discussion were chosen in the context of a programme of health education. There was therefore potential for at least some of the listeners to 'switch off' if the topic did not apply to them as

individuals. Individuals were not motivated to participate even at the discussion level. Participation was not encouraged in many cases.

The second point is that in addition to being disease -orientated, health education also ignored social and political aspects of health. In chapter 9 I referred to the problem for professionals of this new initiative and I suggested that the change over from 'doing' to 'being' was a difficult transition for many health workers and one which produced tension (p169). This is what Downie et al call gratuitous intervention (Downie et al 1996). Professionals are now expected to enable and empower the public to participate in health promotion. Let us consider some of the problems attendant on this ideology. It is suggested that professionals could constitute a threat to the whole idea of health promotion by continuing to impose their own views and values on the public. In the health education setting there was a tendency to address 'the class' or the 'group' or the 'community ' without acknowledging that each group comprises individuals with different needs, different value systems and often different cultures. Indeed some programmes of health education in schools were rejected by parents of particular cultures as inappropriate on the grounds of religious belief systems.

Defenders of a strong professional input in health promotion would argue thus: It is true that professionals bring with them their own value systems and beliefs and are entitled to do so just as the lay public are. However the difference is that the professional knowledge and values must be 'better' or superior since they have been trained in various aspects of health care. If this were not the case then health could not be promoted in a way that would benefit the public. Since the professional is trained he is therefore an expert in his subject and therefore well placed to tell people what they should and should not do in the interests of health. Confusion arises when advice given by the professional is not consistent with the actions of suppliers of goods. For example, the concept of 'good food' as opposed to 'junk food' is frequently cited as desirable for the health of all age groups. Consumers are urged to read labels carefully in order to decide which artificial additives are least harmful. Here the food industry makes no attempt to promote health. Alcohol consumption is another area of conflicting messages. Whereas health education in the past focused on the negative side of alcohol, that situation is now reversed. Only one supplier of wine in the supermarket chain has

so far included a breakdown of units of alcohol on its wine bottles. This would appear to be a far more useful way of informing the public than health educators warnings of the dangers of alcohol. This argument raises a question which is beyond the scope of this discussion, which is, the extent to which the state should control the food industry in the interests of health.

However it is possible for professionals to direct movements in health promotion, and it appears that the projects which take into account the individual in the context of his particular community are the most promising. One such project is the Health and Community Arts Project in Bristol.This includes a drama project, a photographic project and a visual arts project. T hese were aimed at particular groups in the community. The drama group for example, involved a mental health drop in centre, and the visual arts project was based in a local health centre used by women and children. This initiative has , according to the organisers, been highly successful in facilitating and encouraging participation (Hecht 1996). Using art to express opinions and feelings via painting, drawing and photography means that direct professional contact is not necessary all of the time.

A similar idea is reflected in the Bromley by Bow area of East London. In this centre art is also used as one the main projects. Others include community education, Bengali classes, youth projects and nursery facilities.

The projects *are based on a philosophy of integration, excellence and pragmatism. Our aim is to create effective social change within a framework of local, private and public sector partnership, leading to a community of confident individuals who are in a position to engage with the issues of their community and bring about their own transformations* (Mawson 1996).

The above are examples of initiatives undertaken with the true needs of specific communities in mind. The use of the arts to encourage participation appears to remove the reticence if not apathy often demonstrated when the main focus of attention is prevention of disease. These projects also highlight the desirability of involving different cultures in free expression of what health means to them. It is recognised

however that a degree of commitment is required from professionals to act in the background providing support and information, and that this commitment depends to a large extent on the particular type of community. Willingness of local governments to sponsor activities is required as well as assistance from other organisations.

Clearly the success of health promotion must depend on evaluation of specific projects. The method of evaluation used depends on particular area policies. This discussion has mainly focused on health promotion in terms of participatory citizenship. This particular element may prove more difficult to evaluate than the success or failure of preventive measures where for example, statistics for immunisations or mortality rates are collected and analysed.

Having considered several areas in which participation by the public can together promote the idea of active citizenship, it is now time to draw together the other components of the preferred model of citizenship. The other components are the role of the state and the market. First let us return briefly to the idea of tensions in the systems.

11.6 Living with the Tensions In the Progressive Society.

In view of the presence of tensions in the systems already discussed it is clear that such tensions will emerge either intermittently or continuously in any system of government or any model of citizenship. At this point it is not proposed to return to a discussion of particular tensions but rather to work on the premise that the tensions which do exist are an inevitable part of the systems. It has been stated that in the main, the presence of tensions is not to be perceived negatively. Indeed as suggested in chapter 1 (p1) it is the presence of these very tensions which can effect change. However to say this is to imply that change is necessarily positive. One could say, that with regard to government policy on welfare, there is always the temptation to fix that which is not broken or at least to revise the changes made by previous governments. It is as if the mark of any political party is measured in terms of its ability to change aspects of the system. An important question which then arises is whether change is in fact always necessary and /or desirable.

Having considered two systems of health and welfare, and having subjected them to critiques by Illich and Marx, it is clear that what I have interpreted as tensions have been seen as flaws or even contradictions by others. Were we to follow this line of negativity in which flaws were the issue, then frequent change might be justified. If we follow my own proposition of tensions, however, the idea of change appears in a different perspective, one which denies the desirability of change for its own sake. This denial of the desirability of change serves to strengthen my argument for the presence of tensions in the system and for the necessity of such tensions. It is a fact that both the American system and the British system are open to ongoing criticisms. In the case of America this is justified in view of the evidence analysed which revealed substantial shortcomings in the systems of welfare and health (Ch.7). In the case of Britain the criticisms are less obvious but nevertheless evident (Ch. 8). Is there then a case for saying that the changes initiated by successive governments have been for the best or have they merely been change for the sake of change? Had the Conservatives not taken office in 1979, for example, would the Welfare State have failed as predicted ? Had New Labour not arrived recently would the National Health Service have thrived as a market- based strategy as intended by the Conservatives?

In considering the changes brought about by the Thatcher government it is clear that this action was not in keeping with the policies and philosophy of traditional conservatism. If the meaning of 'conservatism' is meant to imply the idea of 'conservation' i.e not to change things, then the New Right have departed from early conservatism (Honderich 1993). At a superficial level this is plausible enough but the counter argument would be to immediately point out the many shortcomings of the Welfare State as part of the collectivist ideology which persisted until the mid nineteen-seventies. In other words the conservative government saw the idea of radical change as a saving mechanism and that given the financial problems of welfare the changes were necessary as well as desirable. Of course this argument cannot hold since the evidence shows that a major defining factor in the changes in the Welfare State instigated by Mrs Thatcher had a strong moral foundation. By this I mean that it was the concept of the reality of a nanny state, a dependency culture and an entitlement society which was the driving force behind the changes.

Clearly the conservatism of the Thatcher government constitutes a departure from the idea of conservatism as written of by Edmund Burke. In his Reflections on the Revolution in France in 1790 he said ..... *Change is novelty, and whether it is to operate any one of the effects of reformation at all or whether it may not contradict the very principle upon which reformation is desired, cannot be certainly known beforehand.(Burke 1790).*
Applying this statement to recent changes in health and welfare services one can see that the changes made were the beginning of a contradiction of the original intentions of Beveridge and Bevan.

It s clear that systems of health and welfare provide the material on which governments generally, and politicians in particular, can raise public awareness about the delivery of services and at the same time draw attention to their own agendas. In the American system we saw a great effort by President Clinton to radically change the system of health care. It is not known how much of this effort, which ultimately failed, was part of an election campaign. One could say that even if this were the case it is irrelevant since the Bill proposed was a vast improvement on any previous scheme. The proposed changes in this case would have improved the situation of many citizens (p134). Welfare by contrast was reformed rather than changed and it would appear that the reforms, while successful in the eyes of the government, may not be perceived in the same way by citizens. I refer to the Workfare schemes and removal of benefits in specific states which came about as a result of the 1996 Welfare Bill (p127).

While not all the changes instigated are beneficial in the longterm there may be a case for saying that the rate of change maintains the disequilibrium or tension in the systems which I have suggested is mainly positive. The fact that the changes usually reflect the particular political ideology of the government in power at any given time enhances the maintenance of disequilibrium. The belief by politicians that their particular mode of change will be effective or remedial is the means by which votes are obtained and the citizen is kept in constant expectation of better things to come.

11.6.1 Devising a Model for Active Citizenship.

My discussion of citizenship so far has concentrated on the idea of active citizenship. In addition three philosophical models were analysed in chapters 2, 3, and 4. The concept of citizenship itself in terms of its history has been confined to an Appendix in order that its factual nature might not detract from the central argument. This argument, it will be remembered , was to arrive at a conclusion that the Neighbour -Centred Model would be chosen as the most appropriate for the practice of citizenship.

In focusing on the concept of the 'active citizen' the idea of participation has been analysed in terms of its practical application within health and welfare systems. One dominant theme is evident throughout each aspect of participation discussed. The concept of ' neighbour' emerges at every level. Under the umbrella of voluntarism came the concepts of self-help, mutual aid and voluntary organisations. Each of these was identifiable with the 'zealous citizen' spoken of by Douglas Hurd and the potential for involvement in the 'little platoon' (Hurd 1988). The concept of neighbour is central to this idea.

All of this is leading in the direction of a pluralist approach in which all of the groups previously analysed are represented. We must now consider where the institution of the state fits into this scheme. Avoidance of state monopoly must also assume the desirability of a role for the market. We will then have a design of many parts and the role of each will contribute to the overall vision of a particular model of citizenship, in this case a Neighbour -Centred Model. The role of the state within the Neighbour - Centred Model of Citizenship is difficult to define. As already stated two extremes must be avoided. These extremes are on the one hand the 'nanny' state, a label attributed to the collectivist-based ideology of the early Welfare State and at the other extreme is the minimal state or 'night-watchman' state described by Nozick and others (Nozick 1996). These could loosely be seen to correspond to the collectivist and individualist ideologies. In order to analyse the possibility of a middle way between these two extremes it is relevant to explore what the perceived role of the state should be. In other words what should be the relationship between the state and the citizen.

What should the citizen expect from the state and what expectations should the state have of the citizen ?

In Part One of this thesis reference has been made indirectly to various types of state. In chapter 2 within the context of individualism the philosophy of Locke was used to demonstrate a particular view of property rights. In chapter 3 the work of Hegel showed how a view of communitarianism placed the individual in a relationship with the deified state. The concept of the supremacy of 'community' was evident in this view and there was a sense of merging of the community and the state. Finally in chapter 4 consideration was given to a unique type of state which some describe as totalitarian and others as utopian. This was The Republic of Plato. Although these three models were used as a means of identifying tensions which were later illuminated in chapters 9 and 10, the idea of particular political ideologies was implicit in each model. Bearing these facts in mind and remembering that the preferred model was the Neighbour-Centred one let us now consider the role of the state and other factions within this context, the overall flavour of which is a pluralistic view. This can best be achieved by an analysis of the concept of pluralism. However a degree of caution is required in the use of the term pluralism as we shall see.

11.6.2 The Idea of Pluralism.

Pluralism is yet another of the terms discussed within this thesis which is ambiguous. Unlike other ambiguous terms such as 'community,' the term pluralism is more elastic and certainly when an attempt is made to define 'pluralism' difficulties emerge. In chapter 3 a similar problem arose with respect to 'community' and 'communitarianism' but it would appear that the term 'communitarianism ' is more easily interpreted as clearly dealing with 'communities, whereas 'pluralism ' is vague and uncertain. It is therefore crucial to state what the idea of 'pluralism' tries to convey in a given argument. In attempting to unravel the many uses to which 'pluralism ' has been subjected it is anticipated that a workable version can be isolated which would be satisfactory in terms of compatibility with the model in question.

Literally translated pluralism means a belief in more than one entity or a tendency to do more than one thing (McLean 1996). Power is distributed across a wide range of groups and the government has the status of intermediary (Johnson 1987). This more or less refers to the political sense of pluralism with which I shall mainly be concerned. However there are other types of pluralism which are indirectly relevant to my discussion. I shall therefore discuss pluralism in the following order: 1. Philosophical pluralism, 2. Ethical pluralism and 3. Political pluralism.

1. Philosophical pluralism, sometimes labelled epistemological pluralism, tends to be associated with the idea of pragmatism of which John Dewey was a proponent in the United States and Schiller in the United Kingdom. The focus here was the application of ideas and the notion that these ideas were plans of action. All knowledge and ideas were subject to criticism so there was no absolute solution to problems. In the work of Dewey this pluralistic view was contrasted to the monistic view of philosophers such as Hegel (Vincent 1987). This latter point i.e the distinction between a pluralistic as opposed to a monistic view is relevant to my particular vision of the states role. The idea of a monistic role for the state will be rejected as will the idea of a minimal role (p234).

2. Another type of pluralism identifiable is ethical pluralism which is the diversity of ethical goals pursued by various groups. These groups could be cultural in which case a variety of customs, beliefs and behaviours are evident. It is this sort of diversity which has given rise to the idea of a 'plural society' (Vincent 1987). In his essay On Liberty Mill emphasises the need for individuals to hold opinions and to be free to express such opinions (Mill 1859). The fact that men may not be in a position to act on these opinions is accepted.

3. Political pluralism is of particular interest since this focuses on the idea of the importance of groups in society. The individual's allegiance is to the group rather than the government. The groups in question might be a church, a club or a union. If we look at the history of British pluralism we find that a major influence came from Otto von Gierke whose contention of the supremacy of groups was taken up by Maitland, Figgis And Laski. The basic thrust of Gierke's argument was that the group has a will and a personality of its own and that it is capable of inventing its own laws and rules (Gierke

Otto von 1900). This idea of attaching the notion of personality to groups, associations and even the state itself again stems from Gierke whose interest was not confined to Germany but to the whole of Europe. It involved a particular type of study into the way in which groups in the widest sense behave in society (Runciman 1997). The idea of the personality of groups was further expanded by Figgis who favoured in particular the small group or association, usually religious in nature. Figgis however denied the idea of the state as having a personality since he did not believe that the state was just another group in society (Nicholls 1975).

The significance of the now out-dated idea of the personality of the group in the context of the overall picture of citizenship is that it demonstrates the power of groups, be they voluntary or statutory, to act in certain ways. This could be perceived both positively and negatively. The negative potential for group personality would be similar to the closed shop mentality of the bureaucracy. On the positive side the perception of group personality assumes solidarity between the members so that any cause can therefore be strengthened.

Particular aspects of political pluralism within groups is attributed to particular historians in particular countries. In Britain for example the notion of pluralism was seen in the Guild Socialist Movement. The Movement had two major objectives. The first was that the main ownership of the means of production should be transferred to the community. The second was to curtail the power of central government to a minimal level Wasserman 1944). Although these organisations were greatly admired for their self-regulating, self- reliant mentality they had nevertheless an element of exclusivity which portrayed the whole notion of 'group mentality' in a negative light as I have suggested in chapter 3 (p45).

In France the Syndicalists demonstrated political pluralism. This was of course a predominantly Marxian structure which fought an ongoing battle against capitalist wage systems, the main argument being that capitalism had destroyed individual pride in work and the product of this work. The syndicalist must therefore rely on himself and his co-workers to organise themselves into union structures which would enable the group to fight against employers and the state (Wasserman 1944).

From the discussion so far it can be said that the whole idea of political pluralism appears to be fragmented and that the main strength emerging is the supremacy of groups within society and their ability to make decisions within the context of communities. There are two other areas of importance propounded by pluralists, and these are the idea of liberty and the rejection of the sovereign state. As far as liberty is concerned, this was seen as being attained only within the context of the group. The idea was that citizens who are treated as responsible people are more likely to develop further responsibility and that human personality develops best when citizens can choose how to live their lives (Figgis 1914). The implication in the writings of many of the English pluralists seems to be that freedom is seen in terms of a particular place in society for the group which should not be seen as subservient to the state. One of the criticisms of pluralism is its lack of expansion of the meaning of liberty and a pre-occupation with securing it (Vincent 1987).

The other important ingredient of pluralism was the idea of the rejection of the sovereign state. It cannot be said with certainty however that this was always the case. It is more likely that it was particular aspects of sovereignty which were rejected. It was the law as part of the sovereign which was rejected. The pluralist view was that the law originated in the community or group and the state must therefore respect this situation (Vincent 1987). What pluralists wanted was a change in the perception of the sovereign state. This was because of the fear of moral sovereignty which proclaimed that the state existed for the good off all citizens an idea which was unacceptable to many pluralists. (Nicholls 1975).

Overall the analysis of pluralism emerges shows it to be weak. Vincent has summarised this succinctly.

1. There is no strong theoretical (political or otherwise) basis to the idea of pluralism. It has been a 'tendency ' rather than a theory (Vincent 1987).

2. The majority of pluralist writers were not political philosophers.

3. The idea of promoting the self governing group in favour of the interventionist state does not work largely because there is not clear explanation or agreement on the states role (Vincent 1987).

What is also clear from the above analysis is that there is lack of agreement between individual pluralists on many issues.
Finally there appears to be no recognition of any undesirable elements of 'groups' in the sense outlined by pluralists. For example the exclusivity of communities which I referred to in chapter 3 (p48) has not been discussed, yet there seems to be potential for such exclusivity within pluralism. There is also the potential for uneven distribution of power between groups which the state would normally protect against.

As stated above there is a difference in perception of pluralism between America and Britain. The above discussion has mainly concerned Britain. The American version of pluralism tended to be describe American politics (Nicholls 1974, Vincent 1987). This can be traced to Madison who was a strong proponent of pluralism and in particular the idea of factions or interest groups. The function of government was seen as protecting the freedom of such groups (Dahl 1956).

Precise details of pluralist perceptions in both countries is beyond the scope of this discussion since the main interest here is discover the strengths and weaknesses of the doctrine. The objective is to discover whether a pluralistic view generally might be compatible with active citizenship.

11.6.3 A Variation of Pluralism for a Model of Citizenship.

Recognising the weakness of some aspects of pluralism, it is nevertheless possible to incorporate a pluralistic view of the state into a model of citizenship. For the purpose of the Neighbour-Centred Model it is clear from previous discussions that the idea of groups is desirable for such a model. The analysis of the idea of voluntarism demonstrated the potential within this broad sector for participatory citizenship. The idea of groups is also central to a communitarian view. The crucial issue which must

now be decided is the part to be played by the state. If we were to agree with some of the pluralist arguments presented above then the state would have a minimal role and political power would be dispersed. The problem with this would be that the potential needs of some members of society would be neglected. The possibility of an elite power structure which would favour certain groups over others could not be ignored.

In the context of the Neighbour-Centred Model of Citizenship already proposed we require a pluralistic view of the state. If this is so then a specific meaning of pluralism must be chosen. But the chosen meaning would incorporate a stronger role for the state than is usually implicit in pluralistic theory. Such a meaning would oppose the idea of the 'nanny state' . This perception is less difficult to accept if, in addition to the state and the various participatory groups, the market is included in the vision of a model of citizenship. Apart from its other functions the state must oversee the working of the market system. Before going on to discuss the market we must clarify the situation of the role of the state. One way of deciding this is to eliminate those views of the state which would be seen as inappropriate. It has already been decided that the collectivist /interventionist state in which the Welfare State functioned in its early years, is inappropriate for the practice of citizenship. It is agreed that there is some accuracy in the charge of the dependency culture. The role of the state in welfare is envisaged as being complementary to other groups such as the voluntary sector and the market. It is further acknowledged that this does not in fact depart dramatically from Beveridge's particular philosophy. It will be remembered that he was a 'reluctant' collectivist (George and Wilding 1976). He was reluctant in that he appreciated the 'good 'of the market but nonetheless decided to join the current trend favouring extensive intervention by the state. He was also an ardent believer in the role of voluntarism in society (Ch.8.2).

The discussion of American welfare and health reflected an individualist ideology, implicit in which was the idea of minimal state action. The analysis of welfare and health care brought out the shortfalls of minimal state action as manifested in an inability of many citizens to obtain the care which they require.

What is required therefore is neither the minimal nor the strongly interventionist state. The pluralist view outlined above appears to fulfill this vision. In other words the

concept of groups is seen as vital but only in the context of the strong state and the supervised market.

The possibility of an intermediary role for the state is seen as consistent with the ideas outlined. The idea of intermediary bodies generally is central to the notion of pluralism. Let us consider these in more detail.

11.7 The Concept of Intermediary Bodies.

The idea of the intermediary is relevant to several aspects so far discussed. The issue is introduced at this point rather than at an earlier stage because it is proposed to consider the term in a general sense, ie the one it which it is ordinarily used, and in a more specific sense i.e the idea of the government as an intermediary. Since there is relevance both to the whole idea of groups and pluralism and to the state, it provides a means of linking these two elements. In view of the fact that a Neighbour-Centred Model of Citizenship is envisaged then the concept of some co-ordinating factor between the state and the citizen is applicable. The concept of intermediary has already been introduced in the Neighbour-Centred Model in the context of the Hegelian philosophy (p20).

It appears that there are various means of employing the idea of the intermediary body within the context of citizenship. This could be perceived as a passive sense of citizenship or more optimistically an active sense of citizenship. It has already been noted that the concept of 'active' citizenship is interpreted differently by politicians, and so when the idea of intermediary associations is raised this too can have either a superficial meaning or a deeper one. Returning once more to the 'little platoon' there is little doubt that Douglas Hurd meant small local groups in which citizens could involve themselves in some form of voluntarism. It is unlikely that he intended his statement to mean political participation of any kind (p195). There is a clear cut off point here between activity and passivity of citizenship that is between political and non-political involvement.

For the purpose of this discussion however it is active citizenship which is recommended. This will necessarily mean a degree of activity beyond the local charity. Indeed it has already been demonstrated that in the context of welfare and health systems there are many avenues of potential for both political and non-political participation. What is important is the availability of opportunity for participation within the community. Clearly individuals must choose their degree of personal involvement and as stated earlier (p195) there is room in the system for chosen passivity by some citizens.

In considering the intermediary body we must return to the voluntary sector to observe it in action. Within the context of voluntary organisations a distinction is drawn between local and national intermediary bodies. These bodies form a co-ordinating role between the voluntary organisation and the government. Examples of the former include Rural Community Councils and Councils for Voluntary Service and the local rural Councils of Social Services in Scotland. The main function of the local intermediary body is to provide a range of facilities and services to the voluntary organisations. They are not usually involved in the direct delivery of services to the public. They act on behalf of the organisations in areas of publicity, provision of training courses and liaison with the statutory sector (Wolfenden 1978).

At national level there are several statutory intermediary bodies which include The Arts Council for Great Britain, the Housing Corporation, The Commission for Racial Equality and many others. In addition to the functions outlined for the local intermediary groups the national bodies also have a regulatory and funding capacity.

The concept of the intermediary body within the voluntary sector is but one example of the idea of a functioning link between the government and the organisation. In the context of participatory citizenship there are also groups whose function is that of intermediary. These allow citizens to be involved as neighbours within the community. Tenant groups and neighbourhood watch groups form a citizen link between an authority within the statutory sector such as the police or the housing sector. The two key issues involved are the concept of neighbourliness and the idea of representation. In other words small groups of interested citizens serve as representatives of the majority in the interests of the community.

There is another sense in which the concept of intermediary is relevant to citizenship. This is the idea of the government as a moral intermediary (Downie 1964). It is assumed that the role of the state will include the protection of its citizens via the legal and statutory systems. This protective function is expected of the government by citizens. The citizen in turn is expected to comply with particular laws relevant to his particular country. This a very limited view of the relationship between the state and the citizen. To the extent that the government is seen as enabling citizens to live harmoniously then it, the government, has another function. This role is a representative one in which the government acts as an intermediary. I do not mean representative in the sense of an ambassador or diplomat although this is indeed an important role in foreign affairs politics. Griffiths has distinguished various senses in which the idea of 'representative' is used.

1. Symbolic representation is the kind of representation in which , for example, the monarch represents the majesty of the state.

2. The sense of ascriptive representation is the sense in which someone represents another person legally (Griffiths 1960). This is also the sense in which the government acts as an intermediary. The way in which the government does this is in the representation of the interests of the people. Just as the various groups previously described rely on an intermediary body to represent their views to the local authority so the government itself can act in a similar way. In practical terms this representation may take the form of one politician representing citizens in a particular geographical area. The significance of this role in the context of citizenship is that it demonstrates a degree of cohesion and cooperation between the citizen and the state.

The role of the state is further illuminated in the context of the market to which I now turn.

11.7 The Market and Citizenship.

The role of the state has been discussed to some extent under the idea of pluralism. However for the purpose of deciding on its involvement within the Neighbour-Centred Model it is necessary to maintain constant links between it and the market. This is because there is a sense in which neither the state nor the market can be isolated from each other. By this I mean that if the two are to work alongside each other the idea of interpreting them as opposing interests is inadvisable. This departs from the traditional state versus the market theory which is often found in economic accounts of welfare distribution. These accounts often focus on the failure of either the state or the market with little promise of cohesion between the two. It has been suggested that the failure of economists to analyse the operation of the state as well as the market has resulted in a weakness of economic justification of the public sector (Heald 1983). The fact remains that markets cannot function without the state because they must be governed by the legal system as a protective agency against unscrupulous persons (Downie and Telfer 1980).

In considering the role of the market within the concept of a Neighbour -Centred Model of Citizenship it is acknowledged that, as in the case of the state, a major determining factor of how this is perceived is dependent on its influence on health and welfare systems. We are therefore concerned with this particular element of markets rather than a purely economic or political stance. It is recognised that the economic view cannot be ignored and will therefore necessarily be referred to . However an in depth analysis of economic market theory is beyond the scope of this discussion.

11.8.1 The Meaning of Markets.

Central to the concept of the market are the ideas of production and consumption. These areas have been discussed in the context of a Marxist critique on welfare (p183). For the purpose of this discussion there are other features of markets which are relevant. These are: **price, choice, competition, and redress.**

A market is in essence, a self-regulating, self-correcting system in which supply and demand and profit and loss are said to allocate resources more efficiently and therefore solve the perreneal economic problem of scarcity better than any known alternative (Barry 1993).

However very few people would wish the market to be involved in all of the resources in life. Even the strongest proponents of markets see a role for the state. A cynical view of this might be to say that only the areas in life which have no price-determining mechanism should be excluded from the market. These services should therefore be left to the state to organise.

The concept of **price** is of central importance to the market philosophy. As Charles Handy points out - *anything that is unpriced is ignored by the market. The environment is the most obvious example. Air is free so we use it and pollute it, without penalty most of the time, likewise the oceans. What is not owned is not priced, and therefore cannot be included in any calculation (Handy 1997).*

The idea of price also reflects the way consumers regard commodities. An element of this is seen in the trickle -down effect which has been put forward by pro-marketers since the time of Adam Smith. This again is related to the idea of price-setting. It means that under the market people's living standards rise more quickly than under any other system. It is based on the belief that what the rich have today will eventually trickle down to the poorer members of society. It also means however that what is perceived by the rich as a luxury today will no longer be so tomorrow. In effect the rich will get richer and the poor will struggle behind (Hoover and Plant 1989).

The idea of **choice** has already been discussed within the context of a Consumerist Model of Citizenship (Ch. 2, p37). Clearly the idea of choice is attractive to the consumer since this gives him a degree of control over goods. In the context of health care in Britain at least, as we saw in chapter 11.1.4, in spite of the Patient's Charter and the introduction of market forces, choice is limited. It is limited in terms of services and in terms of treatment. (p200). It was observed that the element of choice was a major

selling point for the introduction of market forces into public services (p37). Apart from the apparently superficial nature of choice as expressed in documents such as the Patient's Charter there is another aspect of choice which may be a cause for concern in the context of delivery of services. In the context of community care, individuals who choose to opt for home care as opposed to institutional care may put undue pressure on carers especially families (Le Grand and Bartlett 1993). This problem is exacerbated by the lack of back-up services and support for home-carers. While the idea of choice may be attractive the practicalities of implementing it may be problematic.

The idea of **competition** within markets can be perceived as both beneficial and restrictive. The argument for competition usually focuses on elements such as incentive, inducement and quality of services or products. Clearly a competitive element will provide an incentive to succeed and the motivation to improve a particular good or service. Having more than one source from which similar goods can be obtained allows the consumer to shop around and choose the best option available. This it is felt results in a higher standard of goods and services than would be the case if only one source were available from which to obtain the goods in question. It is the lack of choices on the supply side which induces others to set up new businesses thus increasing the likelihood of improved standards and quality for the consumer.

The competitive element of the market is also seen as part of the enhancement of the entrepreneurial spirit of motivated individuals. This particular aspect was promoted strongly by the Thatcher government with its emphasis on the hard-working self-reliant individual (p150). It is also crucial to the notion of consumer sovereignty in America.

In the context of welfare and health services the idea of competition is not always beneficial. This of course depends on the kind of market involved and the kind of system in operation. In Britain the purchaser provider scheme recently introduced into health care has resulted in districts competing against each other for services and in some cases patients are in competition for particular services (p37). In the American system on the other hand we saw that the market worked well for those who could afford it. The problem was that those who could not afford it, and this included self-employed people as well as those on low incomes, had no available alternative. Only

the very poor and those meeting particular criteria were eligible for Medicaid. This particular aspect of the market is criticised frequently because it is felt that it results in an unequal distribution of goods. Defenders of the market reply that it is competition which provides the motivation for individuals to try harder both from the point of view of character building and as an incentive for others to do the same.

Closely related to competition is the notion of self-interest which promotes an 'every man for himself' doctrine. This is more often seen as a criticism although in the United States it is seen as part of the hard-working self-reliant individuality of that culture. Hirsh saw the self-interest component of the market as one of the fundamental problems of the market ideology. He argued that the so-called invisible hand theory has been destroyed by this self-interest (Hirsh 1977). But not everyone agrees either that the market perpetuates self-interest or that self-interest is necessarily intrinsically negative. As previously stated the self-interested nature of individualism is regarded by individualists as essential to the good of others in addition to themselves. This kind of argument has its basis in the invisible hand theory. It is not known exactly what this literally means i.e whether it is the hand of God or some other divine force. It is frequently used in the context of discussions on the market to convey the idea that a certain unintended outcome often results from individual action. The phrase was introduced by Adam Smith as a metaphor for the working of the market (Smith 1776). In relationship to the market this means that although an individual may not set out to help anyone but himself, that in so doing, somehow in this process, others also benefit as a result of his action. Nozick subsequently used the same argument to produce his concept of the ultra minimal state. He also referred to hidden hand explanations which were seen as opposite to invisible hand where unintended, accidental or unrelated events occur as a result of intentional design (Nozick 1997).

The final element of markets to be addressed is the notion of **redress.** This is part of the idea of consumer satisfaction. Information is an important ingredient in this context. The success of the market depends on information at every level. Providers and purchasers must have access to information regarding pricing, quality and consumer satisfaction. Feedback from users of goods and services is therefore crucial. In pure market systems this is taken seriously and much attention is paid to market research and

satisfaction surveys. If this aspect is neglected then openings are provided for others to fill the gap and provide cheaper/better services.

The idea of redress like that of choice is limited in the context of health and welfare in Britain. Although the market system has not been in force for long enough to measure progress it is clear that there are currently limited means of redress. Within the quasi-market structure which I shall address presently this is an area yet to be expanded. While the Patient's Charter provides some avenues for complaints against institutions and professionals, the degree to which these complaints are adequately dealt with is uncertain. Because of the uncertain status of the market in welfare there may be a reluctance on the part of users of services to make complaints and a corresponding reluctance by professionals to encourage it.

Let us now consider the quasi-market in more detail.

Within the Welfare State the idea of markets remains controversial. This may be partly historical in that one possibility for the evolution of Welfare State was to overcome the inadequacies of the laissez-faire market system (p39). Egalitarianism, greater equality and social justice were all cited as reasons why the Welfare State might have been able to overcome the perceived flaws of the early laissez-faire system (p34). Each of these aspects individually and collectively have been the centre of debate and argument since the Welfare State evolved. The question arose as to extent to which did the Welfare State alleviated the apparent inadequacies of the market. Later the idea of efficiency was added to the argument and this provided a firm reason for the reintroduction of market forces into welfare in the Thatcher years.

In chapter 8 I referred to the introduction of the market in some detail and the way in which this came about as a result of the Griffiths' Enquiry (p148). What resulted was a change in the organisation of services so that state financing of services was retained while the system of delivery of services was altered. This occurred not only in the health service but also in education, housing and the personal social services. The idea was that a quasi market status would evolve and not a pure market. This meant that the financing of services would remain in the hands of the state but there would be a radical

change in the way the services were provided (Glennerester and Le Grand 1994). This quasi- market status was eventually included in the 1990 National health Service and Community Care Act as the way forward for the future. This change also constituted a departure from the previous position of the state as provider and financier of services. In addition to the hope of improved efficiency of services there was also the desire do withdraw power from the bureaucracies. The actual mechanism of the purchaser provider system will not be reiterated here. Instead I shall be concerned with the thinking behind these moves in terms of their success or failure to date.

The idea of a quasi-market is a relatively new phenomenon in public services. It must be distinguished from other types of market, for while there are similarities with the pure market there are also differences. The use of the adjective 'quasi' indicates that this particular type of market differs from the conventional one. These differences are both on the supply side and the demand side. Whereas in the conventional market organisations supplying services are privately owned this is not necessarily the case in the quasi-market, nor are the organisations necessarily interested in profit. There is still however, an element of competition between suppliers. On the demand side the ideas of conventional markets are still in place though they are expressed differently. For example in the quasi-market pre-determined budgets are decided upon such as those held by General Practioners. In other words money does not change hands between consumers and budget holders. Sometimes voucher schemes are in operation as for example existed in pre-school care in the late nineteen eighties (Le Grand and Bartlett 1993).

Even from this basic description it is clear that the idea of the quasi-market is complex and uncertain. What then was the justification for their introduction into health and welfare services?

One of the most frequently used arguments for introducing quasi -markets has been that this would achieve cost reduction of public services. This has not happened and there is evidence to confirm that National Health Service spending increased in the first years of the quasi-market (Glennerester and Le Grand 1994).

The whole question of the concept of market forces in welfare and health services focuses attention on what we might call the morals of markets. Much criticism has emerged on just that issue in relationship to health care in particular. This criticism, however would be justified in a pure market system as is almost the case in America. To the extent that the state continues to finance the services in the quasi-market structure, there is then the implication of state control of the market. On the other hand there may be a lack of commitment by professionals and other workers to the idea of a market in welfare services. This point is particularly relevant to the British National Health Service. It would appear that in order for any kind of market status to be acceptable there would have to be a change in attitude to and perception of the market. Given that the basic assumption behind the setting up of the Welfare State was free services for all then the first hurdle to overcome would be the idea of profit. Since the introduction of the market into welfare was to all intents and purposes imposed on the system by the government, there is likely to be a half-hearted response on behalf of professionals. Although we have already ascertained that profit was not part of the quasi-market system neither the public nor the professionals may appreciate this.

In spite of the obvious deficiencies of the market it is nevertheless possible to incorporate a market system into welfare states provided that it is carefully monitored and controlled. The American analysis also showed that such a system works for those who can pay for health care. On the other hand there were negative connotations for the poor in American society (p125). In Britain the introduction of market-based strategies into the health service by the 1979 conservative government was met with disapproval initially. The idea of a pure market system is not seen as appropriate but a situation in which the state acts to protect citizens against the shortcomings of the market may be appropriate. The case for including the market in the proposed model of citizenship rests on the possibility that the presence of a market would eliminate the overly interventionist state and at the same time allow motivated individuals to develop and expand creative and business instincts. This would make room for New Labours vision of the social entrepreneur.

11.9 Conclusions

1. This chapter has been concerned with the idea of citizenship with a view to formulating a workable model based on the Neighbour-Centred Model from chapter 3. To this end a detailed analysis of the concept of participation has been carried out. Various avenues have been explored via which citizens can participate in health and welfare services. It is acknowledged that while the ideas of participation is linked to the label 'active citizen' by all political parties, this label is subject to interpretation and can be perceived narrowly or broadly.

2. One of the means by which citizen participation can be encouraged is under the broad heading of voluntarism. This includes voluntary organisations, self-help groups and community health councils. An earlier form of participation which had a significant influence on the setting up of welfare services was the University Settlement. This movement demonstrates the potential not only for active citizenship but also for promoting the spirit of community among all classes. No attempt has been made by recent governments to re-instate this movement despite the obvious need for such a service.

3. One of the areas of importance for health care in terms of participatory citizenship is the health promotion movement. Although this does not fit neatly into the same logical category as other avenues of participation, it was in fact instigated in order to increase patient/client involvement in their own health and welfare. It also aimed to remove responsibility from the professionals and place it in the hands of the individual. The success of this venture may not yet be measurable by any meaningful statistics, but what can be said is, that professionals generally have infiltrated the scheme to a greater extent than is desirable.

4. The relevance of the whole idea of participation and active citizenship lies its potential to enhance a vision of the Neighbour-Centred Model. The concept of 'neighbour' was therefore evident throughout each aspect of participatory citizenship.

5. In seeking to find an acceptable role for the state within the Neighbour-Centred Model it was concluded that a variation of the pluralistic view of the state would be appropriate. In doing so the idea of the 'nanny state' and the 'night watchman' state were rejected. This was because neither the strongly interventionist state nor the minimal state were seen as providing a potential role for all the factions of voluntarism discuss. Problems were noted within the concept of pluralism mainly relating to the weakness of it as a political theory. Nevertheless it was decided to use this as a basis of a role for the state in which the market should also be represented.

6. The discussion of markets was aimed at discovering whether there was a viable role for any kind of market within health and welfare services. Having explored the positive and negative aspects it was concluded that in spite of many shortcomings the market should be included in the desired model of citizenship. A distinction was drawn between conventional pure markets and the quasi-market. The latter has recently been introduced into public services including the health service. The success of the quasi-market system has yet to be revealed. At worst it appears to be a cumbersome and bureaucratic structure if general practitioner budget holding is held as an example. At best it provides limited choice to patients and clients thus moving away from the monopolistic state-owned, state- run and state-defined delivery of services.

7. The idea of tensions was revisited briefly. Having focused on general tensions and specific tensions in preceding chapters conclusions were drawn about the presence of tensions in the systems. These conclusions maintain that tensions are an inevitable part of systems of health and welfare and may contribute to positive change. For this reason the idea of balancing tensions and avoiding disequilibrium at all costs is not necessarily advocated.

References.

ACHCEW 1994 **Managing the New NHS: Ensuring Effective CHCs in the New Structure.** Feb, 1994;pp8-9.

Ashdown P. **Citizens' Britain, A Radical Agenda for the 1990s**, London: Fourth Estate 1989;pp37-8.

Barnett A. 'Charlie's Army'. **New Statesman,** September 22nd 1989; 9-10

Barry N. **An Introduction to Modern Political Theory,** Second Edition, MacMillan. 1993.

Beacom B. 'Representing the Public in the NHS'. **Greater Glasgow Health Council Annual Report** 1996-1997, 1997.

Beveridge WH. **Voluntary Action.** London:Allen & Unwin,. 1948.

Blair T. **New Britain, My Vision Of A Young Country.** London:Fourth Estate, 1996; pp220-1.

Burke E. **Letter to a Noble Lord.** In: Honderich T. (ed) **Conservatism**, Penguin Books, 1990;pp6.

CanagaRetna A. 'Primary Health Care Teams Involving Patients. Examples of Good Practice'. **NHS Executive Document.** 1997.

Connor A. 'The Role of the Voluntary Sector in the New Community Arrangements'. In: Titterton m. (ed) **Caring for People in the Community; The New Welfare;** London:Kingsley Publishers, 1996;pp130-2.

Dahl RA. **A Preface to Democratic Theory.** University of Chicago Press, 1956;pp5.

Day T. **Getting Closer to the Consumer?** Locality Planning in Exeter Health District, School For Advanced Urban Studies, University of Bristol, 1990;pp9-10.

Department of Health. **Working for Patients.** London:HMSO, 1989.

Department of Health. **'The Patient's Charter;** London:HMSO, 1991.

Downie RS. **Government Action And Morality.** The Concept of the Moral Intermediary. 1964;pp116-117

Downie RS, Telfer E. **Caring and Curing. A Philosophy of Medicine and Social Work.** London and New York:Methuen, 1980.

Downie RS, Tannahill C, Tanahill A. **Health Promotion; Models and Values;** Second Edition; Oxford University Press, 1996.

Eckholm E. (Ed.) **Solving America's Health-Care Crisis.** A **Guide To Understanding The Greatest Threat To Your Family's Economic Security.** Randomhouse New York:Times Books, 1993.

Figgis JN. **Churches in the Modern State;** London:Longmans Green 1914.

Fox DM, Leichter M. 'State Model: Oregon'. The Ups and Downs of Oregon's Rationing Plan: **Health Affairs** 1 (Summer) 1993;pp66-70.

George V, Wilding P. **Ideology and Social Welfare,** London:Routledge and Kegan Paul, 1976.

Gierke Otto von. **Political Theories of the Middle Ages;** Translated by Maitland FW, Cambridge: Cambridge University Press, 1900.

Gladstone D. **British Social Welfare Past, Present and Future,** London:UCL Press , 1995.

Glennerester H, Le Grand J. **The Development of Quasi-Markets in Welfare Provision.** Welfare State Programme Number WSP/102, 1994.

Green TH. **Lectures on the Principles of Political Obligation,** London 1937; p209.

Green D. **Reinventing Civil Society. The Rediscovery of Welfare Without Politics.** Choice in Welfare Series No. 17. IEA, Health and Welfare Unit, London, 1993.

Griffiths AP. **How Can One Person Represent Another?** Aristotelian Society, 1960.

Ham C, Honigsbaum F, Thompson D. ' Priority Setting for Health Gain'. In: Oakley A,Williams S. (eds) **The Politics of the Welfare State**, UCL Press, 1994.

Handy C. **The Hungry Spirit Beyond Capitalism- A Quest For Purpose In The Modern World**. London:Hutchison, 1997;p24.

Heald D. **Public Expenditure. Its Defence and Reform.** Oxford:Martin Robertson, 1983.

Hecht R. 'I Talk Now'. **A Report on the Health and Community Arts Project:** Bristol Area Specialist Health Promotion Service, 1996.

Hirsh F. **The Social Limits to Growth,** London.:Routledge &Kegan Paul, 1977.

Hogg C. **The Public and the NHS:** Association of Community Health Councils for England and Wales, London, 1986.

Honderich T. **Conservatism:** Penguin Books 1990;pp1-3.

Hoover K, Plant R. **Conservative Capitalism in Britain and the United States**, A Critical Appraisal. London:Routledge, 1989;pp56-7.

Hurd D. 'Citizenship in the Tory Democracy'. **New Statesman**, April 28th, 1988.

Johnson N. **The Welfare State in Transition: The Theory and Practice of Welfare Pluralism**, Billings & Sons, 1987;p150.

Kickbusch I, Hatch S. **Self-Help and Health in Europe.** WHO, Copenhagen 1983;pp4-6.

Klein R. **The Politics of the National Health Service.** London:Longman, 1983.

Klein R. 'Warning Signals from Oregon. The different dimensions need untangling'. **British Medical Journal**, 1992;304: 1457-1458.

Le Grand J, Bartlett W. **Quasi-Markets and Social Policy:** MacMillan Press, 1993.

Marshall TH. **Social Policy in the Twentieth Century.** London:Hutchison, 1979.

Marx K, Engels F 1848 **The Communist Manifesto,** Ed. David McLellan, Oxford University Press, Penguin Books 1976.

Mawson A. Bromley By Bow Centre **Annual Report 1995-1996.** 1996.

McLean I. **The Concise Oxford Dictionary of Politics,** Oxford University Press, 1996; pp375-6.

Meachan S. **Toynbee Hall and Social Reform 1880-1914, The Search For Community**. New Haven and London:Yale University Press, 1987;pp16-40.

Mill JS. 1859 **On Liberty.** In: Acton HB. (ed). **Utilitarianism, On Liberty and Considerations on Representative Government.** London:J.M Dent and Sons Ltd, 1988;pp72-3, p122.

Nicholls D. **Three Varieties of Pluralism.** London:The MacMillan Press, 1974.

Nicholls D. **The Pluralist State.** London:MacMillan Press, 1975.

Norman R. 'Citizenship, Politics and Autonomy'. In: Milligan D, Watts Miller W, (eds) **Liberalism, Citizenship and Autonomy**, Avebury Series in Philosophy. The MacMillan Press Ltd, 1992;pp58.

Nozick R **Anarchy, State, and Utopia.** 10th edition, Cambridge US, Oxford UK: Blackwell, 1996;pp 25-7.

Nozick R. **Socratic Puzzles,** Harvard Press, 1997;pp192.

Rooff M. **Voluntary Societies and Social Policy,** Routledge &Kegan Paul, 1957; Ch.1 p3.

Rowbotham S. 'Interpretations of Welfare and Approaches to the State'. In: Oakley A, Williams S. **The Politics of the Welfare State.** UCL Press, 1994;pp28.

Runciman D. **Pluralism And The Personality Of The State,** Cambridge University Press, 1997.

Sabine GH. **A History of Political Theory,** Harvard, 1952;p612-4.

Schumpeter J. **Capitalism, Socialism and Democracy.** London: Allen and Unwin 1976;pp261-3.

Smiles S. 1866. **Self Help with illustrations of Conduct and Perseverence.** IEA Health and Welfare Unit, 1996.

Smith A. 1776 **The Wealth of Nations,** With introduction by Andrew Skinner, Penguin Books, 1976.

Taylor M. 'Voluntary Action and the State'. In: Gladstone D. (ed) **British Social Welfare, Past, Present and Future.** London:UCL Press, 1995;pp218-20.

Tountas Y. 'Health Education and Self-Care'. In: Doxiadis S. (ed) **Ethics of Health Education,** John Wiley & Sons Ltd. 1990; Ch 10, pp145-147.

Trolander JA. **Settlement Houses and the Great Depression.** Detroit:Wayne State University Press, 1975;pp 18- 20.

Vincent A. **Theories of the State,** Basil Blackwell, 1987;pp182-200.

Wasserman L. **Modern Political Philosophies And What They Mean.** Philadelphia:The Backiston Company, 1944

Weatherall D. **Science and the Quiet Art. Medical Research and Patient.** Oxford University Press, 1995;136-7.

WHO. **Health Promotion, A discussion document on the concept and Principles.** WHO, Copenhagen. 1984.

Winkler F. 'Community Health Councils as an Organisational Structure for Promoting Community Participation'. **Paper presented to the International Conference on Primary Health Care**, Dusseldorf, 1986.

Winkler F. 'Involving Patients'. In: Meads G. (ed) **A Primary Care-Led NHS; Putting it into Practice.** Ch 12. Churchill Livingstone, 1996;

Wolfenden Committee. **The Future of Voluntary Organisations.** Report of the Wolfenden Committee, 1978;pp13-39.

Younghusband E. **Social Work in Britain: 1950-75, Vol. 1,** London:Allen & Unwin 1978.

FINAL SUMMARY AND CONCLUSIONS

This thesis has focused on three main issues. These are:

1. The concept of citizenship,
2. Health and welfare systems and
3. Tensions within systems of welfare and health.

Each of the eleven chapters has drawn seven main conclusions based on selective reviews and extended discussions of early and recent literature on the concepts listed above. In this section an attempt will be made to draw together the main conclusions and to focus attention on the central arguments.

At the core of the analysis of the three philosophical models of citizenship was the citizen in three different guises. These were: the citizen qua consumer, the citizen qua neighbour and the citizen qua client. From an exploration of these three models it emerged that the most acceptable for the practice of modern citizenship was the Neighbour -Centred Model. But there were problems to be overcome. The analysis of Community and Communitarianism uncovered the traditionally exclusive nature of communities. The element of fraternity was seen as restrictive and was therefore replaced by neighbourly solidarity. Although the Neighbour-Centred Model was the most appropriate for the practice of citizenship, the other two philosophical models i.e the Consumer-Centred Model and the Client-Centred Model also revealed aspects of citizenship which must necessarily work in tandem with the preferred model. This means that while the communitarian view is upheld, the citizen is also a consumer, and at various times a client. These three models cannot in practice be split, which is why a predominantly individualistic, or a predominantly communitarian view is rejected.

I have suggested that a major manifestation of citizenship is seen in the way health and welfare services are delivered in specific countries. In the context of this thesis the systems analysed were the American and the British systems. Broadly speaking these can be seen to demonstrate an individulalist political ideology (America) and a more

communitarian/ collectivist view (Britain). It is however acknowledged that the latter is becoming more 'Americanised,' particularly in the field of welfare provision.

An analysis of the two systems led to the conclusions that, in the case of the American system of welfare and health, the tensions are unbalanced due to a pull in the direction of consumerism. Several areas of concern emerged. The fact that welfare and health are regarded as separate entities leads to problems, one of which is to associate the idea of welfare with a degree of stigma which widens the gap between rich and poor. As far as health is concerned clearly the current system is inadequate but so too is the political will necessary to effect change.

The analysis of the British Welfare State focused on the argument that the current situation has departed from Beveridge's original plan. It is concluded that this departure is consistent with changes in communities and populations generally, and that the actual changes i.e from predominantly state-run services to a quasi-market situation will erode the basic 'cradle to the grave' philosophy.

In Britain there is some justification to the charge of a 'dependency culture'- as a result of an overly protective and interventionist state-- but the new proposals to remove welfare benefits constitute an unacceptable alternative to the 'nanny state'. The idea of the state protecting the interests of the most vulnerable groups must be upheld.

The idea of citizenship is constantly evolving. Whether we consider global or national citizenship, socio/economic or political citizenship there is, inherent within the concept of citizenship, some expectation on behalf of citizens of a relationship with the state. This relationship is crucial to the way in which particular systems and services are delivered.

The concept of citizenship cannot be separated from the idea of rights. From the earliest perception of citizenship the notion of rights was central to it. From the point of view of this thesis it is welfare rights which are central. It is concluded that although a right to welfare cannot be subsumed under the general heading of traditional natural

rights, it must nevertheless be accorded some other status within the system, one which at least recognises welfare and health-care as part of the formula for a flourishing life.

If the delivery of health and welfare services is a manifestation of citizenship (as it is argued) then consideration must be given to the role of various institutions within such a plan. Public participation is essential to the idea of the active citizen. This means that the active citizen must be allowed, enabled and empowered to participate at an individually chosen level in the delivery of welfare and health care. In advocating a Neighbour-Centred Model of citizenship therefore, a strong case is made for the inclusion of the voluntary sector and any scheme related to health which encourages citizen involvement. A pluralistic state is conducive to this sort of multi-sectorial involvement. In arguing for the inclusion of the market it is assumed that this would remove the idea of the monolithic state and allow for individual growth. The market must however be regulated by the state in order to protect citizens against unscrupulous individuals.

A critique of the systems by Illich was useful in a) highlighting tensions and b) placing the tensions in perspective. In the early nineteen- seventies, when the whole ethos of professional infiltration of the systems was at its peak , in the United States and in the United Kingdom, Illich created a forum for debate which caused professionals and institutions to consider the notion that they themselves created the 'needy' client and that this would escalate as professionals grew in numbers. To the extent that Illich a) highlighted the need for self-assessment by professionals and b) predicted the likely outcome of a society of experts as perpetuating need, Illich's arguments have acted as useful tools. Nevertheless when terms such as 'medicalisation' and 'systematisation' are used as generalisations some of the force behind the arguments is lost. Thus those who have criticised Illich's work may be justified in the claim that many of his arguments are unfounded.

A Marxist critique of the systems illuminated tensions which were specific to the economic system of capitalism. I refer to the Marxist thinking on alienation, exploitation and class. Each of these is reflected in the working of the systems of welfare and health as tensions. These tensions may be dormant or active, but their

presence highlights the need for change. For example, in the light of the observed parallels between the Marxist view of class and the apparent inequality in service distribution as found in the Black Report, a case can be made for some re-distribution of national wealth.

Finally, three firm statements can be made in relationship to health and welfare systems in the overall context of citizenship.

Firstly, the idea of providing a sustainable system of welfare and health care to citizens is a major pre-occupation of governments in most countries of the western world.

Secondly, the method of delivery of these services is a manifestation of the idea of citizenship.

Thirdly, it emerged that tensions exist within these systems of welfare and health. These tensions derive from the different conceptions of citizenship which have developed in the modern period, and to a lesser extent from different conceptions of welfare and health. The tensions are inevitable and can lead to progress, although they can be destructive if they lead to permanent disequilibrium.

APPENDIX.

The Origins of Citizenship

The aim of this Appendix is to provide details of historical aspects of citizenship. These details are relevant to the overall perspective of citizenship, but supplementary to the arguments raised within the various chapters. Since the thesis is concerned with specific models of citizenship the references made to historical periods are seen as offering a more complete analysis while at the same time not detracting from the central arguments.

Many commentaries on the history of citizenship appear to begin at the period of the French Revolution. This creates the impression that the concept of citizenship is a relatively modern phenomenon. This is misleading, for the foundations of citizenship are actually rooted in the early Greek and Roman periods. Indeed, throughout history we see at various times, (particularly during the Middle Ages), replications of these early styles of citizenship

In many ways **Greek citizenship** was unique in that it was highly exclusive; women, slaves, peasants and foreign residents were not included in Aristotle's State. Citizenship was a privilege usually inherited and ownership of property was a requirement for the status of citizenship. Duty and obligation were emphasised more than rights and entitlements. The city state was extremely compact and for that very reason its comparision with any modern type of citizenship is unrealistic. Considerable skill was expected from each citizen; they were required to act as politicians and administrators, as well as judges and soldiers. This system was organised so that some citizens would acquire political skills while others, particularly the youth would be trained in the laws of government as well as military skills (Aristotle).

The idea of a cosmopolitan view of citizenship did not become popular until the time of the Stoics whose philosophy had an important impact on both Greek and Roman politics. The Stoics basically held an egalitarian philosophy in which all men were seen as equal regardless of race or status. Wisdom was seen as being the most important

quality necessary for citizenship and all men were capapable of achieving this. Two important doctrines emerged from Stoic philosophy one was the nature of the relationship between man and God and the other was the idea of the Law of Nature (Sabine 1952). Inherent in the law of nature was the notion that various basic elements of justice came from divine reason. This formed the basis for Natural Rights theory which has been referred to in more detail in chapter two (p28).

A more complex, though more flexible form of citizenship evolved in **the Roman era**. The privileges and rules of citizenship were engraved in The Twelve Tables (Barrow 1949). By the fifth century there was complete equality before the law regardless of race or status. The emperors Cato and Cicero emphasised the idea of rights and obligations as ideals of citizenship. The idea of dual citizenship was also introduced so that one could have Roman citizenship despite residency in another town. Further expansion of citizenship came about at the time of Caracalla under whose scheme all except slaves were eligible.

However, Caracalla's motivation for offering citizenship to vast numbers of people was in fact corrupt and involved financial self -interest, and soon the whole concept of civic responsibility was eroded. At the same time the system of education had declined and Rome was now a vast empire apparently without moral purpose (Heater 1990).

There then followed an era in which the role of the church became important in demanding loyalty from the people Constantine in his Edict of Milan in 313 succeeded in inculcating a Christian ethic into the lives of individuals. This marked a period of conflict between Church and monarch which continued into the medieval era. Men found themselves serving two masters (Heater 1990). At this time some of the early nation states were emerging, including England and France. A new sort of conflict arose between a feeling of national and local identity.

Some of the most sophisticated medieval cities were in Italy. These were loosely based on the Greek -City states. Perhaps one reason for the progress of these municipalities was the lack of monarchy. The structure and size of these areas was very close to Aristotle's compact polis . In fact this was the first revival of Aristotlean politics which

was now taking hold in parts of Europe. Thomas Aquinas was a strong proponent of this ethic. Like Aristotle he thought that the purpose of political association was not material gain but virtue, and that the State should enable its citizens to achieve such virtue. Unlike Aristotle however Aquinas was not interested in specific types of government. Any regime, whether it was ruled by one or many, was seen as a just system as long as it promoted the common good (Black 1988).

Along with the revival of the Greek type citizenship in the **thirteenth** and **fourteenth centuries** there was also considerable progress in the study of Roman law and history. Under the influence of scholars such as Machiavelli cities like Florence were beginning to display an interest in an active citizenship. Florence was unique among the cities in that it had a constitutional form of government and all men except labourers held citizenship status. Machiavelli along with contemporaries Leonardo Bruni and others were instrumental in conceiving a republican view of citizenship. Machiavelli's State could be described as modern in that he saw it and its institutions as the building blocks of society's individuality and power (Plamenatz 1963). According to Machiavelli, the citizen must be prepared to protect the State against intruders and in that respect he saw a citizen army as being of crucial importance.

The importance of citizenship at this time was also seen in the wrtiting of Jean Bodin. Two elements in his work have received much attention in the literature. One was his emphasis on the importance of the family, and the other was the relationship between the individual and the sovereign. According to Bodin the family forms a natural unit and from this the State and all other communities evolve. The father of the family becomes a citizen once outside his own house and interacts with other fathers. Citizenship is then subjected to the sovereign since the key elements of the State are the subject and the sovereign (Sabine1952).

The **seventeenth century** marked a critical period in the history of citizenship. Heater refers to some of the factors responsible for this.

1. Acknowledgement of the fact that the State was essential to the notion of citizenship.

2. The supreme authority of the monarch was now being challenged and this was particularly important in view of the religious context at the time.

3. A legal distinction was now being drawn between aliens and residents and the idea of rights was also being questioned (Heater 1990).

Citizenship was still medieval in nature. The gentry controlled many functions of government. Only property owners could vote. Towards the end of the century however various legislation was passed on behalf of the ordinary man. Religion continued to be a central aspect of citizenship. Church attendance was compulsory and Catholics were considered to be second class citizens. Much political debate continued on the issue of the franchise, who should be included and who should not. The issue of religious toleration was also under scrutiny. Another important topic during this period of individualism was property and its rightful owner. Two groups whose importance is recognised are 1. The Levellers and 2. The Diggers.

1. The Levellers were an off-shoot of Cromwells army , a small group of politically minded men from the lower classes. Their aim was to 'level' differences socially, politically and in terms of property rights so that equality could be achieved. (Sabine 1952).

2. The Diggers were a group of radical socialists whose aim was to dig up some common land so that it could be divided among the poor. Like The Levellers the group eventually collapsed. Both groups believed in the law of nature. For The Leveller this became a particular vision of rights in particular property rights. The Digger saw the law of nature in a more communal right to property especially the land (Sabine 1952).

By the middle of the **eighteenth century** there was political unrest in many countries. It was also a period of great public interest in politics both in England and other parts of Europe, particularly in France.

A major landmark in the history of citizenship was the French Revolution. It was then that the term 'cityeon' was flaunted as embodying the ideals of liberty, equality and fraternity. However, since the Revolution lasted for ten years, and since it included a period of 'terror' with devastating consequences, it is unlikely that any of these ideals held much force at the time. Fraternity for example was supposed to portray a feeling of fellowship but in fact in a very short time many groups had become informers (p47). Liberty also turned out to be rather a flimsy label although the replacement of absolute monarchy by a Constitution was hailed as immense progress in 1789. As far as equality was concerned apart from the fact that it secured the franchise for more men than any other country at that time, the Declaration of Rights itself was worded in quite vague terms with ample scope for manipulating it to suit particular influential members of government. In spite of all of its flaws the Revolution served to focus attention on the concept of citizenship. It also provided many future political theorists with a basis for discussion- Marx On The Jewish Question is an example (p178).

As far as the effect of the Revolution on the future is concerned it was the idea of National Sovereignty which was the most crucial outcome. In practice this meant the absolute power of the nation to do whatever it chose via its representatives. This included ruling the Church, controlling all levels of education, and destroying the ancient provinces (Barker 1951).

Another view of the nation state and citizenship is seen in German Romanticism. This period epitomised the idea of the 'Volk' or 'Folk'. This was an entity which created culture in the form of music and folklore. But this was not something which ran alongside the working of the State, for it was actually identified as being part of the State. This was yet another version of the all-inclusive Nation -State from which emerged Hegelianism which was discussed in chapter three (p53).

The history of citizenship throughout the **nineteenth** and **twentieth centuries** is very much concerned with the establishment of political and social rights. Suffrage was only one aspect of citizenship still to be adequately resolved. Religious toleration was still a problem but was alleviated somewhat by The Catholic Emancipation Act of 1829.

Other factors influencing the importance of citizenship at this time can be summarised broadly under economic, philosopical and political themes. Threre was a growing political awareness among the working classes as trade unions, friendly societies and co-operatives evolved. The middle class professional was beginning to demand a more just society with some sort of participatory role in government decisions. Under the influence of Kant and Hegel the importance of the State for the individual was now under scrutiny. Economically the idea of property and citizenship needed to be addressed (Heater 1990).

From the outline provided, so far it is clear that citizenship is continuously evolving and that the next stage must involve more than suffrage. The desirability of and necessity for some form of public involvement comes into focus. Beveridge among others recognised the need for economic and social equality in order to achieve a more just society (p143). This would require more action on the part of the State.

American Citizenship

This brief review of American Citizenship is intended to provide a background to the previous analysis of various aspects of the country's unique system of service delivery specifically health and welfare (chapter 7) and philosophical aspects of its political ideology (chapter 2).

In contrast to its European counterparts, the beginning of a realisation of the concept of citizenship emerged at a later stage. The history of American citizenship begins with the birth of the new country, that is at the time of the first settlements. The early colonies, by virtue of their diversity in terms of culture and history formed the basis of modern American citizenship. Several factors were influential in drawing attention to the need for a particular perception of citizenship at this early stage. These included: political unrest in Europe, the Religious Wars, famine and the slave trade. The immigrants and colonists were keen to create a whole new society although they were limited to some extent in this enterprise by the fact that they were under British rule. The various immigrants brought with them their political beliefs as well as their

knowledge and culture. In this setting a sort of semi- English style citizenship evolved between the new settlers and the colonists. Since there was obviously some confusion surrounding citizenship status the question of distinguishing aliens from English subjects and from naturalised subjects, some sort of internal arrangement had to be made. This took the form of reciprocity so that the immigrant voluntarily accepted membership of the community and the colonists agreed. (Heater 1990). Thirteen colonies evolved in this way.

By the middle of the eighteenth century there was conflict between the colonies and the home country. As in England there was heightened political conciousness. The Declaration of Idependence stated that the the constitutions were invalid so new ones were drafted. In fact this period provided an opportunity for people to act as citizens in the participative sense in so far as they were invited to confirm their agreement to a new constitution.

Paine and Jefferson were extremely influential in encouraging the colonies to seek independence. Jefferson who represented the Southern Plantation and frontier farmer interests has been referred to as the prophet of democracy (Simons 1929). He wrote extensively on the topic of citizenship. But a particular vision of citizenship prevailed. The writers of The Constitution were not so much concerned with suffrage as with the process of naturalization and whether an individual should be a citizen of his own state or of the United States. The Constitution finally decreed that citizens of each state would be entitled to all the privleleges of several states.

Gradually the barriers to full citizenship such as wealth, property and religion were removed. But Negroes, slaves and women were excluded. It was not until after the Civil War 1865 that slavery was abolished under the thirteenth Amendment and a year later the Civil Rights Act accorded the same rights to blacks as to whites (Heater 1990). Even then voting rights were not included until the Fifteenth Amendment.

The Amendments in the Constitution have given a strong legal foundation to the concept of citizenship for Americans. It is The Constitution which is quoted and depended upon whenever rights are in question. According to Brogan more respect is

shown generally to The Constitution than any other political body (Brogan 1960). This seems to be a reasonable assumption given the diversity of states and cultures and the level of population mobility. Having one particular set of written rules nationally applicable would appear to be a necessity.

In summary it could be said that citizenship is a complex and continuosly evolving concept. Part of the reason for its complexity, I believe is that it can never be considered in isolation from the state, the community and the individual. Equally the political, social and economic citizen must be seen as part of a whole.

A certain repetition of ideas is evident throughout history. Aspects of Greek and Roman citizenship have been revived at intervals. The idea of civic virtue as portrayed in Aristotlean thought was seen also in the writing of Machiavelli and again in The United States under president Andrew Jackson. Conditions necessary for achieving citizenship appear remarkably similar throughout history especially with regard to property ownership and wealth. Religion and race have also been important factors. With regard to American citizenship it emerges as being unique in that it began with the birth of the new country. The Constitution and Declaration of Independence gave it a solid legal foundation. The philosophy of Locke has also been influential in the writing of the Constitution and the subsequent laws proecting individual property rights

References to Appendix: The Origins of Citizenship.

Aristotle **Politics** Ed. E Barker, Clarendon Press 1946;pp105-108.

Barker E. **Principles of Social & Political Theory.** London:Clarendon Press 1951; pp17-19.

Barrow RH. **The Romans,** Penguin Books, 1949;pp206-207

Black A. 'Saint Thomas Aquinas as the State and Morality'. In: **Political Thought from Plato to Nato** introduced by Brian Redhead, Chicago:The Dorsey Press 1988; p68-69.

Brogan DW. **Citizenship Today: England - France - The United States.** Chapel Hill University of North Carolina 1960; pp81-84.

Fine S. **Laissez-Faire and the General Welfare State: A Study of Conflict In American Thought (1865-1901).** Oxford University Press, 1956.

Heater D. **Citizenship: The Civic Ideal In World History, Politics and Education.** London: Longman 1990.

Marx K. 1843. 'On The Jewish Question'. In: **Early Writings,** Translated by Rodney Livingstine, Penguin Classic, 1990.

Plamenatz J. 1963 'Machiavelli's Conception of the State'. In: **Man and Society**: Vol 1. London:Longmans 1963:pp18-19.

Prior D, Stewart J, Walsh K. **Citizenship Rights, Community and Participation,** Pitman Publishing, 1995; p5-6.

Sabine GH **A History of Political Theory** Third Edition, London:George C Harrap & Co. Ltd, 1952;pp343-346, 414-418.

Simons AM. **Social Forces in American History,** New York.:The Book League of America, 1929.

BIBLIOGRAPHY.

ACHCEW. **Managing the New NHS: Ensuring Effective CHCs in the New Structure**. Feb. 1994.

Almond B. 'Rights'. In: Singer P. (ed) **A Companion to Ethics.** Oxford: Blackwell 1991.

Aristotle. **Politics.** Barker E. (ed) Clarendon Press 1946.

Aristotle. **Nicomachean Ethics.** Translated by David Ross, Oxford University Press, 1991.

Aronowitz RH. 'From Myalgic Encephalitis to Yuppie Flu: A History of Chronic Fatigue Syndrome'. In: Rosenberg C, Golden J. (eds), **Framing Disease : Studies in Cultural History**. New Jersey:Rutgers University Press, 1992.

Ashdown P. **Citizens' Britain, A Radical Agenda for the 1990s.** London:Fourth Estate, 1989.

Audit Commission. **'Making a Reality of Community Care'.** London: HMSO, 1986.

Barker E. **Greek Political Theory: Plato and His Predecessors.** 2nd Edition, London: Methuen Books, 1925.

Barker E. **Principles of Social & Political Theory.** London: Clarendon Press 1951.

Barnett A 'Charlie's Army'. **New Statesman,** Sept. 22nd, 1989.

Barrow RH. **The Romans.** Penguin Books 1949.

Barratt Brown M. **The Welfare State in Britain**. Socialist Register, Merlin Press, 1971.

Barry B. **Political Argument.** Routledge & Kegan Paul. 1965; pp48-49.

Barry N. **An Introduction to Modern Political Theory**, Second Edition, MacMillan. 1993.

Bartley M. 'The Relationship Between Research and Policy; The Case of Unemployment and Health'. In: Oakley A, Williams S. (eds). **The Politics of the Welfare State.** London: UCL Press, 1994.

Beacom B. 'Representing the Public in the NHS'. **Greater Glasgow Health Council** Annual Report 1996-1997. 1997.

Bellah RN, Madsen R, Sullivan WM, Swindler A, Tipton SM. **Habits of the Heart. Individualism and Commitment in American Life**, University of California Press, 1996.

Benn SI, Peters RS. **Social Principles and the Democratic State,** London: George Allen & Unwin 1959.

Beveridge WI. **Full Employment in a Free Society.** London:Allen & Unwin, 1944.

Beveridge WI. **Voluntary Action; A Report on Methods of Social Advance**, London: George Allen & Unwin, 1948.

Black A. 'Saint Thomas Aquinas as the State and Morality'. In: **Political Thought from Plato to Nato**, introduced by Brian Redhead, Chicago:The Dorsey Press, 1988.

Black D, Morris C, Townsend P. 'Towards an explanation of health inequalities'. In: Townsend P, Davidson N. and Whitehead M. (eds) **Inequalities in Health: The Black Report: The Health Divide,** Penguin Books, 1992.

Blair T. **New Britain, My Vision Of A Young Country.** London:Fourth Estate, 1996.

Blustein J. **Care and Commitment: Taking the Personal Point of View**, Oxford University Press 1991.

Bockington F. **World Health.** Pengiun Books 1958;.

Bosanquet B. **The Philosophical Theory of the State.** London: Macmillan, 1930.

Bowes AM. **Kibbutz Goshen:** An Israeli Commune, Illinois:Waveland Press 1989.

Bretonneau P. 1892 'Bretonneau et ses correspondents'. Quoted by Major RH. In: **Classic Descriptions of Disease,** Illinois: Charles C Thomas, 1965.

Brogan DW. **Citizenship Today: England-France-The United States**, Chapel Hill University of North Carolina 1960.

Brooker P. **The Faces of Fraternalism: Nazi Germany, Fascist Italy and Imperial Japan**. Oxford:Clarendon Press, 1991.

Burke E. **Letter to a Noble Lord**. In: Honderich T. (ed) **Conservatism**. Penguin Books, 1990.

Cameron JR, Skofronick JG. **Medical Physics.** New York:John Wiley & Sons, 1978.

CanagaRetna A. 'Primary Health Care Teams Involving Patients, Examples of Good Practice'. **NHS Executive Document,** 1997.

Carr-Saunders CM, Wilson PA. **The Professions.** Oxford:Clarendon Press, 1933.

Cassel C. 'Pre-Death Health Care Varies Widely By Location', Dartmouth Study Shows; **Washington Post, Wednesday** October 15, 1997.

Challis D. 'Case Management: A Review of U.K developments and Issues'. In: Titterton M. (ed). **Caring for People in the Community; The New Welfare**. London: J Kingsley, 1996.

Cmnd 6404. **Social Security and Allied Services**. Report by Sir William Beveridge, London: HMSO, 1942.

Cmnd 8713 **Growing Older**. London:HMSO, 1981

Cm 849. **Caring For People:** Community Care in the Next Decade and Beyond, London:HMSO, 1989.

Connor A. 'The Role of the Voluntary Sector in the New Community Arrangements'. In: Titterton M. (ed) **Caring for People in the Community; The New Welfare.** London: Kingsley Publishers, 1996.

Corfield P. **Power and the professions in Britain 1700-1850**. London and New York: Routledge, 1995.

Cranston M. **What are Human Rights**? London:The Bodley Head Ltd, 1973.

Crossman RHS. **Plato Today**. Second Impression, London:Unwin Books, 1971.

Culyer AJ. **Needs and the National Health Service**. Oxford: Martin Robinson, 1976.

Dahl RA. **A Preface to Democratic Theory**. University of Chicago Press, 1956.

Day T. **Getting Closer to the Consumer?** Locality Planning in Exeter Health District, School For Advanced Urban Studies, University of Bristol, 1990.

Dean H, Taylor-Gooby P. **Dependency Culture, The Explosion of a Myth.** London:Harverster Wheatsheaf, 1992.

De Beauvoir S. 1953. **The Second Sex.** Translated by A.M Parshley, Picador, 1988.

Department of Health. **Working for Patients**. London:HMSO, 1989.

Department of Health **The Patient's Charter**. London:HMSO, 1991.

Department of Health and Social Security. **Patients First**. London:HMSO, 1979.

d' Iribarne P. 'The Relationships Between Subjective and Objective Well-Being'. In: Strumpel B. (ed) **Subjective Elements of Well-Being: The OECD Social Indicator Programme**. Paris: OECD, 1972.

Downie RS. **Government Action And Morality**. The Concept of the Moral Intermediary, 1964.

Downie RS. 'Professions and Professionalsism'. **Journal of Philosophy of Education**, 1990.

Downie RS, Telfer E. **Caring and Curing. A Philosophy of Medicine and Social Work.** London and New York: Methuen, 1980.

Downie RS, Loudfoot E, Telfer E. **Education and Personal Relationships:** A Philosophical Study, London: Methuen, 1974.

Downie RS, Tannahill C, Tannahill A. **Health Promotion; Models and Values.** Second Edition; Oxford University Press, 1996.

Doyal L, Pennell I. **The Political Economy of Health:** Southend Press, 1979.

Dubos R. **Man Adapting**. New Haven:Yale University Press, 1965.

Durkheim E. 1893 **The Division of Labour in Society.** Translated by George Simpson, London:Collier Macmillan Ltd.

Durkheim E. 1897 **Suicide.** Translated by J.A Spaulding & G Simpson, Routledge Kegan Paul, 1952.

Dworkin R. 'Liberal Community'. In: Avineri S, de Shalit A. (eds) **Oxford Readings in Politics and Government: Communitarianism and Individualism**, Oxford University Press. 1989.

Eckholm E (Ed.) **Solving America's Health-Care Crisis. A Guide To Understanding The Greatest Threat To Your Family's Economic Security.** The Staff of the New York Times, 1993.

Editorial Cover Story. 'This is an Employee Benefit on the Wane'. **USA Today**, Thursday October 16, 1997.

Employment Department Group. **Labour Market Quarterly Report**: Employment Department, London, 1993.

Engels F. 1892 **The Condition of the Working Class in England.** London:Panther, 1969.

Etzioni A. **The Spirit of Community**: Rights, Responsibilites and the Communitarian Agenda, London:Harper Collins, 1995.

Figgis JN. **Churches in the Modern State.** Longmans Green, 1914.

Filmer R. (1680) **Patriarcha and other Writings.** In: Somerville JP. (ed) Patriarcha The Natural Power of Kings.

Fine S. **Laissez-Faire and the General Welfare State:** A Study of Conflict In American Thought (1865- 1901), Oxford University Press, 1956

Flynn K. **Structures of Control in Health Management.** London:Routledge 1992.

Fowle TS. **The Poor Law.** London:Blackwell, 1890.

Fox DM, Leichter M. 'State Model: Oregon. The Ups and Downs of Oregon's Rationing Plan'. **Health Affairs** 1 (Summer), 1993.

Fraser D. **The Evolution of the British Welfare State.** London:Macmillan 1984.

Gamble A. **The Free Economy and the Strong State**; The Politics of Thatcherism; London:Macmillan, 1988.

General Assembly of The United Nations. **The Declaration of Human Rights.** Dec. 10th, 1948.

George V, Wilding P. **Ideology and Social Welfare.** Routledge Kegan Paul, 1976.

Gewirth A. **Human Rights.** University of Chicago Press, 1982.

Gierke Otto von (1900) **Political Theories of the Middle Ages**; Translated by Maitland FW, Cambridge:Cambridge University Press.

Ginsburg N. **Class, Capital and Social Policy.** London: MacMillan, 1979.

Gladstone D. **British Social Welfare Past, Present and Future,** London:UCL Press, 1995.

Glennerster H. **British Social Policy Since 1945;** Oxford:Blackwell 1995.

Glennerster H, Le Grand J. **The Development of Quasi-Markets inWelfare Provision.** Welfare State Programme Number WSP/102, 1994.

Glennerster H, Midgley J. **The Radical Right and the Welfare State.** Herts:Barns & Noble, 1991.

Goffman E. **Asylums:** Essays on the Social Situation of Mental Patients and other Inmates, Penguin Books, 1962.

Goffman E. **Stigma:** Notes on the Management of Spoiled Identity, Englewood Cliffs, New Jersey:Spectrum, 1963.

Gough I. **The Political Economy of the Welfare State.** London: MacMillan., 1979.

Gramsci A. **Prison Notebooks.** Hoare Q, Smith N. (eds) New York: International Publishers, 1971.

Green D. **Reinventing Civil Society. The Rediscovery of Welfare Without Politics.** Choice in Welfare Series No. 17, 1993.

Green D. **Community Without Politics: A Market Approach to Welfare Reform.** Choice in Welfare No. 27. IEA Health and Welfare Unit, London, 1996.

Green TH. **Lectures on the Principles of Political Obligation** London, 1937.

Griffin J. **Well-Being. Its Meaning, Measurement and Moral Importance.** Oxford: Clarendon Press, 1986.

Griffiths AP. **How Can One Person Represent Another?** Aristotelian Society, 1960.

Griffiths Sir R. **NHS Management Report:** (The Griffiths Report), London:HMSO, 1983.

Griffiths Sir R. **Community Care: Agenda For Action,** London:HMSO. 1988.

Hall P. **The Social Services of Modern England.** London: Routledge & Kegan Paul, 1952.

Ham C, Honigsbaum F, Thompson D. 'Priority Setting for Health Gain'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State.** London:UCL Press, 1994.

Handy C. **The Hungry Spirit. Beyond Capitalism - A Quest For Purpose In The Modern World.** London:Hutchison, 1997.

Harrison S. **Managing the National Health Service, Shifting the Frontier?** London: Chapman and Hall, 1988.

Hayek FA. 1944 **The Road To Serfdom.** 6th Edition, London:Routledge, 1993.

Heald D. **Public Expenditure. Its Defence and Reform.** Oxford: Martin Robertson, 1993.

Health/Human Services Report. 'Clinton's Health Care Plan Laid to Rest'. **Congresssional Quarterly Almanac,** 1994.

Heater D. **Citizenship: The Civic Ideal in World History, Politics and Education.** London:Longman, 1990.

Hecht R. 'I Talk Now'. **A Report on the Health and Community Arts Project:** Bristol Area Specialist Health Promotion Service, 1996.

Hegel GWF. **Lectures on the Philosophy of History.** Translated by J Sibree, New York, 1956.

Hegel GWF. 1821 'The Philosophy of Right' quoted by Plamenatz J. in **Man and Society.** Volume Two, London:Longmans 1963.

Held D. **Political Theory and the Modern State.** California:Stanford University Press, 1989

Hesse H. 1960 **The Glass Bead Game,** 7th Edition, Penguin Books, 1977.

Hirsh F. **The Social Limits to Growth,** London: Routledge & Kegan Paul, 1977.

Hogg C. **The Public and the NHS:** Association of Community Health Councils for England and Wales, London, 1986.

Hohfeld WN. **Fundamental Legal Conceptions: as applied in Judicial Reasoning and the Legal Essay**. Yale University Press, 1923.

Honderich T. **Conservatism:** Penguin Books, 1990.

Hoover K, Plant R. **Conservative Capitalism in Britain andthe United States:** A Critic Appraisal, 1989.

Hugman R. **Power in the Caring Professions.** London:Macmillan, 1991

Hurd D. 'Citizenship in the Tory Democracy'. **New Statesman** April 28th , 1988.

Illich I. **Deschooling Society,** 6th Edition London:Marion Boyars, 1974.

Illich I. **The Right to Useful Unemployment**. London: Marion Boyars, 1978.

Illich I **Limits to Medicine. Medical Nemesis: The Expropriation of Health**, Fourth Edition, Penguin Books, 1981.

Illich I. **Tools for Conviviality,** 3rd Edition, London:Marion Boyars. 1990.

Illich I. 'Death Undefeated, from Medicalisation to Systematisation'. **British Medical Journal,** 1995.

Illich I, Zola IK, McKnight J, Caplan J, Shaiken H. **Disabling Professions,** London: Marion Boyars, 1992.

Jenkins KD. 1983 'Code of Professional Conduct for Teachers'. **Scottish Education Review,** Vol. 27 No. 1, 1995.

Jessop B. **The Capitalist State** Marxist Theories and Methods, Oxford, 1983.

Jewson ND. 'Medical Knowledge and the Patronage System in Ninteenth Century England'. **Sociology,** 1975.

Johnson N. **The Welfare State in Transition: The Theory and Practice of Welfare Pluralism**, Billings & Sons 1987.

Jordan KN. **Philanthrophy in England 1480-1660**: **A Study of the Changing Pattern of English Social Aspirations**, London: George Allen & Unwin , 1959.

Katz JL. 'Long Awaited Welfare Proposals Would Make Gradual Changes'. **Congressional Quarterly Fall** 1994, Library of Congress Washington DC, 1994.

Kickbusch I, Hatch S. **Self-Help and Health in Europe.** Copenhaegen:WHO, 1983.

Klein R. **The Politics of the National Health Service,** London: Longman., 1983.

Klein R. 'Warning Signals from Oregon. The different dimensions need untangling'. **British Medical Journal**, 1992.

Kropotkin P. **Revolutionary Pamphlets**: **A Collection of Writings by Peter Kropotkin,** Ed. Roger Baldwin, New York: Dover Publications, 1927.

Langdon S. 'Kennedy Kassebaum Steer Insurance Safety'. **Congressional Quarterly Weekly Report**; 1996.

Larson MS. **The Rise of Professionalism. A Sociological Analysis.** University of California Press, 1977.

Laski H. **Grammar of Politics.** 5th Edition, Yale University Press: George Allen & Unwin, 1948.

Le Grand J, Bartlett W. **Quasi-Markets and Social Policy,** London:Macmillan, 1993.

Lewis J. 'Choices, Needs and Enabling; the New Community Care'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State.** London: UCL Press, 1994.

Locke J. 1690 **Two Treatises of Government .** Peter Laslett 1963, Mentor, New American Library.

Lowe R **The Welfare State in Britain Since 1945.** London:Macmillan, 1993.

Lukes S. **Individualism: Key Concepts in Social Sciences.** Oxford:Blackwell, 1973.

MacDonald M. 'Natural Rights'. **Proceedings of the Aristotelian Society,** 1949.

McKeown T. **The Origins of Human Disease.** Oxford:Blackwell, 1988.

McKeown T, Lowe C. **An Introduction to Social Medicine.** Oxford:Blackwell, 1977.

McLean I. **Oxford Concise Dictionary of Politics.** Oxford University Press, 1996.

McLellan I. **The Concise Oxford Dictionary of Politics,** Oxford:Oxford University Press, 1996.

MacPherson CB. **The Political Theory of Possessive Individualism**: Hobbes to Locke, Oxford University Press, 1964.

Mc Turk LM. **Equity and Efficiency in the Management of Health Care Research** : PhD Thesis Glasgow 1993.

McWilliams WC. **The Idea of Fraternity in America,** University of California Press, 1973.

Marmor TR, Mashaw JL, Harvey PL. **America's Misunderstood Welfare State,** Harper Collins USA, 1990.

Marsh DC. **The Welfare State** Concepts and Development. London: Longman 1980

Marshall TH. **Social Policy in the Twentieth Century.** London:Hutchison, 1979.

Marx K. 1843 'Critique of Hegel's Doctrine of the State', in **Early Writings**, Penguin Classics, 1990.

Marx K. 1843 'On the Jewish Question', in **Early Writings**, Translated by Rodney Livingstone, Penguin Classics, 1990.

Marx K. 1844 'Economic and Philosophical Manuscripts', in **Early Writings**, Penguin Classics, 1990.

Marx K. 1867 **Capital.** A Critique of Political Economy, Vol. 1 The Process of Capitalist Production; Sixth Edition, Translated by Moore & Aveling New York: International Publishers, 1967.

Marx K, Engels F. 1848 **The Communist Manifesto,** Ed. David McLellan, Oxford University Press: Penguin Books, 1976.

Marx K, Engels F. 1845-6 **The German Ideology**: Part One, Ed. Arthur CJ, New York:International Publishers, 1991.

Mawson A. **Annual Report 1995-1996,** Bromley By Bow Centre, 1996.

Meachan S. **Toynbee Hall and Social Reform 1880-1914, The Search For Community.** New Haven and London:Yale University Press, 1987.

Mead L. 'From Welfare to Work: Lessons from America'. The IEA Health and Welfare Unit, **Choice in Welfare**, Deacon I. (ed), No. 39. London, 1997.

Miliband R. **The State in Capitalist Society.** London: Coronet Books 1979.

Mill JS. 1859 **On Liberty.** In: Acton HB. (ed). **Utilitarianism, On Liberty and Considerations on Representative Government**. London:JM Dent and Sons Ltd, 1988.

Miller D. **Market State and Community,** Oxford University Press, 1989.

Morgan M, Calnan M, Manning N. **Sociological Approaches to Health and Medicine.** London:Croom Helm, 1985.

Murray C. **Underclass: The Crisis Deepens**. The IEA Health and Welfare Unit, Choice in Welfare Series No. 20, London. 1994.

Navarro V. **Medicine Under Capitalism.** New York: Prodist, 1976.

Navarro V. **Crisis, Health and Medicine.** New York and London: Tavistock, 1986.

Navarro V. **Dangerous To Your Health: Capitalism In Health Care,** New York: Cornerstone Books, 1993.

Navarro V. **The Politics of Health Policy: The US Reforms 1980-1994.** Cambridge USA: Blackwell, 1994.

Nicholls D. **Three Varities of Pluralism,** The MacMillan Press Ltd. 1974.

Nicholls D. **The Pluralist State,** London:Macmillan Press, 1975.

Nietzsche F. 1887 **The Gay Science,** With a Prelude in Rhymes and an Appendix of Songs: Translated by Walter Kaufmann, Random House, New York: Vintage Books

Nixon PFG. 'The Broken Heart'. **Journal of the Royal Society of Medicine,** 1993.

Norman R 'Citizenship, Politics and Autonomy'. In: Milligan D, Watts Miller W, **Liberalism, Citizenship and Autnomy,** Aldershot:Avebury, 1992.

Nozick R. **Anarchy, State, and Utopia.** Oxford: Blackwell, 1996.

Nozick R. **Socratic Puzzles.** Harvard Press, 1997.

Oakley A, Williams S. (Eds) **The Politics of the Welfare State.** London:UCL Press 1994.

Offe C. **Contradictions of the Welfare State;** London:Hutchinson Education, 1984.

Ollman B. **Alienation.** Marx's Conception of Capitalist Society, Cambridge Unversity Press, 1971.

OPCS. **Topic Monitor 1991 Census: People aged 60 and Over, Great Britain.** The Government Standard Services, 1991.

Orloff AS. 'The Political Origins of America's Belated Welfare State'. In: Weir M, Orloff AS, Skocpol T. (eds) **The Politics of Social Policy in the United States,** Princeton University Press, 1988.

Oxford Dictionary. **The Oxford Dictionary of Current English,** Ed. J.B Sykes London:Clarendon Press 1978.

Pateman C. 'The Fraternal Social Contract'. In: Keane J, (ed). **Civil Society and the State: New European Perspectives,** London:Verso, 1988.

Petch A. 'The Best Move I've Made': The Role of Housing for People with Mental Health Problems. In: Tipperton M. (ed) **Caring for People in the Community; The New Welfare,** London: J Kingsley, 1996.

Pierson C. **Beyond the Welfare State? The New Political Economy of Welfare.** Pennsylvania: The Pennsylvania Press, 1991.

Pinker R. **The Idea of Welfare.** London: Heinmann, 1979.

Piven F, Cloward R. **Regulating the Poor: The Functions of Public Welfare.** New York:Pantheon Books, 1971.

Phillips A. 'Fraternity' In: Pimlott B. (ed). **Fabian Essays in Socialist Thought.** London: Heinmann. 1984.

Philips DL. **Looking Backward: A Critical Appraisal of Communitarian Thought.** Princeton University Press, 1993.

Plamenatz J. 'Machiavelli's Conception of the State'. In: **Man and Society.** Volume One, London: Longmans Publishers, 1963.

Plant R. **Modern Political Philosophy.** Oxford:Blackwell, 1992.

Plant R, Lesser H, Taylor-Gooby. **Political Philosophy and Social Welfare.** London: Routledge Kegan Paul 1980.

Plato **The Republic of Plato.** Translated with Introduction by Francis MacDonald Cornford, 20th printing 1962 New York and London: Oxford University Press.

Popay J, Williams G. 'Local Voices in the National Health Service: needs, effectiveness and sufficiency'. In: Oakley A, Williams S. (eds) **The Politics of the Welfare State** London :CL Press, 1994.

Prior D, Stewart J, Walsh K. **Citizenship Rights, Community and Participation** . Pitman Publishing, 1995.

Quadagno J. **The Transformation of Old Age Security: Classs and Politics in the American Welfare State**, Chicago:University of Chicago Press, 1988.

Raison T. (Ed.) **Founding Fathers of Social Science.** London:Pall Mall Press, 1972.

Raphael DD. **Problems of Political Philosophy.** London: Pall Mall Press, 1970.

Rector R 'Wisconsin's Miracle. Policy ' . **The Journal of American Citizenship** March-April, 1997.

Rescher N. **Welfare: The Social Issues in Philosophical Perspective.** University of Pitsburg Press, 1972.

Reynolds S. **Kingdoms and Communities in Western Europe 900-1300,** Oxford:Clarendon Press, 1984.

Richman J. **Medicine and Health.** Longman UK Ltd, 1987.

Ritchie D. **Natural Rights:** A Criticism of Some Political and Ethical Conceptions, London, 1894.

Rooff M. **Voluntary Societies and Social Policy,** Routledge & Kegan Paul, 1957.

Rosenblum N. **Another Liberalism: Romanticism and the Reconstruction of Liberal Thought.** Cambridge Mass, 1987.

Rosenberg C 'Framing Disease, Illness, Society and History'. In:. Rosenberg C & Golden J (eds) **Framing Disease: Studies in Cultural History.** New Jersey: Rutgers University Press, 1992.

Rowbotham S. 'Interpretations of Welfare and Approaches to the State'. In: Oakley A, Williams S. (eds). **The Politics of the Welfare State.** London:UCL Press, 1994.

Rubin AJ, Connolly C. 'Clinton Delivers Health Bill, All 1,342 Pages Of It'. **Congressional Quarterly Fall** 1994 Library of Congress, Washington D.C, 1994.

Runciman D. **Pluralism And The Personality Of The State,** Cambridge University Press, 1997.

Ryle G. **The Concept of Mind.** London:Hutchinson's University Library, 1949.

Sabine GH. **A History of Political Theory.** Third Edition, London: George C Harrap & Co. Ltd, 1952.

Sandel M. **Liberalism and the Limits of Justice,** Cambridge University Press, 1982.

Sandel M. **Liberalism and Its Critics.** New York: New York University, 1984.

Scott PA. 'Care Attention and Imaginative Identification in Nursing Practice', **Journal of Advanced Nursing,.** Chicago: University of Chicago Press, 1995.

Schumpeter J. **Capitalism, Socialism and Democracy**. London: Allen and Unwin, 1976.

Shimokawa K. **Property and Justice: A Critical Historical Study of Lockes' Liberalism.** PhD Thesis Glasgow University, 1985.

Sigerist HE. 1940 **The Social History of Medicine** in Henry E Sigerest on the History of Medicine Ed. Marti-Ibanez 1960 edition. New York:MD Publications.

Sigerest HE. **Civilization and Disease**, Chicago:University of Chicago Press, 1943.

Simic P. 'Moving out of hospital into the community'. In: Titterton M. (ed) **Caring for People in the Community: The New Welfare**. London: J Kingsley, 1996.

Simons AM. **Social Forces in American History,** The Book League of America, New York, 1929.

Smiles S. 1866 **Self-Help with illustrations of Conduct and Perservance**, The IEA Health and Welfare Unit, Rediscovered Riches Series No. 1, 1997.

Smith A. 1776 **The Wealth of Nations:** Books I-II. With an Introduction by Andrew Skinner, Penguin Books.

Starr P. **The Social Transformation of American Medicine**. New York:Basic Books, 1982.

Sulkunen P. **Constructing The New Consumer Society**. In: Sulkunen P, Radner H, Schulze G (eds). Consultant Ed. Campling J, London:Macmillan, 1997.

Strachey J. **Contemporary Capitalism**. New York: Gollanez,. 1957.

Szasz T. **The Myth of Mental Illness.** New York:Harper & Row, 1961.

Szasz T. **The Manufacture of Madness.** New York: Routledge & Kegan Paul,. 1971.

Taylor C. 1985 'Atomism'. In: Avineri S, de-Shalit A. (eds) **Communitarianism and Individualism**, 4th Edition, Oxford University Press, 1996.

Taylor M. 'Voluntary Action and the State'. In: Gladstone D. (ed). **British Social Welfare, Past, Present and Future**. London: UCL Press, 1995.

Telfer E. 'Justice, Welfare and Health Care' . **Journal of Medical Ethics,** 1976.

Telfer E. **Happiness.** London :Macmillan, 1980.

Thatcher M. **The Downing Street Years,** 1993.

Thompson T, Bennett W. 'The Good News About Welfare Reform: Wisconsin's Success Story'. **Heritage Lecture** No. 593 Sept. 29th, 1997.

Timmins N. **The Five Giants. A Biography of the Welfare State,** Fontana Press Harper Collins, 1995.

Titmuss R . 'The Welfare State: Images and Realities'. **Social Services Review 37** 1963.

Titmuss RM. **Commitment to Welfare** London: Allen & Unwin, 1968.

Titmuss R **The Gift Relationship. From Human Blood to Social Policy.** New York: Pantheon Books, Randomhouse,. 1970

Tuck R. **Natural Rights Theories; Their Origins and Development.** Cambridge University Press 1979.

Tocqueville A de 1835 **Democracy in America**: Translated by George Lawrence, Ed. Mayer JP, New York: Doubleday, Achor Books, 1969.

Tocqueville A de 1835 **Memoir on Pauperism.** Translated by S. Drescher: Rediscovered Riches No 2: IEA Health and Welfare Unit London, May 1997.

Tonnies F. 1857 **Community and Association** (Gemeinschaft and Gesellschaft, Translated by Charles P. Loomis London\; Routledge & Kegan Paul.

Tountas Y. 'Health Education and Self-Care'. In: Doxiadis S. (ed) **Health Education,** John Wiley & Sons Ltd, 1990.

Trolander JA. **Settlement Houses and the Great Depression.** Detroit: Wayne State University Press, 1975.

Vincent A. **Theories of the State,** Basil Blackwell; 1987.

Wasserman L. **Modern Political Philosphies and what they mean**. Philadelphia: The Blackiston Company, 1944.

Watkins AD. 'Perceptions, Emotions and Immunity: An Integrated Homeostatic Network'. **Quarterly Journal of Medicine,** 1995.

Weatherall D. **Science and the Quiet Art.** Medical Research and Patient Care Oxford University Press, 1995.

Weber M.. **Essays in Sociology,** edited and introduced by C. Wright Mills, Oxford University Press, 1946.

Weber M. 1930 **The Protestant Work Ethic and the Spirit of Capitalism,** Translated by Talcott Parsons London:Routledge 1992.

Weber M. 'Bureaucracy', **Essays in Sociology**, Translated & Edited by H.H Gerth & C. Wright Mills, Oxford University Press, 1946.

Weir M, Orloff A, Skocpol T. **The Politics of Social Policy in the United States,** Princeton University Press, 1988.

Webster C. 'Conservatives and Consensus: The Politics of the National Health Service, 1951-1964'. In: Oakley A, Williams S. (eds). **The Politics of the Welfare State** London:UCL Press, 1994.

Whelan R. **The Corrosion of Charity: From Moral Renewal to Contract Culture.** IEA Health and Welfare Unit, Choice in Welfare Series, 1996.

Williams R. **Keywords: A Vocabulary of Culture and Society**. London:Fontana Press 1988.

Winkler FI. 'Community Health Councils as an Organisational Structure for Promoting Community Participation'. Paper presented to the **International Conference on Primary Health Care**, Dusseldorf, 1986.

Winkler F. 'Involving Patients'. In: Meads GA. (ed), **Primary Care-Led NHS; Putting it into Practice** 1996.

WHO (World Health Organisation). **Constitution** New York, 1946.

WHO **Health Promotion, A discussion document on the concept and Principles.** WHO Copenhagen, 1984.

Wolfenden Committee. **The Future of Voluntary Organisations**. Report of the Wolfenden Committee, 1978.

Younghusband E. **Social Work in Britain: 1950-75, Vol. 1,** London: Allen & Unwin 1978.