Left Orthodoxy and the Politics of Health

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> 'I conceive of a millenium on earth—a millenium not of riches, nor of mechanical facilities, nor of intellectual facilities, nor absolutely of immunity from disease, nor absolutely of immunity from pain, but a time when men and women all over the earth shall ascend and enter into relation with their bodies—shall attain freedom and joy.' (Edward Carpenter, *Towards Democracy*.)

INTRODUCTION

The following article is based on a paper first produced during the latter part of 1978 for discussion within the Politics of Health Group. It sought to summarise points reached in our collective discussions and, in places, to extend the analysis. While it is in no way a statement of POHG's policy, there is widespread agreement in the group on the fundamental arguments presented in the paper.

POHG has been engaged in discussion around health politics for several years now. Originally we concentrated very much on the NHS. Some of the early debates were around such questions as: 'Is health care a commodity, and if so, what kind?'. 'What relevance do such notions as the "fiscal crisis of the state" hold for the analysis of cutbacks in public expenditure?'. In other words, we took the pre-existing analytical tools of Marxist political economy and sought to apply them to the medical sector.

These discussions floundered, partly because not everyone was familiar with Marxist concepts. It was ironic that health professionals in the group should be confronted by what they sometimes felt to be mystification. It reversed their usual relationship to esoteric knowledge. They had become patients! Yet there was also a more *general* dissatisfaction, a feeling we were getting bogged down, combined with an increasing awareness that too many issues were being excluded by our approach.

Within the group there were women who had been active around women's health issues, and whose starting point tended to be different. Rather than working downwards from the categories of Marxist theory to the world of daily experience, they tended to move in the opposite direction. One feature of this was an often critical stance towards the content of health care, which was usually missing from Marxist analyses. It contrasted with the left's undiscriminating 'no cuts in health services' position, which tends to lead to an uncritical stance towards existing services.

As well as contributions from those who had been active around women's health issues, there were others who had been involved in health struggles outside the NHS. In particular those concerned about work hazards, and the relationship between health and anti-imperialist struggles in the Third World, looked beyond health services. The former saw the need to remove the fundamental causes of ill-health in the places where people work, rather than to patch them up in shiny citadels of technological medicine; the latter knew that the export of western models of medicine had proved patently inadequate to deal with the health problems generated by neocolonial economic and social relations—indeed were a significant feature of them. Finally, the group contained radical epidemiologists who were able to show that the improvements in health made in the past century had more to do with improvements in social conditions than health services. They were therefore more interested in identifying the social and economic causes of ill-health, recognising that the struggle for health could not be separated from the struggle to remove the widespread inequalities which continue to permeate our society.

With these main contributory elements to our discussions, we began to make progress. We defined our terms of reference as broadly as possible, emphasising both the need to transform the social relations of health care *and* the need to show why the struggle for wider social change is necessary to achieve significant improvements in health. These two aspects of POHG philosophy are reflected in our first two pamphlets published during 1979, *Cuts and the NHS*, and *Food and Profit: it Makes you Sick*.

In working out these perspectives, we have begun to examine the relationship between socialism and the struggle for health. Many of us have been profoundly influenced by the approach taken to health question in the women's movement. In the Politics of Health Group we are seeking to generalise the women's movement's concern with health, and believe that this is necessary if we are to broaden and revitalise the appeal of socialism. The politics of health helps to illuminate much of the relationship between the personal and the political, in the first place by insisting upon their *political* character, rather than the unchallenged mandate of technocratic experts.

As a result I have felt my own views change towards much more libertarian socialism: towards a much more eclectic socialism, one which does not rely overly on a few great figures, or issues, or on political economy, and one which does not imagine that socialism must necessarily fulfil tendencies manifest within capitalism. It can

incorporate features of precapitalist societies as well as generating structures which have no historical precedent. The paper represented a move towards such politics. Its implication is that the left has not simply got to tack onto its programme a strategy for health, but think anew about what socialism means. There are signs that a 'new' politics, partly based on forgotten or suppressed utopian traditions, is emerging in this country. I hope this paper can form a small contribution to that trend.

THE POLITICS OF ORTHODOXY

The guiding principle of this article is that there is a need to move from an overriding concern with cuts to that of health, from a defence of the health service, to a defence of people's health. This is not to say that the fight against health service cuts is unimportant, but we need to start from a consideration of people's health needs, otherwise we are always simply reacting to the right wing offensive against the NHS. Ironically, only when we are clear about the kind of health service we want—and what part health services can play in the struggle for health—can we hope to fight the cuts effectively. A right wing critique of the effectiveness and appropriateness of health care has been mounted. On the left, this has largely been dismissed as a smokescreen to justify cuts. While this is partly true, the conservative critique has some substance. What we have yet failed to do is to provide a comprehensive alternative. Instead we allow the right to make all the running, and at best fight a feeble rearguard action.

It is this inadequate one-dimensional politics of health that is characterised here as 'left orthodoxy'. The phrase describes the consensus that seems to exist about health politics among left activists. As a preparation for this article, I surveyed the pamphlets and publications produced by the left groups during the 1970s.[1] All reformists and revolutionaries displayed marked tendencies towards this orthodoxy, even when, in some cases, aspects of their argument seemed to contradict it. (This paper is not, however, a critique of any particular group. That would require a contextualisation of the arguments in ways which I am not able to undertake here).

The basic source of left orthodoxy is not hard to trace. It lies in the widespread over-romanticised attachment to the NHS on the left, which derives from a belief that the 'principles of 1948', under which it was set up, form the basis for a socialist health care service. More than any other public institution, it is believed to embody the principle of production for use. Schools are more often identified as institutions through which the state seeks to reproduce dominant ideologies and exercise social control. The content of education is therefore an issue in a way that the content of health care is not. The railways and other utilities are clearly run to realise exchange value, while the health service, despite prescription and other charges, appears to embody quite different principles. Yet this is not to argue that the Left Orthodoxy is restricted solely to the NHS. It is simply more marked in the medical sector. It would be productive to examine left policy on issues such as housing, education, free

collective bargaining, unemployment etc., for signs of a substantive (if not tactical) consensus, which transcends the apparent divide between reformists and revolutionaries.

Let us take for granted that the NHS is different. Nevertheless, if we accept the 'socialist' character of the NHS at face value, it leads to the acceptance of a particular kind of socialism, obscures the way in which the NHS serves fundamentally conservative purposes. It has led socialists in this country to think of health services as the 'natural' means of tackling the ill-health effects of capitalism, and it has on the whole led them to accept the medical mandate to define health and ill-health even when criticising aspects of doctors' practice.

1) The health service is publicly owned and health care removed from the market place;
2) Services should be comprehensively available and accessible to all who need them.

The health service is seen as a 'quasi-socialist' institution to the extent that it partially realises these objectives. It is criticised as *non*-socialist, equally, because such principles have never been realised in practice. The left critique of the NHS, therefore, is largely one which criticises the health service for not having lived up to the socialist promise of 1948. Much of the subsequent analysis is then concerned with the identification of the *internal* and *external* constraints which have frustrated its realisation, with the obvious implication that action should be taken to remove them.

The *internal* constraints upon the implementation of the principles of 1948 are those structural features of the NHS which give rise to privileged groups who are opposed to, or fight a rearguard action against, them. The most important is quite correctly seen to be the excessive sway which the medical establishement has over the service. It frustrates the implementation of Principle (1), for example, by fighting to retain private practice, and Principle (2) by concentrating resources and doctors in middle class areas and towards particular kinds of services [2] and by delaying the development of health centres. The *external* constraints focussed on include the pharmaceutical and supply industries which are said to 'milk' the NHS for their own ends, helping to embarass the service financially. There is also, of course, the reintroduction of charges for various services (one of the biggest demands placed upon the NHS in the early days was for basic things like spectacles and false teeth, which led to charges intended to dampen demand.) But what has received attention as the greatest threat recently has been the financial retrenchment due to the crisis in state expenditure.

The chronic starvation of resources for the NHS (as evidenced by the lower proportion of the Gross National Product spent on it compared to many other countries) has long been recognised. The massive cutbacks on expenditure growth of the 1970s, however, qualitatively changed matters. No longer could we be said to be moving, at however slow a pace, towards the gradualist utopia when the principles of 1948 would finally be attained. For the first time it

appeared to many that things were moving in the opposite direction. This naturally led to a change in emphasis on the left away from the organisational questions of the 1950s and 1960s (i.e. a focus on internal constraints) towards a focus upon problems of finance (that is, upon external constraints) as the major threat to the principles of 1948.

THE PROBLEMS OF ORTHODOXY

It would be as well to distinguish between a left politics which is inadequate even within the terms of orthodoxy, and that which is inadequate because it flows from orthodoxy, of however sophisticated a variant. To begin with, some recent approaches deal almost exclusively with external financial constraints and ignore internal organisational obstacles altogether. Quite simply, a favoured solution is often to slush-in extra money which, unless it was associated with organisational changes, would largely reproduce the present maldistribution of resources, but at a higher level of expenditure. Just to quote one example, it might provide the basis for further rationalisations which could lead to more small hospitals being threatened.[3]

A more fundamental issue concerns the inadequacy of the principles from a socialist perspective. The extent to which they can be dubbed 'socialist' at all depends crucially on the criteria that are chosen. In one version of the desired future, socialism is seen as bringing material abundance. With the transformation of the relations of production into common ownership, the barriers to the final abolition of scarcity are removed and all forms of waste associated with capitalism done away with. This vision of socialism imagines the anticipated future largely as a materialist cornucopia. There is, however, another vision which, while not necessarily ignoring material scarcity, nevertheless places much greater emphasis on qualitative than quantitative factors, seeing in socialism a moral as much as material future. It sees a transformation in human relationships as desirable in itself. The fulfilment of the latter vision requires much more than a transformation in ownership or the volume of production. Rather it provides the occasion by which people may begin to discover non-alienated ways of relating to each other, and gain control over their lives. The defining feature of left orthodoxy is its emphasis upon the abolition of scarcity in provision as the sufficient as well as a necessary step. Its associated vision of a socialist health service is primarily one where medical care is freely available to all who need it, regardless of cost. The identification of internal and external constraints is almost exclusively in terms of their ability to frustrate this goal. Socialism, in other words, is plenty for everyone, with some left over besides. As a result, vitally important political questions concerning health and health care are left off the agenda. They do not appear as issues. These problems are of two sorts: an inadequate conception of the relation between health and capitalism, and of the health service in capitalism. Thus, the chief way in which orthodoxy understands the relation of the NHS to capitalism is in terms of the contradiction of trying to run a service based on

the principle of use value in a society dominated by production for exchange. The limits on state expenditure under capitalism mean it is too costly to underpin an NHS based on production for use. So it sees the NHS as a socialist institution hopelessly embedded in a capitalist political economy.

The view that the NHS embodies, partially or wholly, the principle of use as opposed to exchange value begs a great many questions, not least of which is what we mean by production for use! There is need for some caution here. For those exponents who focus primarily on external (ie financial) constraints, this is particularly true. In their terms, medically determined services are to a large extent assumed to be beneficial and socially neutral. If doctors in this model are seen to have too much power it is usually seen purely in terms of an abstract rather than rooted critique of hierarchy in the health service. The argument for a more democratic structure is rhetorically presented simply as desirable in itself, rather than fundamentally necessary to changing what the health service does. In the more sophisticated variants of orthodoxy, those which focus also on internal constraints, a more critical view of medical decision-making processes is taken: questioning in particular the distribution of care, but also some medical procedures.

Yet both can be said, in their different ways, to be assuming the social neutrality of the State. The 'external' stream of orthodoxy regards the content of State expenditure as neutral and only constrained by capitalism in the sense of not having the resources to do more. In the second case, the ills of the health service are often attributed to the power of the medical profession vis-a-vis the state, and the call is therefore for the establishment of 'rational' controls over the profession from above (by such techniques as 'medical audits' which seek to determine 'efficiency'). In other words, though lip service is paid to democracy, bureaucratic controls from above are typically seen as the major corrective to the dominance of the medical profession.

Again we must distinguish between unsophisticated and sophisticated variants of orthodoxy. The former accepts the egalitarian basis of the health service as a given fact, and has an almost blind faith in the wonders of medical science (very few seem to be aware of Illich's claim that much modern medicine produces as much ill-health as it ameliorates [4]). For them, the only problems are financial ones, since nobody can have too much of a good thing. At its more sophisticated, however, there is an awareness that so called regional inequalities have a class basis, that middle class areas are better-endowed with health services. This is what lies behind the notion of an 'inverse care law' [5] which suggests that the working class, while suffering a disproportionate amount of sickness, receive less than their fair share of the benefits of the health service. One problem of such approaches however, is that they focus far too much upon a redistribution of the 'benefits' of health services as a solution to class differences in the distribution of disease. Insufficient attention is given to transforming the social conditions that produce ill-health in the first place. Another problem is a very limit-

ed critique of medical care itself. Essential to a socialist critique ought to be an assault on notions of 'benefit' and 'need' as determined by an expert authority autonomous from the mass of the people who use the health service. An 'inverse care' notion in no way challenges these strutures of political control over the sick, because it does not question the content of health care, only its distribution. The failure of even sophisticated variants of orthodoxy to see this has meant that the left has been unable to respond adequately to such Government initiatives as the Resources Allocation Working Party (RAWP), which were informed by some concept of distributing health care according to 'need'. Critics have argued that RAWP is a formula for disguised cuts, and also that it is not a *real* attempt to redirect resources at the point of patient care. While both arguments are true, they largely miss the point. It is not a more refined version of RAWP which is required, for this would only substitute a bureaucratically determined planners' assessment of 'need' for the medical one.

The question of restructuring the social relations of the health service is rarely seen as a major problem by exponents of orthodoxy (although a limited form of 'democratisation', usually local authority control, is sometimes posed). Within a wider and humanistic vision of socialism this becomes an extremely urgent necessity. The choice is not between particular kinds of service, imposed from above: care versus cure, community medicine versus hospitalisation, high technology versus low technology: in themselves these are false polarisations. To pose choices in such terms is not to start from first principles, but from notions of need derived independently of people themselves. A socialist health service will be one which seeks to devise social relations of health care which respect the personal autonomy of both those who work for it and those who are unavoidably sick. It will be one where all barriers of hierarchy and mystification, between health workers and between them and the sick people they work with are torn down. It will be health care provided neither because of the material necessity of wage workers nor out of an imposed set of obligations which fall upon certain people, mainly daughters and wives. The problem of what to do about the sick will not be seen as a purely technical medical issue, where non-humanistic criteria of scientific rationality are imposed upon sick or debilitated people, and notions of 'caring responsibilities' imposed on others. This is different from the old fashioned notion that the 'whole person' rather than the 'symptoms' should be treated. We must attack the notion of 'treatment' itself which implies that the sick person is still someone to be 'dealt with', whether whole or fragmented. And we need to be clear that these are truly revolutionary demands, for they require a fundamental change in social relationships, from those based on wage labour and familial responsibilities. Transforming the social relations of health care is ultimately tied up with changes in the whole nature of people's material and social existence.

This may be a utopian vision, but it can still inform our daily struggles, can help us to think clearly about the demands we raise.

We must get away from the idea that the kinds of care that should be provided are simply technical questions, whether determined by doctors, nurses or even planners and sociologists. We can see the potential in these directions in the experience of some recent local struggles around hospital closures, and in the approach of the women's movement to health issues. The latter has, from the outset, struggled against what it sees as patriarchally determined definitions of 'need'.

Such a vision—which requires much greater clarification than is attempted here—might help us to understand what a truly democratic health service would be like. It would view any imposed definitions of need (medical, bureaucratic or sociological) as oppressive. The question 'who benefits?' cannot be separated from the question 'who decides?'. In a democratic health service, democratic political structures would exist at a number of levels. However, a meaningful workers' and users' control would radiate outwards from the point at which, on a day to day basis, needs are assessed and determined. It would create collective organs of control but also allow individuals to articulate and define, with expert assistance, their own needs. Yet it would be very different from 'consumerism'. The latter is solely individualist; it accepts the commoditisation of medicine, and can lead to the subordination of the worker to the user. A democratic socialist health service is not one where power relations between worker and user are simply reversed, but one where they are transcended.

THE POLITICS OF HEALTH AND ILL-HEALTH

The demand for control can be concretised initially, at least, by separating out different elements of control. To do so, it may be helpful to think of two dualisms:

—Control as a means and control as an end

—Control over health and control over health care.

These dualisms are, of course, related dialectically to each other. Our goal is a society in which domination of people by people is ended and our critique of capitalism is based on the premise that the individualised 'freedoms' of these societies, though at one stage a liberating force, have led inevitably to new and masked forms of domination. A fuller freedom can only be achieved by collective struggle and socialists assert that, on the contrary, it is *individualism* and freedom which are ultimately in greatest contradiction (though perhaps we need to give more thought to the relationship between individual freedom and socialism). In any case, a situation where society is genuinely run by the mass of the population, is fundamentally different from collectively *organised* societies like the Soviet Union which is run by and for a minority and which is unaccountable to the mass of the population. Once again, the question of 'benefit' is the central issue. The definition of socialism in terms of pure abundance is more compatible with a paternalist bureaucracy which claims to 'look after' and provide for the masses, than one which sees socialism as a collective means of restructuring social

relations in order to achieve freedom from domination, to create the context where people can begin to control their own lives. It is the difference between a socialised and a socialist society.

Personal control over health has to be seen as both a means and an end. It is an end because control over our bodies, as the women's movement has emphasised, is central to controlling our lives. But—and this will be argued later in more detail—personal control over health cannot be achieved merely by individuals, for the forces which threaten it can often only be opposed by collective action. Only when we have collectively controlled the social forces producing ill-health, can people genuinely be said to be taking entirely 'free' risks with their health. However, as well as being a primary objective, an end in itself, it also has *secondary* effects. For when people desire to control their own health—or the context in which they will take risks with it—it is because it is necessary to other goals. In a capitalist society people are forced to take risks with their health in order to compete in labour markets to earn their subsistence. In a socialist society the desire for health would be related to totally different sets of goals, connected with developing oneself as a human being. To the well-known question 'education for what?' could be added 'health for what?'

This is not to say that we should envisage the creation of a totally healthy society. Even if that were a realistic goal, to define it as an 'aim of socialism' is to rob socialism of what I take to be its essential character, that no social goals are determined external to conscious human choices. In capitalism on the contrary, health and ill-health are both made to serve the needs of capital accumulation. In other words, health is a secondary as well as primary goal, but the exact nature of its secondary character cannot be defined in abstract, but only by reference to the total social context. One way of driving this point home is by noticing that the National Front has a policy of massive improvements in health by physical fitness campaigns and health education. In doing so they are betraying their secondary goals (health as a *means*): under the guise of 'health' as an 'unquestionably' desirable goal, they are seeking to militarise social life. The NAZI regimes of the 1930s also used such campaigns as a preparation for military conquest. The founding programme of the Nazi Party stated: 'The State must apply itself to raising the standard of health . . .and increasing bodily efficiency by legally obligatory gymnastics and sports, and by extensive use of clubs engaged in the physical training of the young'.[6] As every student of social reform knows, attempts in the early 20th Century to improve the health of the population were not unconnected to the secondary goal of defending and extending the British Empire.

The total abolition of ill-health is not of course a feasible goal in any mode of production, even though much ill-health could so be removed at source. Therefore alongside it must go attempts to restructure health care.

THE STATE AND THE NHS

One approach to orthodoxy might be a critique which claimed that rather than being a 'semi-socialist' or socialist 'island' in a capitalist society, the NHS 'functions' in the interests of Capitalism by helping to 'reproduce' labour power and take care of 'useless' labour power as cheaply as possible. This is to a large extent true. When I worked as a nurse there was a saying that the NHS was concerned with three types of task: 'hatch', 'patch' and 'dispatch'. I know of no better way of expressing the relation of the NHS to capitalism.

Is this functional view, however, the only alternative to orthodoxy? It seems to me that, in its own way, it is just as crude. For it is simply *what* the NHS does which is the crucial issue for the Marxist functionalist approach. From the previous discussion, a socialist critique of *what* the NHS does cannot be separated from the *way* it does it. The separation of the mass of the people and health workers from real determination of what is of benefit to them, is crucial to Capital's domination of the health service. Professional knowledge serves to impose notions of benefit on the working class and other oppressed groups in the guise of a 'helping' ideology,[7] but one which often accords with the interests of Capital. As socialists we cannot easily isolate the question of whether what is done is beneficial to Capitalism, when part of that process is the very act of imposing definitions of benefit.

Perhaps the distinction that some make between the *form* and the *function* of the State may be helpful.[8] The form of the State—an individualist practice based on imposed notions of benefits (which to work must often be *genuinely* ambiguous and not straightforwardly oppressive)—is a capitalist one: it is opaque because the form disguises the character. In practice, however, the way in which it operates directly, or indirectly, in the interests of Capital is complex and not automatic.

The best place to start—and the question can only finally be settled by detailed empirical examination—is to examine the relationship between the NHS, the labour market, and other institutions like the family which are grouped around labour markets. A glimpse of these relationships can be seen in *Industrial Democracy*, where the Webbs identify what they believe are two major threats to national efficiency: 'weaklings' and 'degenerates'. State social policy in a capitalist society always needs to deal with each, though at different times the response has varied, oscillating from direct repression to attempts to 'help', to contain or 'rehabilitate'. However, whether the approach is hard or soft, curative or custodial, both groups are always considered a burden.

Detailed consideration needs to be given to why the response to these social problems varies, and to the specific role of the health service. Here we can note that the State form is based on the premise that when individuals cannot cope either in the factory or the family, for whatever reasons, it is individuals who have failed the system rather than the system which has failed individuals. A good part of the NHS is concerned to deal with or prevent such problems: care of children to prevent weaklings, the emotional and physical patching up of people who threaten to become labour market or domestic

failures, their containment and rehabilitation and, finally, dispatch of the remainder at low cost. This is not a total explanation for the activities of the health service, nor does it prevent a great deal of genuine human concern, kindness and committed care. However the chances for humanistic tendencies to come to the fore are diminished in a NHS so powerfully constrained by the need to help reproduce, on behalf of the capitalist class as a whole, the total social Capital.

The relation between Capital and the NHS is not a constant but a changing one, within which expenditure crises play a significant, but overemphasised part. But it is the dynamic relationship with the outside society, mediated by the labour market, which must be borne in mind. For example, in a near-full employment economy workers are relatively irreplaceable and this may help to justify workers' demands for extra spending on the NHS, on the assumption by the state that it has pay-offs for maintaining productivity. The NHS is also used to release women from caring roles which might tie them to the reserve army of labour. In a period of capitalist downturn, changes in both these needs of Capital (and general doubts about medical efficacy) have helped to exacerbate the expenditure crisis. We also need to examine the dynamics within capitalism which place changing demands on the NHS. Perhaps those most worth examining are: (i) the ways in which capitalism has led towards urbanised living patterns which both create new physical and mental health problems and disrupt the traditional means of dealing with them; (ii) changes in the labour process which not only lead to new physical and mental hazards of work, but through a process of intensification burn people out quickly and reject those who cannot maintain a certain pace of working; and (iii) the vested interest firms often have in promoting harmful consumption patterns.[9]

The health service also has important legitimating purposes, not least by giving contemporary capitalism a 'human face'. Those of us who grew up with the welfare state were told that though not as rich as the Americans, we did have the NHS. Its existence helped sweeten the acceptance of relative economic decline—and there was more than a germ of truth in the claim that British capitalism was as a result more civilised, even if it was also more impoverished. Other forms of legitimation have been pointed out by the women's movement—the health service power structure provides some of the most powerful archetypes of relations between men and women. Medicine has become one of the major legitimating occupations in a society where inequality is presented not so much as God-given, but as due to innate biological properties distributed differently between classes, races and sexes. When doctors participate in this biologistic legitimating process they help to provide 'expert' arguments against the social determination of inequality and domination. They thus seek to remove it from human control: making class, sex and race inequality seem everlasting by giving them a medical stamp of approval. Doctors are 'experts' in a health service which in appearance is based on achievement principles rather than ownership of property, yet which reproduces the same class, sex and race inequalities

to be found in any capitalist firm.

Yet whatever we may say about left orthodoxy, it has emphasised a commitment to free health care for all, regardless of its utility to capitalism. To the extent that this has been achieved, it has represented a drain on Capital and is profoundly different from pre-war health services, which serviced 'key' insured workers and children. Of course 'equal rights' to health care are not realised in practice, but in most people's minds this is probably not self-evident, and this may serve legitimating purposes. Just as the myth of equal access to education helps to legitimate a 'social mobility' society (i.e. one based on individual rather than collective advance) so the same arguments could be applied to the NHS. The NHS creates the myth that people start with an equal 'stock of health' which they can then 'invest' or lay waste by working hard (which never did anyone harm) to maximise their potential. Of course, in reality, working class people have sickness problems which the NHS does not deal with at source, or even adequately after the event, and health and education are not the most fundamental means of distributing people to social positions. Nevertheless, the NHS has mediated the relation between sickness and labour market institutions in a way which, whilst not directly in contradiction with capitalism, does confer what I think are perceived as 'benefits' by most working class people. The fact that the NHS does not increase the financial burden that sickness brings is, of course, a contrast with health services in countries like the USA.

However, the NHS cannot deal directly with the economic effects of ill-health upon individuals except by patching them up and returning them as functioning workers, parents or pensioners. Illness is a profoundly decollectivising experience. Even though the insecurity and loss of control which are associated with it are essentially social, it is experienced, and dealt with, largely as an individual or individual-family crisis. Yet the crisis and loss of control brought in the wake of sickness is, for those who live by selling their labour power, or are dependent on those who do, as much economic and social in origin and effect, as biological. We cannot hope to understand the power relations that exist between health workers unless we also understand that dependency is closely related to loss of market capacity, or the threat of it, as a major social consequence of much illness. Neither can one understand relations between family members when one of them is sick without looking at the economic and social relations of all family members, and the effect or potential effect of sickness on them. In the last section of the paper I will argue for a materialist analysis of *sickness* as a necessary means of transcending orthodoxy. It must be complemented, however, by a materialist analysis of the *sick*. We must show how the individual crises of sickness are not only biological events but mediated by the social institutions of capitalist societies. They are as much a product of them as is exploitation itself: it is a class, not a socially neutral 'welfare' issue. To demand economic security for the chronic sick is necessarily to contradict a basic principle of capitalism, that rewards should be related to market capacity.

It is factors such as these which constrain the way in which the NHS operates, but the relation is a complex one. The 'functionality' of the NHS for capitalism is not given but constantly has to be realised in practice—and there is struggle over it, though not necessarily always of an explicit kind. This happens in any State institution: but particularly in the NHS. Because it is supposed to operate in individuals' interests, it has a genuinely ambiguous character. This is ironically part of its functionality, but it is thereby also to some extent its Achilles' heel. There are important constraints on the NHS operating against the interests of Capital, but even within those constraints some degree of variation is possible.

THE NEW BOURGEOIS CRITIQUE OF MEDICAL CARE

So far in this article it has been argued, or implied, that to transform the social experience of sickness requires a general social transformation, alongside changes in the social relations of production in health care. In short, a socialist health service can only flourish in a socialist society. In the final sections, the argument is taken a step further: a general transformation of society is also necessary in order to make substantial inroads into the forces making people sick.

It is on this basis that we complete our critique of orthodoxy. For one of its major deficiencies is that it takes for granted medical definitions of health and disease which direct attention away from the social causes of disease. Orthodoxy gives little attention to those features of the social organisation of our society which produce ill-health. Indeed it helps to foster 'the NHS illusion'—that the problems of ill-health in our society can be largely dealt with by more and 'better' health services, the 'better' meaning to a considerable extent 'whatever doctors decide'. Left orthodoxy thus encourages the false political conclusion that a strategy for health can be more or less equated with a strategy for the NHS. It compartmentalises health issues into medical ones and fails to confront the truly revolutionary implications of a politics of health.

One result of our anxiety to defend the NHS from attack is the dismissal of right wing attacks on the effectiveness of health services as diversionary. Yet there is often some truth in their arguments. Increasing expenditure on health services may well lead to diminishing returns in terms of achieving significant improvements in health. Nevertheless it is still open to us to dispute many of the arguments used to reach seemingly similar conclusions, as well as to differ sharply on solutions to that crisis. Hence we should seek to identify the inadequate bourgeois character of the critique of capitalist medicine.

In the first place, it is necessary to distinguish the attack on the NHS from the critique of medicine in general. The right in this country has tended to argue that the absence of the price mechanism is a prime cause of abuse. According to this mythology, the NHS has long since achieved substantial improvements in the health of the population, and people are now putting trivial or false demands on

the health service. Often associated with this is the view that demand for health services is potentially infinite, and that, in the absence of price rationing, policy-makers simply have to decide on a cut-off point. Since this arrangement assumes that basic health needs have been met it clearly legitimates cutbacks in the growth of expenditure. A basic problem with this view is that it emphasises the amount of influence that patients have in determining the health care they receive. While having some influence, an elite group of producers play the most important role in distorting services towards 'trivial' or 'false needs' at the same time that more basic needs go unmet. Because of this there is no guarantee that cutting off services at a particular point will change the situation for the better. It is just as likely to change it for the worse, as the elite groups fight hard to protect their services.

The critique of commentators like Illich is more telling. It gets closer to the truth for it is primarily an attack on medicine rather than the NHS. it blames *producers* for encouraging false expectations that medicine can solve all kinds of problems for which, he argues, there is ultimately no solution. Illich furthermore believes that attempts to deal socially with the causes of disease are either 'engineering for a plastic womb', or self-defeating:

> 'Our prevailing ailments, helplessness and injustice are largely the side effects of strategies for more and better education, housing, diet or health'.[10]

His solution is to put the wheels of progress in reverse, and he preaches stoicism in the face of disease, pain and suffering.

Behind his views on health, as on other issues, is the assumption that there are simply two social alternatives: on the one hand 'traditional' society, which embodies everything wholesome, where life is lived spontaneously in obedience to human values, and modesty our protection against folly, on the other 'industrial society', the embodiement of all that is dehumanised. An over-rationalised society, whose faith in the effectiveness of conscious plans and intentions, leads to a constant tendency to overreach ourselves. Illich's critique of medicine cannot be taken in isolation from a general critique of 'modernity'. The merit of Navarro's in many ways excellent critique, is that it confronts Illich precisely at the level of his overall politics. Navarro uncovers many of the capitalist processes underlying industrial societies tracing their effect on health and health care:

> ' . . .the greatest potential for improving the health of our citizens is not through changes in the behaviour of individuals, but primarily through changes in the patterns of control, structures, and behaviour of our economic and political system'.[11]

Unfortunately Navarro goes beyond this to claim that all 'life style' politics is 'not only very limited but naive and sheer escapism'. While much of the pressure towards self-care and the adoption of new 'healthy' lifestyles has been conservative, focussing on the individual not the social obstacles to health, it is wrong to see all such

moves in this direction as inherently reactionary. Like many on the left, Navarro has overacted against

> '. . .the cultural politics of the Woodstock nation (which) proved easily cooptable and irrelevant to the solutions of our problems in the sixties.'

The tendency to counterpose 'lifestyle' politics against the undisputed need to obtain wider changes is one which has been much criticised by the women's movement. It is also where alternative forms of self-help and cultural change in health care have occurred that are poles apart from Illich's prescriptions. Of course, tendencies towards cooptation are present, but that danger is by no means restricted to cultural politics. Illich addresses himself to difficult questions which ought to concern us as socialists: how can people be helped to cope better with suffering if it cannot be entirely eliminated?

The conservatism of Illich's critique of medicine is in some respect matched in psychiatry by the persistent polemics of Szasz. One difference is that Szasz brings in an element significantly missing from Illich (and Navarro): the relation between professional control and patient oppression. Szasz sees much psychiatry as a means of social control, by which it

> '*fulfils a basic human need*—to validate the Self as good (normal), by invalidating the Other as evil (mentally ill)'.[12]

This is the strand in Szasz's thought which has received most attention: his defence of the mental patient as a convenient scapegoat who is labelled sick and therefore in need of help, whether she wants it or not. This has led many to associate him with radical psychiatrists like Laing and Cooper. But Szasz is not unreservedly on the side of the victims, except when they are being persecuted by institutional psychiatry. He also, in ways strikingly similar to Illich, defines mental illness on some occasions, as a means of refuge for those who wish to avoid the difficult moral dilemmas that accompany life:

> 'I have tried to show that, on the one hand, by seeking relief from the burden of his moral responsibilities, man (sic) mystifies and technicises his problems in living; and that, on the other hand, the demand for 'help' thus generated is now met by a behavioural technology ready and willing to free man of his moral burdens, by treating him as a sick patient'.[13]

Underlying this is a pessimistic view of human nature. Szasz describes humanity as:

> '. . .the innocent and helpless victims of internal passions and external controls that shape and possess him . . .(T)he prerequisites of industrial liberty are not only freedom from arbitrary political and interpersonal control . . .but, also, and more important still, self-discipline'.[14]

Szasz's message, despite its surface radicalism, is ultimately as chill-

ing and comfortless as Illich's. Yet while the latter is a 'Tory' opponent of all medicine, Szasz is more of a free market opponent of 'institutional psychiatry', regarding 'contractual psychiatry', (where the patient pays his way) as free of oppression. [15]

The proponents of the 'deviancy' approach to mental illness are open to the charge of being insensitive to a great deal of mental suffering. This charge is misplaced to the extent that the deviancy school seek to protect us from suffering caused by psychiatric persecution. And perhaps it is also justifiable to be suspicious of 'treatments' which help only by anaesthetising the mental suffering or which are a means, as one critic describes electroconvulsive therapy, of 'pursuing happiness through brain damage'.[16]

Yet Szasz pays little attention to the circumstances which lead to mental disturbance, nor how it is subsequently experienced. He sees it as a label imposed by outsiders, or a manifested defect in an individual's moral character.

Alongside individualist critiques of illness as a form of social control stand corporate celebrations of it. Social control can easily be reified into a functional necessity, as it is by Parsons' heartless concept of the 'sick role'.[17] Here social control operates only if we assume that modern medicine is effective. Illness represents a threat to the social order: it interrupts an individual's social functioning and limits overall productivity. But there is no need to deal with this by overtly repressive means; instead the sick-role enables the liberal-professional facade to be successfully maintained. By learning and internalising its norms, individuals are temporarily excused from normal obligations so long as they are motivated, not only to get better, but to seek appropriate professional help.

But that was in other more confident days. Now, doubts have set in. While Illich aims most of his missiles at the medical profess-

set in. While Illich aims most of his

ion, others save most of their criticism for us. After having been sweetly reassured for years that it was only a matter of time before a cure was found for every ill, we are now informed that *we* are to blame for not taking sufficient care of our own health. The right have been so successful in putting this message across that it has eagerly been adopted by Fabian socialists like Brian Abel-Smith. Assessing the track-record of the first 30 years of the NHS he declares that

> 'Faster progress could be made in doing what needs to be done if the burden of preventable illness and accidents could be lightened—if people took more responsibility for safeguarding their own health rather than expecting health professionals to restore what has been thrown away.'[18]

This new ideology has been succinctly summarised by Rob Crawford in the phrase 'you are dangerous to your health'[19]. Traditionally, ill-health was not considered culpable. Now state policy is differentiating the 'undeserving sick' in a similar fashion to the undeserving poor.[20] The current ruling-class obsession with levels of public expenditure is, of course, a major influence. Health education ad-

vertisements encourage us to wear seat-belts, not just for our own sake:

> ' . . .people who feel they should have the freedom to go through a car windscreen if they choose to, might consider this: have they really the right to occupy hospital beds unnecessarily when medical resources are already so stretched'[21].

Many of the advertisements are aimed at, and largely blame, women—for overfeeding their charges, or for leaving the front door open and allowing their children to stray out and get run over.

THE CRISIS OF COMMODITY HEALTH CARE

The aim of the new right is to achieve a general lowering of expectations of the NHS. Advertisements in GP's surgeries warn us not automatically to expect a prescription. The Government has launched a 'Look After Yourself' campaign, and the parks are full of joggers. We need to respond to these developments at two levels. First, to recognise that in some areas the NHS is not meeting needs which clearly exist (for example, the 50% of abortions which are carried out in the private sector). Where this is the case, the attempt to lower expectations is purely reactionary and to be unequivocably opposed.

But secondly there are other instances where a lowering of expectations concerning medical care can have a potentially progressive impact. This can lead us to rely more on our own resources and knowledge rather than place trust in a medical elite which expropriates from us knowledge and control over our minds and bodies. It can also direct our attention to the *social* rather than individual causes of much ill-health.

There is no need for us to make the preposterous claim that individuals cannot and ought not safeguard their own health. We can still emphasise that the major factors which affect people's health and set the framework in which individual choices are made, can only be properly tackled collectively. And we can also show that to do so requires a frontal assault upon the most powerfully entrenched vested interests in our society. Professionals may control the sick, but they are hopelessly weak in the face of the forces in our society which make people ill.

The new right assumes, on the contrary, that individual avoidance is possible, because it also makes the additional assumption that people are, or ought to be, masters and mistresses of their own lifestyles. Yet in the factory and the wider community the priorities set in motion by capitalism have a profound influence on lifestyles. The power of Capital over people's lives is the power to structure the context in which personal choices are made. As Marx claimed in the *18th Brumaire*:

> 'Men make their own history, but they do not make it just as they please.'

A foremost task of a socialist strategy for health is to develop means

of struggling collectively to alter the social context in which personal choices are made. Intellectuals should serve and assist that process, without taking over by imposing their own definitions of people's health needs. A necessary task is to try to combat the NHS illusion that health care is the major route for dealing with ill-health; another is to try to make as transparent as possible, the opaque relationships between ill-health and the mode of production in contemporary Capitalism. As far as the first is concerned, we have to make clear that the crisis of the NHS is not just a question of finance but, from a socialist perspective, a crisis in the commodity form of health care. Since this enters a very complex area, a few paragraphs of explanation are required.

Marx's analysis of the commodity focusses on its dual character: as well as having a use-value, a commodity also has an exchange value. What he means by this is that a commodity is a particular way of satisfying human needs through market transactions, i.e. a specific set of social relationships organised around the consumption of use values. Although Marx's practical examples are largely in terms of physically concrete articles, like bales of cotton, he makes it clear that it is the *form*, whether something is bought or sold, rather than its tangibility or 'thingness' which determines commodity status. Indeed, he explicitly attacks Adam Smith for viewing 'productive' and 'unproductive' labour largely in terms of 'thingness'. The critical distinction is whether something can be sold to make a profit and accumulate value, and he makes it plain that education and health care *could* qualify as commodities on these grounds.

Clearly work in the NHS is, directly at least, unproductive labour in the strict sense that it obviously does not lead to the accumulation of value. Yet there are other difficulties which derive primarily from Marx's failure to define use values (since he disposes of the issue in a cavalier fashion on the very first page of *Capital*). While use values clearly exist independently of commodities, exchange values cannot exist independently of some underlying use value. However, as far as Marx was concerned, this underlying use value could be taken for granted. It did not matter whether it was 'real' or 'imaginary'.

To an extent this was valid, for Marx was concerned to understand a system where use-values were always mediated by exchange values. But it leaves great problems in its wake, not least the ways in which production for exchange distorts use-values, leads to forced wants. It is perhaps of some significance that such issues have come to the fore in the era of monopoly capital when wants are increasingly manipulated by marketing techniques. In a sense, medicine has always been such a commodity, because the monopoly power of producers to determine use values has been long established. For this reason, the claim that medical care is not a commodity because producers rather than consumers determine use values does not seem a valid objection. In many areas of economic life, this is becoming the rule rather than the exception.

The danger of the commodity analogy is that it can lead us to

assume the patient is a consumer and always receives any use values produced. Yet in whole areas of psychiatry, for example, it is difficult to talk in any convincing sense of patients as the prime beneficiaries of any use values produced. Another problem is that of 'multiple' use values although this is a characteristic of many, more familiar commodities. As Marx emphasised, the felt need by workers to feed and clothe themselves is matched by a need for capitalists to reproduce labour power. These problems are compounded in the case of health care. For example in the case of an elderly person cared for in hospital, who does the use value accrue to? To the patient, or to the woman who can now go out to work? To her or the employer who profits from her labour power, or to the family who can now afford a holiday? Perhaps it is the *reality* of multiple use values that helps to mask the class character of the NHS. Another important feature of use values is that they often have time scales attached to them. Some products produce immediate use values but carry long term drawbacks—like cigarettes. A major operation may offer no immediate use-value but carry the promise of long term advantages. A distinctive feature of medical care as a commodity is therefore the weighing of present discomforts against future use-values, which inevitably involves a degree of uncertainty. Even so, many critics of 'high technology' medical care claim that discomforts outweigh ultimate use-values. But it would be dangerous (as we insisted earlier) for socialists simply to assume that more 'low technology' caring services of necessity have a greater use value, if the problem of *who* determines use-values is not tackled.

Bearing these points in mind, it is still valid to consider the kind of health care provided under the NHS as a commodity form. It is a nationalised rather than a socialist form of health care: the position and dominance of physicians in the labour process largely bears the stamp of the period when medicine was a petty-commodity form of production despite it now being within the State sector. Medicine may appear to depart from mass-produced commodities in being supposedly tailored to individual needs by producers, even though this is channelled through the standardised products of drug and equipment manufacturers. However, in reality, a lot of care is mass produced too—like the routine prescription for tranquillisers that most GPs give their depressed women patients.

Yet there is a politically more fundamental way in which health care is a commodity, by virtue of its being an individualist form of consumption. The production and consumption of the commodities churned out by capitalism are responsible for much of the ill-health and mental disturbances we find around us. Instead of tackling these at source, with all the political implications that would follow, we are encouraged to seek to deal with it by consuming another commodity—health care. The commodity form makes no impact on the forces outside the immediate control of individuals which crucially affect health and ill-health. It could even be suggested that it yields diminishing returns for individuals. For all these reasons, even when the health service is not operating in ways directly funct-

ional for capitalism, it does not actively operate against its interests, not only because of what it does, but also because of the way it intervenes, at the level of individuals. (For some bourgeois critics this seems a poor justification, while others are more concerned with the cost to the state, particularly when health services are socialised.)

There is therefore a crisis in the NHS—as in modern medicine in general—which goes deeper than finance. Pouring money into health services cannot deal with the central contradiction: that between its individualistic mode of intervention and the social and economic production of health and ill-health. Critics like Illich recognise the diminishing returns of modern medicine, but fail to identify any structural causes. Indeed, he sets his face against collective solutions, and can only offer stoicism in the face of pain and suffering. But we can complete the critique begun by bourgeois critics of modern medicine whose suspicion is often based on the classic liberal-economic distrust of monopoly power. A collective democratic solution to the social causes of ill-health is the opposite of social engineering. It means assisting oppressed groups in society to mobilise against, and ultimately control, the forces which make them unnecessarily sick.

THE SOCIAL PRODUCTION OF HEALTH AND ILL-HEALTH

Helping to dissolve the opacity of the relation between capitalism and ill-health—which is *genuinely* complex—is an important intellectual task. The reason Marx placed such amphasis upon intellectual effort and discovery was not to produce elegant theories. It was based on his conviction that capitalism, unlike feudalism, was an opaque form of exploitation which appeared, on the surface, to give labourers a 'fair' price for their labours. Only by digging beneath those surface appearances could the exploitative nature of the system be laid bare. Essentially the same task confronts those concerned about health and illness: the relation between, for example, stress, ill-health and the mode of production is highly complex and mediated through many processes. However the most important requirement is, in the first instance, a sensitivity to the possibility that the capitalist mode of production may be implicated, otherwise we will not seek to establish causative links and miss them even when they are apparent. For example, the link between cancer and vinyl chloride in the manufacture of PVC took much longer to be established because we do not *automatically* link cancer with occupational conditions.

Bourgeois ideology is an integral part of medicine, because it reifies disease categories. Reification is the tendency to fetishise features of the social world by making them appear as relations between things rather than people. They become part of the 'natural order of things'. It is not so much futile to try to change them, rather the idea of change is inconceivable in itself. Disease categories are reified firstly when acts of deviance are defined as individual forms of sickness. This lessens the threat of having to accept them as

authentic acts, the need is for individuals to adapt rather than to change the social circumstances that give rise to them. Soviet psychiatry's treatment of dissidents in only an extreme example of this tendency. As Zola has argued,

> 'By locating the source and treatment of problems in an individual, other levels of intervention are effectively closed. By the very acceptance of a specific behaviour as an "illness" and the definition of illness as an undesirable state, the issue becomes not whether to deal with a particular problem, but *how* and *when*'[22].

To assert for example that homosexuality is a form of deviance and not illness, can lead us to accept its authenticity. But not of necessity, for 'social control' can also be reified in ways which see deviance as a self-evident problem.

It should also be remembered that the notion of deviancy can be related to that of sickness in more than one way. Parsons' conception that the sick-role was deviant does not challenge medical definitions of illness, but sees the social component of the role as *complementary*. It is deviant because the normal (in the sense of an ideal?) expectation is to function adequately in one's *primary* role as worker, mother or whatever [23]. This is very different from the concept of deviancy described above which sees it as an *alternative*, and a challenge, to the validity of the medically reified notion of illness.

It should not be thought that the patient is always an unwilling victim in this labelling process. For example, Alcoholics Anonymous believes that alcoholism is a disease rather than a form of social deviance, perhaps because 'disease' is seen as synonymous with 'involuntary', and the burden of shame and personal responsibility is thereby lifted. As we saw, Szasz comes close to arguing that mental illness is a form of subconscious 'hiding' from the moral dilemmas of life, not far short of malingering. A more humane approach would be to understand that such hiding is an understandable response to immensely difficult human problems, but that it is ultimately a false solution. It often involves great suffering in itself, and makes us dependant objects of the decisions of others, rather than the active subjects of our own destinies.

Yet we may talk of reification in a second sense, even when we do not challenge directly the appropriateness of medical definitions of disease. In such circumstances, we accept the reality of diseases, but attack the failure to go beyond their manifestation in individual bodily processes, to identify the social and economic forces which led them to be there in the first place. Where causes are identified there is rarely any attempt to go beyond a description of the specific agents concerned. As a result disease is either seen as an unfortunate occurrence which, like a comet, strikes out of the blue or else individual acts of avoidance are typically recommended. Until recently, the observance of scrupulous rituals of personal hygiene was seen as the best prophylactic. But with the decline of serious infectious diseases, increasing attention is given to promoting the

idea of the 'discriminating consumer' and the 'careful' motorist, worker, housewife etc.

The possibility that collective means of intervention might obviate the need for such individual acts of avoidance is rarely discussed. The use of disease categories need not always blot out considerations of such forms of action, but it often does. In such circumstances plain common sense might be more useful—a central point made in this excerpt from Brecht's beautiful poem 'A Worker's Speech to a Doctor':

> Are you able to heal?
>
> When we come to you
> Our rags are torn off us
> And you listen all over our naked body.
> As to the cause of our illness
> One glance at our rags would
> Tell you more. It is the same cause that wears out
> Our bodies and our clothes.
>
> The pain in our shoulder comes
> You say, from the damp, and this is also the reason
> For the stain on the wall of our flat.
> So tell us:
> Where does the damp come from? [24]

Brecht wrote these words at a time when the relationship between ill-health and the mode of production was much more transparent. Even then, apparently, doctors had, despite their high skill and learning, a 'trained incapacity' to draw the connections between ill-health and the society in which it occurs. There are two reasons why the relationship has now become much more opaque.

First, there is the assumption that nowadays it is no longer the diseases of 'poverty' which afflict us but the diseases of 'affluence'. Yet the relation between poverty and ill-health is just as strong.[25] A glance at the morbidity and mortality tables for different Registrar General's classes, shows this connection. These are, of course, largely based on income gradations, rather than classes as defined by their relationship to the means of production. However, the class differential for a major range of diseases from coronary thrombosis, stomach ulcers, lung cancer and accidents is, by the Government's own figures, very marked indeed. And though women on the whole have a higher life expectancy than men, here too there are marked variations according to social class [26]. The Government conducts virtually no research into the reasons why, and the medical profession appears also to be largely uninterested. However, the assumption is simply made that it is people's 'life-style' or irrational behaviour which is the root of the problem—without any evidence being brought forward to back up these assumptions.

The importance of the 'diseases of affluence' argument relates to the notion of 'individual responsibility', which implies that

no longer may the blame for ill-health be pinned upon capitalism. Blame may have attached at some long distant date, but the ill-health from which people now suffer is deemed to be a result of capitalism's success, in increasing people's longevity, and in providing people with the income which they can choose to spend on t things which cause them harm. This too, helps to legitimise cutbacks on the NHS, placing question marks over its future expansion. For it is said that the kinds of demands now being placed on it are qualitatively different from those in the past. The NHS has, it is falsely argued, cleared the backlog of poverty-related ill-health. It is now up to individuals to adopt a healthy life style and not place 'false' or unnecessary demands on the NHS.

If we are not to fall into the trap of left orthodoxy, we need to approach this ideology with caution. It cannot be denied that there have been considerable improvements in health for substantial sections of the working class. It is now widely accepted that these have much more to do with improved living standards than with better health services. But it must also be asked: 'where did the improved living standards come from?' Of course, they were fought for by generations of working class people, and were partly made possible by imperialist expansion. The fact that degenerative processes are inevitable in the long run does not mean that the replacement of 19th Century epidemics largely by degenerative diseases is entirely a sign of our success in our combatting ill-health, for they strike those lower in the class structure earlier. In other words, there is something in the way working class people live which burns out their bodies quicker *relative to other classes*, despite the fact that working class people now generally live longer.

The problem for us is to show exactly how and why this happens, which is no easy task. To go beyond the epidemiological evidence which shows clear enough *associations* between class and differential morbidity and mortality, to specify causal connections is not easy. It can only be done by collaborative efforts between socialist scientists, social scientists and political activists, if the mists surrounding the social production of ill-health in contemporary Capitalism are to be cleared. It involves identifying the ill-health effects of how people live, work and enjoy themselves, and the extent to which people are in control of these circumstances. To say that the causes of ill-health are in 'the environment' is too vague: it merely begs other questions, like what mechanisms propel that environment in the direction it takes.

Some have answered this by saying that the pursuit of economic growth as the main social priority leads both to pressure to cut the health service, and a worsening of health—in the factory, on the roads, and through the goods people consume. Such an approach, associated with the work of the Unit for the Study of Health Policy [27], challenges both the notions of individual responsibility and left orthodoxy, but within a social democratic framework. It emphasises the need to change economic priorities if we really care about improving health. These arguments represent an advance but they do not go far enough. They tend to see problems as ones of 'economic

priorities' rather than fundamentally connected with the distribution of power in our society. The focus on 'growth' is idealist. Where does growth come from? What kind of obstacles are there in changing course? Furthermore, they tend to accept the idea that much ill-health derives from 'affluence', For revolutionaries it is not the pursuit of growth which is the major obstacle to devising—if people wish them—healthier life styles, but the pursuit of capitalist accumulation, which capitalism must *of necessity* pursue. The implications are profound. First, we do not have to argue that wicked capitalists deliberately set out to produce ill-health, but that economic activity under the Capitalist mode of production will not lead to the pursuit of health goals if these conflict with the need for profits. Second, the extent to which the State can change capitalism's course from the pursuit of growth (accumulation) is likely to be extremely limited. The accumulative mechanism is the central dynamic of our society which mediates the process by which deviants are labelled sick, and the sick as deviant; it channels the biological agents of disease and structures personal disease-inducing choices.

Work is already under way in the USA to construct what has been called a 'materialist epidemiology'[28]. In this country there is already sufficient information on industrial health and safety to show the contradiction between workers' health and profits [29]. The recent *Science for People* issue on health has begun to raise wider issues in this country. The debate around nuclear power has health as one of its central implications—not just for working class people but for the whole human race. The POHG pamphlet *Food and Profit: It Makes You Sick* has shown how apparent individual choices are in fact heavily influenced by the profit priorities of the food industry. Research has also illuminated the relation between the nuclear family and depression among women [30].

The struggle for significant improvements in health is of necessity one also against capitalism, just as it must be made much more central to the struggle for socialism. Capitalism does not just extract surplus labour and value from working class people, in so doing it also shortens their lives, and often cruelly incapacitates them during their available span. No greater indictment of capitalism exists, no greater reason for fighting to create a socialist society.

NOTES

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1 The left literature consulted included the following, all published during the 1970's: Socialist Medical Association: *Private Practice out of the NHS, Forward to a Socialist Health Service*; Radical Statistics Group: *In Defence of the NHS, Whose Priorities? RAWP deals*; Communist Party: Issues of *Medicine in Society*; *Quality, Inequality and Health Care* by John Robson, *Take a Pill* by John Robson, *The NHS in England and Wales:*

A Marxist Perspective by Julian Tudor Hart; Militant Tendency: *A Socialist Programme to Save the NHS*; International Marxist Group: 'Struggle for Health' Pamphlets 1-4, (i) *NHS: A Suitable Case for Socialist Treatment*, (ii) *Crisis in the NHS: For a Workers' Solution*, (iii) *Defend the NHS*, (iv) *Crisis in the Health Service: The Socialist Solution*; International Socialists (now Socialist Workers' Party): *What is Happening to Our Health Service?* It is my contention that all the works cited above display, to greater or lesser degrees, signs of being influenced by versions of Left Orthodoxy.

2 For example, see Julian Tudor Hart, 'The Inverse Care Law', in C.Cox and A.Mead (eds.) *A Sociology of Medical Practice*, Collier-Macmillan (1975), pp.189-206.

3 Tom Manson has pointed out that many small hospitals were closed as part of the expansion of the NHS. See his article, Health Policy and the Cuts', *Capital and Class* 7 (Spring 1979), pp.35-45.

4 Ivan Illich, *Limits of Medicine: Medical Nemesis—The Expropriation of Health*, London: Marion Boyars (1976).

5 See note 2.

6 Quoted by *Searchlight* magazine (1978).

7 M.Edelman, *Politics and Society*.

8 See the three papers by the Edinburgh Cuts Group in the 1978 collection of CSE Conference Papers; and, since the writing of this paper, the London-Edinburgh Weekend Return Group, *In and Against the State*, London (1979).

9 In retrospect, it can be said that the present article, amongst other things, fails to take sufficient account of the implications of an ageing population for a socialist politics of health.

10 Ivan Illich, *Medical Nemesis*, p.155.

11 Vicente Navarro, *Medicine Under Capitalism*, London: Croom Helm (1976), chapter on Illich, pp.103-131.

12 Thomas Szasz, *The Manufacture of Madness*, London: Palladin (1973), p.27, emphasis added to illustrate the teleological character of Szasz's reasoning.

13 Thomas Szasz, *Ideology and Insanity*, London: Penguin (1974), p.3.

14 Ibid, p.2. A clear majority of mental patients have always been women, see Phyllis Chester, *Women and Madness* and Carol Smart, *Women, Crime and Criminology*.

15 See *The Manufacture of Madness*, p.23.

16 See Leonard Frank (ed.), *A History of Shock Treatment*, San Francisco: Leonard Frank (1979); obtainable from the editor, 2300 Webster St., San Francisco, California, 94115.

17 Talcott Parsons, *The Social System*, London:RKP (1951).

18 Brian Abel-Smith, *NHS: The First Thirty Years*.

19 Rob Crawford, 'You Are Dangerous to Your Health' *International Journal of Health Services*, 7 (1977).

20 'Health Issue Special'. *Science for People*, 38 (Winter 1977-8).

21 *The Guardian*, 23 May 1978.

22 Irving Zola, 'Medicine as an Institution of Social Control', in C.Cox and A.Mead (eds.) *A Sociology of Medical Practice*, pp.170-185.

23 Parsons, op.cit.

24 Bertolt Brecht, *Poems: Volume 2* London: Eyre Methuen.

25 See the impressive evidence in Peter Townsend, *Poverty*. Penguin (1979).

26 The figures are quoted in *Prevention and Health: Everybody's Responsibility*, London: HMSO. See also 'Equal Health for All?' *Labour Research* March 1979.
27 N.Dennis, P.Draper, T.Smart, *Health, Money and the NHS*, Guys Unit for the Study of Health Policy (1976).
28 Associated with the work of the US based Health Movement Organisation (HMO), unfortunately not available in this country. However, parts of their work have been published as articles in the *International Journal of Health Services*, in recent years.
29 See for example, Theo Nichols and Pete Armstrong *Safety and Profit* Falling Wall Press; monthly issues of *Hazards Bulletin*; and Pat Kinnersley, *The Hazards of Work*, Pluto (1973).
30 G.Brown and T.Harris, *The Social Origins of Depression*, London: Tavistock (1979). However, the authors work very much within a 'one-dimensional' approach to environmental factors, and in no way seek to challenge the medical mandate to define 'depression' as a clinical as opposed to a social entity.