Who cares for health? Social relations, gender, and the public health

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It is important to begin by thanking those who invited me to give this lecture, which will provide me with an opportunity to talk about all my favourite topics. You will be pleased to hear that I am able to trace some respectable historical antecedents in the field of public health. A paternal relation of mine was William Farr, statistician to Britain’s first Registrar General. My father was Richard Tittmuss, whose work in the late 1940s and early 1950s on class inequalities in health and illness jointly with Jerry Morris helped to shape the emerging discipline of social medicine. Social medicine was closely related to the domain of public health, as is its successor, the sociology of health and illness.

But genetic credentials for talking about public health, or social medicine, or whatever one chooses to call it would be a bit thin, even in a culture which is increasingly moving towards a disturbingly new genetic determinism, as ours is. My credentials for being here this evening are more than genetic. I have worked for nearly 30 years as a sociologist centrally concerned with issues to do with health and the division of labour, especially the division of labour between men and women. Like most people’s careers, my own was not the product of carefully considered rational choice. A crucial biographical moment – and I mention it only because it is germane to the substance of my talk – occurred in 1969 when in the act of dusting my husband’s bookshelves (he was a sociologist, too, so he had a lot of books) I picked up one on the sociology of work and noticed that housework was almost entirely missing from it. It appeared only as an aspect of the feminine role enabling women to be satisfied with low status poorly paid jobs outside the home; this allowed men to have the high status highly paid ones. Had my husband taught the sociology of health – which in those days was called medical sociology – I would probably have been equally disturbed to note that women’s unpaid health care in the home was missing from that as well.

Gardens of Eden

In 1988 the Acheson report on the future of the public health function in England talked fashionably about the “intersectoral” nature of public health. The report quoted from the World Health Organization document on Targets for Health for All to the effect that “the key to solving many health problems lies outside the health sector or is in the hands of the people themselves ...”2 When we turn to the later (1992) Health of the Nation report, we find a section at the back entitled “Key areas and the health of people in specific groups of the population”. The groups mentioned here are infants and children, elderly people, women, people from black and ethnic minorities, working class people, and people with disabilities, in that order.3 In other words, middle aged, middle class white men are the dominant group, according to which the needs of other groups can be regarded as specific.

The theme of my lecture is the relation between these two points: the responsibility of the people for producing their own health, on the one hand, and the socially structured differences between men and women, on the other. It isn’t, of course, fashionable these days to talk about gender: we are in what some people describe as the “post-feminist” era. This means two things: either it means, we’ve solved all those problems to do with gender equality, or it means we’re absolutely fed up with feminism and now is the time to move on to more important matters. But underlying my talk is the argument, which I might as well spell out now, that issues to do with the relative positions of men and women are absolutely critical to an understanding both of factors shaping the public health, and of the way ahead in terms of improving it. From this perspective, gender inequalities are as crucial as class inequality and inequalities between people of different ethnic groups. We live in a profoundly unequal society, but some people are more unequal than others. This inequality damages health. But it also itself proceeds from an unequal division of labour in health care work.

I want to try to link the gender division of labour in health care with two other themes: the first of these is the epidemiological evidence connecting socially supportive relationships with positive health outcomes; the second is the enduring puzzle of the division of labour in health itself: the fact that men die more while women seem to be sicker. In trying to accomplish these tasks, I shall draw rather cursorily on a wide range of publications and on three particular research projects carried out in my research unit in London. Two of these
Figure 1 Teenagers’ participation in housework: proportions of young men and young women who carried out selected tasks once a week or more. (Source: reference 4.)

THE MATTER WITH EVE
But I’ll begin in a place you will all recognise: the Garden of Eden. The Irish writer George Bernard Shaw once wrote a play about the Garden of Eden called Back to Methuselah. In the first scene, Adam and Eve are in the Garden of Eden. Adam comes across a dead animal, and both he and Eve are disturbed by this reminder of death in the midst of life — that very substance and business of public health, of course. But Adam and Eve react differently to the reminder of mortality.

“You must be careful,” says Eve, the good housewife, to Adam, “Promise me you will be careful”.

Adam objects that there’s little point in being careful, as something fatal is bound to happen to him sooner or later. Then he realises with horror that the same is true for his helpmate Eve. “You must never put yourself in danger of stumbling,” he instructs, “You must not move about. You must sit still. I will take care of you and bring you what you want.”

Eve’s not over the moon about this idea that she should spend the rest of her life sitting still and being dependent on Adam. In any case, as she observes, she really has no time to think about herself — she’s kept far too busy thinking about Adam. She has to think about Adam, because as she tells him in no uncertain terms, “You are lazy; you are dirty; you neglect yourself; you are always dreaming; you would eat bad food and become disgusting if I did not watch you and occupy myself with you.”

Provided health care and gender
Most of the world’s primary health care is carried out by women. Women’s health care work is sometimes paid — as in the case of nurses, health visitors, social workers, and other professions allied to medicine — or it is unpaid. In the home, it is predominantly women who care for men and for children and other dependents. These activities are commonly called housework, and the people who do it are usually called housewives. These terms effectively disguise the importance of the health work done in the home, but they also make an important point in linking personal health work to public health concerns. Caring for health is both about personal care — ensuring that people eat good food, are kept warm and clean, and so forth — and about providing a health-promoting material environment which facilitates the individual striving towards good health. As the sociologist Hilary Graham has put it: “Providing for health involves all the basic domestic activities we associate with the maintenance of a home. It involves the provision of a materially secure environment: warm, clean accommodation where both young and old can be protected against danger and disease . . . the purchase of food and the provision of a diet sufficient in quantity and quality to meet their nutritional needs . . . the provision of a social environment conducive to normal health and development . . . orchestrating social relations within the home . . . to minimize health-damaging insecurities.”

“NEW MAN” FAILED TO REACH MANHOOD
The point about social relations is an important one, to which I’ll return later. But first, I want to consider some of the ways in which this gender division of labour manifests itself both within and outside the home. We have all heard of the “new man”: the question is: does he really exist? Data on the domestic division of labour in British households in 1984 and 1987 do not indicate that things are moving fast in the direction of gender equality. In a study of adolescent health carried out in six London schools in 1990, 15 and 16 year olds had already established a clear gender-differentiated division in responsibility for household tasks (fig 1). Note particularly the column entitled “Making meals for others”. There was almost no difference between the frequency with which the young men and young women in this study made meals for themselves.

Gender and meanings of parenthood

<table>
<thead>
<tr>
<th>Mothers % (no)</th>
<th>Fathers % (no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed full time (30 h or more)</td>
<td>53 (29)</td>
</tr>
<tr>
<td>Fits employment round family</td>
<td>98 (49)</td>
</tr>
<tr>
<td>Fits family round employment</td>
<td>34 (16)</td>
</tr>
<tr>
<td>Conflict between role as parent and individual fulfilment</td>
<td>44 (24)</td>
</tr>
<tr>
<td>Mothers and fathers are different</td>
<td>82 (44)</td>
</tr>
<tr>
<td>Main responsibility for young person:</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>35 (19)</td>
</tr>
<tr>
<td>Father</td>
<td>6 (0)</td>
</tr>
<tr>
<td>Both</td>
<td>28 (15)</td>
</tr>
<tr>
<td>Negative feelings about young person leaving home</td>
<td>31 (16)</td>
</tr>
<tr>
<td>Worries a lot about young person</td>
<td>48 (26)</td>
</tr>
<tr>
<td>Influence over young person’s activities:</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>14 (6)</td>
</tr>
<tr>
<td>Some</td>
<td>63 (27)</td>
</tr>
<tr>
<td>A lot</td>
<td>23 (10)</td>
</tr>
</tbody>
</table>

Effect of young person on parental relationship:

| None | 54 (27) | 46 (13) |
| Positive | 8 (4) | 25 (7) |
| Negative/mixed | 38 (19) | 29 (8) |

Effect of parental relationship on young person:

| None | 38 (17) | 42 (11) |
| Positive | 7 (3) | 31 (8) |
| Negative/mixed | 56 (25) | 27 (7) |

Based on total of 55 mothers and 31 fathers; percentages are calculated on total numbers answering particular questions (Source: ref 4).
The healthy factors he drew included vitamins, weights, exercise machines, running and jogging, ambulances and hospitals, and healthy food. Another boy at the same school identified the following as unhealthy: sweets, smoking, fire, water (sometimes), tanks, car fumes, bombs, germs, factories, and John Major. The children's material environments affected their perceptions of health and ill health, as can be seen from the drawing in Fig 3 done by a girl in an urban school: moving from chips and drugs and chocolate and sweets and alcohol and pills to cars, suicide, diet, red meat, nuclear bombs, bedsits, police, stupid doctors and – yes – John Major again.

These drawings can be analysed in many different ways, apart from the incidence of spelling mistakes. I am not here to talk about education but about health; however, at the risk of being unpopular among educationalists, I shall note that schools, teachers, and school dinners cropped up fairly often as bad for health. The identification of schools as health damaging environments is confirmed by other work which has looked at children's perspectives on health and education. One interesting point which emerges from the children's drawings is the tendency for the health services to turn up as both good for health and bad for it. A second conclusion would reasonably be that these children have a fairly sophisticated knowledge of the common health education messages. They know that a poor diet, drugs, smoking, and drinking are bad for health. They know that exercise and a good diet are good for health. But thirdly – and this is the conclusion I want to draw for the purposes of my talk this evening – what is notable is the lack of distinction in many of the drawings between individual lifestyle factors on the one hand, and material/environmental factors on the other. It is here, however, that we notice a gender difference: boys are more likely to focus on individual lifestyle factors and girls are more likely to combine these with aspects of the wider environment, from homelessness to nuclear war.

Other data from these two studies help to answer the question: what do men and women worry about? Young men are more likely to worry about unemployment, while young women go for AIDS, cancer, death, and nuclear war. These worries are related to health: more young women than young men think that AIDS will affect their future health; other important factors are what's happening to the ozone layer, the use of chemicals in food, and nuclear war. Young men seem to be more concerned with traffic. When it comes to what teenagers consider to be the most important things in life, these are mainly job security and health for young men, whereas young women pick out happiness, a happy family, friends, and love.

I want next to try to move on from all these "soft" data to the "harder" epidemiological concern about the links between socially supportive relationships on the one hand, and the broad picture of health and illness, on the other.

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Figure 2 Children's beliefs about healthy factors in daily life: drawing by a 10 year old boy in an inner city school. (Source: reference 4.)

Figure 3 Children's beliefs about unhealthy factors in daily life: drawing by a 10 year old girl in an urban school. (Source: reference 4.)

The table shows data from the same study relating to the parents of the young people in question. Mothers, compared with fathers, are far more likely to fit their employment round the needs of their families. They are also much more likely to worry about their children. Like women's greater share of health care work, otherwise known as housework, their tendency to worry about health, like Eve in the Garden of Eden, starts young. As teenagers, girls are considerably more likely than boys to worry about health.
Friends for life?
In a study of Nazi concentration camp survivors, the people who had most problems recovering from their ordeal were those who were moved from camp to camp during the war; those who stayed in the same camp did better.11 A study of mice showed that mice placed in a conflict situation were more likely to develop hypertension when strange mice than with their litter mates.12 Researchers looking at the growth of barley seeds demonstrated that seeds watered from a beaker which had been held for 15 minutes by a healer grew faster and taller than seeds watered with a more standard method.13 In Alameda County, California, part of a State Health Department Human Population Laboratory study, people who lacked social and community ties were two to three times more likely to have died between initial data collection and a nine year follow up.14 These disparate examples all come from the same body of literature, one which has burgeoned enormously over the last 20 years - the study of the links between social support and health. Lisa Berkman, the American epidemiologist who has specialised in this field, had this to say about it in a review published in 1984:

"From shopping bags in California bearing 'Friends make good medicine' to editorials in the Journal of the American Medical Association, 'A friend, Not an Apple a Day will Help Keep the Doctor Away', the message is that social support is both good preventive and curative medicine. Like chicken soup, its powers are believed to be pervasive, the reasons for its effects are unknown, and knowledge of its qualities is widespread and based on folk wisdom... From interactions among mice litter mates to collegiality among university graduates evidence has been garnered to support the notion that social ties are related to good health and well-being".15

We now have good evidence that people who have close social relationships with other people have better physical and mental health.16 The obvious rejoinder, that both good health and close social relationships are due to some other factor such as material advantage or better past health, does not explain this link. For example, in the Alameda County Study, the relationship between lower mortality and high social support held independently of previous physical health status, social class, smoking, alcohol use, level of physical activity, obesity, ethnicity, life satisfaction and use of preventive health services.14 A number of prospective studies show that the extent to which people are embedded in socially supportive relationships and networks is a strong predictor of health and mortality, and of life versus death. Two examples of this link from the reproductive field are the well known work of Marshall Klaus and colleagues in the US showing the impact of social support in labour on health outcomes for mothers and babies,17 and the findings from a controlled trial of social support during pregnancy I carried out with colleagues in 1985-9.18 In this study, there was improvement in a range of health outcomes among women offered social support during pregnancy and their babies. These included both physical and psychosocial outcomes.

NEVER MARRY A MAN
The social support in both these cases was provided by women. There is a large body of evidence suggesting that social relationships with women are more health-promoting than social relationships with men.19 Thus, marriage is generally better for men's than for women's health because men are married to women whereas women are married to men. Women generally benefit more from relationships with friends and relatives, which run predominantly along same-sex lines. When married men are asked in whom they confide, the answer is their wives, whereas married women asked the same question give a different answer: friends.20 Research gives us some pointers as to why this should be so. For example, men tend to define intimacy as "doing things together" whereas women tend to define it in terms of talking and listening.21 Women disclose more than men do in close social relationships.22 In surveys of help-seeking behaviour, women are more likely to be mentioned as helpers.23

HEALTH SERVICES MAY NOT IMPROVE HEALTH
One of the research studies in which I've been involved recently is a re-analysis of data from our social support study as part of an Economic and Social Research Council (ESRC) initiative on what the council somewhat misleadingly terms "personal welfare" (the renaming under Thatcher of the ESRC which used to be the Social Science Research Council was accompanied by the banning of unfashionable terminology to do with public or more social forms of welfare). In this re-analysis we have attempted to quantify the effects of different types of social support on health, and to compare the role of social support with the role of the health services. On reflection, this was a pretty silly thing to try to do, as it was bound to take us into sticky and even more unfashionable waters. It did. What we found is summarised in fig 4,23 a tendency for social support to improve health and for health service use to have the opposite effect. I have no doubt that the highlighting of health service use as not
automatically health-promoting may be regarded as controversial. We were somewhat surprised by it ourselves. However, when you place it in the context of the health needs of this particular population (pregnant women and mothers of young children), and view it in the light of what we already know about user satisfaction in these groups, it ceases to be so surprising. The common complaints of lack of continuity of care, long waiting times, and other practical difficulties, and "ritual" medical encounters with unsympathetic health professionals hardly add up to a recipe for health. The relevance of the health services to the promotion of the public health is the fundamental question here.

Going back to the analysis of the social support and pregnancy study data, when we looked at where the social support came from, the three sources most related to health outcomes were the women's own mothers, their friends, and the research midwife. Figure 5 shows the relationships between different types of life events and women's psychological health six weeks and one year after childbirth. Again, we have controlled for previous health problems and for social class. Most types of life event have a negative effect on women's health. At six weeks, the category of life events most strongly related to the mothers' psychological health was associated either with the relationship with the partner or with events in his life. For example, women who had problems with their partners were three times more likely to have poor rather than good psychological health.

**Does caring for health do women any good?**

Differences between men and women in mortality and morbidity exist in all developed countries. It's a familiar pattern: women have lower death rates than men at virtually every age and for most causes of death. But despite this advantage in mortality, they have higher rates of non-fatal acute and chronic conditions, and experience more illness diversity than men: they also have higher rates of service use. The sex difference is especially marked for indices of mental well-being. It is a consistent finding of epidemiological research that women experience higher rates of psychological distress and depression than men. Various explanations have been offered for this female specialisation in poor quality of life: the three main ones are (1) that it's women's biology that makes them ill, (2) that it's their social roles, and (3) that they aren't really ill at all, they're only inventing it.

While there is little evidence for the first hypothesis, there is a good deal in favour of the second. Poor emotional well-being in married women compared with other gender and marital states, for example, emerges as a consistent finding in much of the literature. The sex difference is heightened when non-employed married women are compared with all other categories.

The "artefactual" explanation – that women make up their symptoms – is an interesting one, and this is not the place to discuss it in detail. We live in a culture with a long tradition of discounting women's experiences as unimportant. Unsurprisingly, this is reflected in strategies for researching health. For example, tiredness or fatigue, a symptom much more frequently reported by women than by men, is conceptualised in much of the research literature as a psychological rather than a physical symptom. If you redefine it as a physical symptom, then women's health is worse than men's controlling for social class, household income, marital status, and relationship to paid work. What this analysis suggests is that it is women's worse physical health that leads to the gender differences in mental health, and not the other way around; women feel sick because they are sick.

An interesting analysis by Lois Verbrugge, who has been much occupied professionally by the puzzle of these gender differences, shows that the strongest risk factors for poor health status are also those which show the greatest gender differences. This analysis, which used data from a large study carried out in Detroit, also showed that if these risk factors (which included such items as non-employment, role stress, and low mastery) are controlled for, the overall differences in morbidity by gender are substantially narrowed.

**PHYSICAL WORK AND CARING AS FACTORS IN POORER HEALTH**

There are two gender differences in daily life that underlie this finding of women's poorer health. One is the physical burden of work associated with women's domestic roles, and the other is the physical and psychological costs to women of being the ones who care. A reanalysis of General Household Survey data shows relationships between the extent of the domestic work-load and the reporting of physical symptoms. This is perhaps another
indicator of the importance of research in establishing the strength of common sense: working hard makes you tired and may damage your health in other ways. Another aspect of our cultural tradition which influences the way we conceptualise health and its links with the physical and social environment is our focus on the health hazards of work outside the home. In trying to understand what makes people sick we ignore the conditions of their domestic lives; yet it is these very conditions that form the physical context for much of women's primary health care work. Working conditions in the home may be more dangerous than those in the public domain.32 The Italian social scientist Patrizia Romito has shown how the hazards of women's domestic roles are systematically ignored in the literature and medical practices relating to risk and pregnancy outcome. Full time housewives have worse pregnancy outcomes than women employed outside the home, controlling for the "healthy worker" effect.

RISKS ASSOCIATED WITH "WOMEN'S" WORK
Romito also demonstrates that the conditions of women's work more generally pose important risks that are often not taken into account. For example, one traditional feminine activity is that of nursing. Nurses have high rates of preterm and low birthweight babies, and their work involves them in tasks whose links with these outcomes are well known: standing for long periods, lifting and moving heavy loads, the strain of night shifts. Moreover, nurses, like anaesthetists and radiologists - also predominantly female occupations - are exposed to directly teratogenic risks. "Protective" labour legislation can control these hazards to some extent. But a double standard operates. For example, women in the United States are not allowed to work in industries involving contact with lead, but the exclusion is limited to heavy industries where salaries are relatively high. Women are not excluded from light industrial work involving lead such as ceramics where salaries are much lower, and a higher proportion of the workers are women.33

LIVING CONDITIONS AND HEALTH
The ways in which working and living circumstances damage health, of course, been known for many years. Whenever parents of young children are interviewed about their child health work, for instance, the significance of physical features of the home and its environment emerge as absolutely crucial. In a study conducted by Berry Mayall in London several years ago in which mothers of under 3s were interviewed about how they kept their children healthy, a third of working class mothers identified aspects of housing they were powerless to alter (such as badly placed doors in rented property, steep stairs, and non-childproof windows) as major dangers to their children's health.34 Parental concerns about the links between damp housing and respiratory illness in children prompted a survey in Glasgow which did, indeed, establish a connection.35

Poverty and its impact on health represent another unfashionable subject. Here the links between class and gender inequalities are close: widening class inequalities in health are associated with increasing gender differences, as demographic trends establish women and children as the single largest and fastest growing poverty group.36 This means that a growing proportion of women's health care work in the home is accomplished in conditions of poverty. I want to say a little bit about caring in conditions of material constraint before trying to bring all the various themes I've mentioned together in the form of conclusions about agendas for public health work.

CIGARETTES – THE STRESSED CARER'S FRIENDS
One of the things women do when they're trying to look after other people in difficult circumstances is that they smoke. Smoking is increasingly a marker for poverty, and it is increasingly women, and not men, who are taking up and continuing the smoking habit.37 There is no evidence that women smoke out of ignorance about its health effects. On the contrary, most are sharply aware that smoking is bad for them. The point is that their smoking is "good" for the people they have to look after - young children, difficult adolescents, demanding husbands, elderly relatives. Smoking provides a strategy for calming the nerves and coping with stress, a fact that is sometimes literally expressed in the metaphor of the smoke ring: the young overburdened socially disadvantaged mother of two or three children securing a break from her maternal work by sitting down, having a cigarette, and retiring for a moment to the world inside the smoke ring where she can find enough energy to carry on.38 Women's smoking is intimately related to social deprivation, stress, and disadvantage.39 As one mother in our social support study said:40

"I tried to give up, but I get so as I want to kill everybody. I don't think it's worth it at the moment ... at the hospital, they have asked me again if I smoke ... The doctor at the clinic, he said I should really give it up. He was the same doctor I had last time. I felt so sorry for him. I couldn't give up. I told him I would cut down ... If I'd gone back and he'd said, 'Have you?' I would have said, 'Yes' ... you don't want to hurt their feelings, do you?"

Note this woman's sensitivity to the doctor's feelings. Being aware of other people's feelings may mean that you give them inaccurate information: this has implications for the research base of public health. In this study we compared the information about smoking rates provided by the same women to health professionals in hospital, to researchers in an interview, and in a postal questionnaire, and found the highest smoking rates reported in the postal questionnaire.41

Gender, social relations, and the public health
There is nothing biologically inevitable about the gender differences I've been discussing. All
the evidence is that these result from an unequal pattern of socialisation in which girls are sensitised to the need to care for others and boys are given the message that real men don’t care. Real men also don’t do housework, and studies of gender differences among children and adults in household work show that women do most, followed by girls, followed by boys, followed by men. We live in a culture which holds up certain images of family life and of femininity and masculinity as ideal; yet there is much weighty evidence showing the strains these ideal formulas impose.

So to sum all this up: the first point is a conceptual one. In carrying the cultural division between the private and public domains – the world of the home and the world outside it – into the field of health, those whose professional concerns are with researching or promoting health are committing a basic error. Health care work isn’t only done by those who are paid to do it – doctors, nurses, health visitors, health educators. Most of it is done by people who aren’t paid at all. This health care division of labour is fundamental to the public health. Underlying what we might call invisible health care work is a different and more accurate model of how health is “really” produced: one which combines caring – social support in technical language – and the more usual physical-technical strategies.

THE IMPORTANCE OF CARING

Thus, a second point concerns the best way to promote health. Health is most effectively promoted in the context of caring relationships. It is when people feel cared for and cared about that they are most likely to feel well. There is an important lesson here for the health services. Historically speaking, the evolution of high technology services has been at the cost of caring services. It is not impossible for a health care system to provide high technology care in a caring way, but this will only happen when the provision of care in the generic sense is recognised to be a legitimate and primary goal shaping the form the health services take. This means that an important task ahead for those concerned with the public health is a radical look at what health services actually achieve, beyond the rhetoric which equates them automatically with health promotion. As Jane Lewis has shown in her history of the development of community medicine, public health medicine became progressively alienated from its wider environmental function in the UK from late 1940s on. Public health gain came to be equated increasingly with counts of service provision – numbers of hospital beds provided, of children inspected. Under the new NHS in 1993 there is a real impetus to re-evaluate the role of the health services, though driven by economic cost-cutting motives rather than by a rational philosophy of health promotion. It will be essential in future to ensure that economic costs and benefits are not the only criteria used in reshaping services for health, and that these do not develop so as to inflate the health-damaging gender divisions I’ve talked about.

TOWARDS EQUALITY

Thirdly, one important means of improving the public health would be to dissolve the socially imposed differences between the life-chances of men and women. Specifically, the same need as was expressed in the early 1900s and the early 1970s (the two most recent periods of feminist activity) to improve the social and economic position of women still holds. Housework, well paid employment work, caring, and poverty ought to be more equally distributed between the sexes than they are now.

EDUCATING THE HEALTH CARE EDUCATORS

Fourthly, much of the rhetoric today is about educating people about health in order to lessen the burden on the health services of morbidity due to unhealthy lifestyles. Women are the prime targets of these health education messages. I would suggest on the basis of the evidence I’ve presented to you that the health education message ought to be the other way around: it is the health educators who need educating about what women as primary health care workers themselves know about health. The broader point here is one about the importance of daily, lifelong experience and the knowledge derived from this in contrast to the professionalised agendas of the various groups of experts we have put in charge of life in modern industrialised societies. Some years ago, the science fiction writer Ursula LeGuin wrote a short essay called The Space Crone. In this she considers what might happen when a space ship arrives from some other planet and the captain says there is room for one passenger from earth, a passenger who can convey to the natives of his own planet the essence of the experience of life on earth. “I suppose,” says LeGuin, “what most people would want to do is provide them with a fine, bright, brave young man, highly educated and in peak physical condition. A Russian cosmonaut would be ideal (American astronauts are mostly too old). There would surely be hundreds, thousands of volunteers... But I would not pick any of them...” says LeGuin:

“What I would do is go down to the local Woolworth’s, or the local village marketplace, and pick an old woman, over sixty... Her hair would not be red or blonde or lustrous dark, her skin would not be dewy fresh, she would not have the secret of eternal youth... She has worked hard at small, unimportant jobs all her life, jobs like cooking, cleaning, bringing up kids... The trouble is, she will be very reluctant to volunteer... You ought to send one of those scientist men... Maybe Dr Kissinger should go?... ‘Me?’ she’ll say, just a trifle slyly. ‘But I never did anything’... But it won’t wash. She knows though she won’t admit it, that Dr Kissinger has not gone and will never go where she has gone, that the scientists... have not done what she has done. Into the space ship, Granny.”

10 Mayall B. Keeping healthy at home and at school: it's my body so it's my job. Sociology of Health and Illness 1993;15:469-871.