8. "The best thing since wearing boots:" Working-Class Health Culture after 1948

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INTRODUCTION:
DEPRESSION, WAR, AND PEACE

After World War II, traditional working-class health culture faded and a national culture regarding conceptualization and management of health and illness developed in Britain. This transition is associated with the introduction of the National Health Service in 1948. However, I argue that, like that legislation, alterations in working-class health behavior and beliefs were evolutionary rather than revolutionary, fostered by earlier social policies and programs, and nurtured by public education and the popular media. Changes that can clearly be observed after 1948 have roots particularly in the interwar years, which served as a watershed for the transformation of formal health care delivery and the hegemonic development of professional medicine’s cultural authority among working-class people in Barrow, Lancaster, and Preston. They also stem from wartime policies and social developments that increased working-class utilization of official health services, undermined the previous multitiered delivery system, and encouraged the collective expectation that after the shared agony and challenge of war, a new Britain would shed some of its former inequalities—including those associated with health and medical care.

As we have seen, the 1920s and ’30s witnessed significant expansion of formal health services in the study cities, including maternity and child welfare clinics, school medical and dental care, and provision of hospital beds for a widening range of conditions (e.g., tuberculosis, tonsillectomy, and childbirth) and individuals (e.g., children and pregnant women). At the same time, a growing number of wage earners were covered by National Health Insurance (NHI) for services from general practitioners (GPs), and
hospital prepayment “schemes” provided low-cost or free in- and outpatient care to rising numbers of working-class people, including women and children. Furthermore, admission to isolation hospitals, recommended and sometimes enforced by local health authorities, made hospitalization an increasingly familiar and expected experience for working-class children.

Accompanying proliferation of and easing access to formal health services was escalating pressure to use those services. In the era of social medicine and advocacy for health citizenship, some of this pressure was policy-driven and supported by public revenues; both school and local authority health care provision, initiated before World War I, expanded after 1918.1 Schoolchildren were examined by doctors and nurses; sent to dentists, physicians, public health clinics, and open-air schools for treatment; and taught about germs, personal hygiene, and the importance of professional medical attention. Mothers of infants and ailing schoolchildren received mandated visits and recommendations from health visitors; those recommendations often included the instruction to consult the “family doctor.” At the same time, infant welfare clinics wooed mothers by offering cheap or free milk and other supplies along with professional advice about child care. As we have seen, these services were not universally popular, but they did become routine aspects of working-class life in Barrow, Lancaster, and Preston.

More subtle pressure to use formal health services came from the popular media. Box-office films, which were especially popular with working-class audiences, glamorized white-uniformed doctors and nurses and endowed their endeavors with dramatic urgency and altruism. Radio programs broadcast advice based on current biomedical knowledge, “keep fit” routines, and medical dramas into millions of working-class homes. Through advertisements, advice columns, and stories, popular magazines targeting working-class readers straddled these approaches, offering both information from “experts” and entertainment glorifying professional medicine. And health-related organizations ranging from the British Medical Association and the Central Council for Health Education to the Empire Marketing Board and the British Social Hygiene Council used propaganda approaches borrowed from the popular media and advertising, including posters, magazine articles, films, and public events, to change working-class behavior and attitudes regarding health, illness, and medicine.

Paralleling the enthusiasm for “modern medicine” projected by such material was repudiation of “old wives’ tales,” which encompassed the

information and advice these tales contained as well as the tellers—the informal working-class health authorities whose knowledge and techniques were marginalized, invalidated, and ultimately demonized. Indeed, regardless of whether traditional health lore “worked,” through the social class and professional power dynamics identified by Beverley Skeggs, by the mid-twentieth century this lore had become non-knowledge and its purveyors tinged with suspicion of dirt, vice, and illegal activities.² At the same time, information provided by medical experts—regardless of ongoing changes and contradictions in that information or, indeed, whether it proved to be right, wrong, effective, or dangerous—because of its association with science and professional authority became the only valid knowledge regarding a widening range of human activities and experiences.

Despite powerful pressure in the 1920s and ‘30s for working-class people to alter their traditional ways of preventing illness and managing birth, disability, and death, the oral evidence shows that those ways survived and were usual in most working-class households in Barrow, Lancaster, and Preston until World War II. “Doctor’s medicine,” although increasingly sought or experienced for reasons explored in chapter 3, remained either a luxury or an unpleasant necessity. Women, mainly without formal medical training, continued to manage health events in dwellings and neighborhoods using traditional knowledge and home- and over-the-counter remedies. How can we account for this survival?

One contributing factor was the economic downturn that followed World War I and lingered until the late 1930s. The cotton and shipbuilding industries of Preston and Barrow were particularly affected. According to Elizabeth Roberts, “Unemployment was a serious problem in the interwar years, especially in Barrow where 49 percent of the insured workers were unemployed in 1922, and in Preston, where 27 percent were unemployed in 1931.”³ Indeed, between 1921 and 1931, Barrow’s population dropped by 16.2 percent as residents left to seek work elsewhere.⁴ Even in Lancaster, where oilcloth, linoleum, and services provided a more stable employment base, hours and wages were cut, and unemployment rose.⁵ Regardless, then, of the general improvement during this period in work-

². For example, both Dr. Armstrong of Lancaster (born 1918) and Mrs. Jenkins (born in Barrow 1932) remembered babies’ “wind” (gas) being relieved by cinder tea made of the ashes from the fire, despite their recognition that this technique, used by “Granny,” was outdated. See chapter 6, n145. Chapter 5 explored the memories that oral history informants had of stereotypical criminal backstreet abortionists, who were perhaps the quintessentially demonized old wives. Regarding knowledge, social class, gender, and legitimacy of knowledge, see Beverley Skeggs, Formations of class and gender (London: Sage Publications, 1997), 19–20.
⁴. Roberts, A woman’s place, 181.
⁵. See, for example, Lancaster MOH Report, 1925, 9–10.
ing-class lifestyles, housing, and health that has been observed by many scholars, the oral history evidence records memories of comparative want and widespread exercise of the traditional skill of making the best of very little. Furthermore, it is clear that women, always both the health care and budget decision-makers and the least advantaged regarding resource distribution in working-class homes, experienced disproportionately high levels of need when work and wages declined.

Economic insecurity fostered continued reliance on neighborhood mutual aid, which for many was a preferable alternative to the financial and medical support available through means-tested public assistance. While, as chapter 2 indicates, neighbors and relatives did not always help each other, tradition favored this type of support, which was especially requested and given during times of ill-health. And informal assistance was both less expensive than care from a general practitioner and less stigmatized than medical attention provided via the Poor Law Guardians or later local welfare authorities. Even maternity and child health clinics were considered by some to be part of the same operation as the former Poor Law infirmaries; therefore, respectable working-class people avoided the stain of pauperization that clung to use of such facilities and preferred to depend on relatives, neighbors, and informal home care. While the more prosperous increasingly consulted physicians, went to hospitals, and took advice from public health professionals, poorer families continued to deal with health matters traditionally. Thus, the Depression arguably delayed the transformation of working-class health culture.

However, after 1939, with the dislocation of peacetime society coupled with enhanced governmental involvement in daily life—including health care provision—working-class utilization of formal health services grew. In the course of planning for civilian and military casualties, Britain’s hospitals were nationalized and regionalized. This brought to an end older categories of hospitals—voluntary, Poor Law, local authority—bringing them all under central governmental control, beginning expansion programs that would continue after the war, and eliminating barriers (such as required payment or the need for a “recommend” from an employer or governmental official) to working-class admission. Furthermore, policy-backed social services, from wartime nurseries to evacuation of children


from areas under direct military threat, ratcheted up working-class contact with official health care providers and advice. As a shared enterprise and experience, World War II brought the social classes together as, perhaps, never before. World War II generated consensus that change was necessary and possible—in matters of health and medicine as well as other quality-of-life issues.

**ESTABLISHMENT OF THE NATIONAL HEALTH SERVICE**

Articulating a local expression of the national consensus regarding need for post–World War II reconstruction, in 1945 Barrow’s Medical Officer of Health, A. R. Forrest, wrote: “One hopes that in the future post-war world that we shall see freedom from want, economic security for the family by full employment and adequate wages which will not require the mothers to work in industry, and better housing so that each family can have a decent home of their own in order to bring up their children.”

Oral history informants echoed Forrest’s hopes. Mr. Rollins, born in 1931 in Barrow, said his parents were very pleased with the new Labor government that came to power in 1945: “We are going to progress and everything is going to improve and everybody is going to be more or less equal.”

The National Health Service (NHS), initiated in 1948, by offering medical and public health services based on the latest biomedical science free at the point of use, was expected to eliminate disparities in access, service provision, and health status among Britain’s social classes.

As unexpectedly high initial utilization figures indicate, from its inception the NHS was popular with patients from all social backgrounds. The popular stereotype of an avalanche of demand for dentures and spectacles is borne out by statistics. According to Charles Webster, “During the first eight months of the new service, the rate of demand for the general dental service ran at about eight million cases a year, which was twice the expected level. One-third of the patients treated required dentures.” Similarly, in the same time period, “some five million people had their eyes tested and the public was supplied with no fewer than 8.3 million pairs of glasses.”

11. Mr. R3B, 50.
13. Ibid., 48–49. According to Brian Watkin, “By 1953, nearly 7 million people, or one in six of the population, were wearing a full set of dentures, nearly 6 million pairs of which had been issued under the NHS” (*The National Health Service: The first phase, 1948–1974 and after* [London: George Allen and Unwin, 1978], 32–33). Similarly, the cost of optical services was more than 20 times the original estimate: “By 1953, about 19.5 million people had been supplied with 26.1 million pairs of spectacles” (33). However, once the initial need was filled, demand for spectacles and dentures declined.
Oral history informants and scholars agree that the early and continued high demand for medical services revealed, not working-class greed and improvidence, but needs that had hitherto gone unmet. Mr. Boswell, born in 1920 in Barrow, observed:

People wanted their teeth out . . . and wanted a set of dentures, they just could not afford to buy them, so they had aching teeth . . . . Or somebody was ill, send for the doctor, you would get a bill. So they would go down to the chemist and make a bottle up or something like that, you know, and of course the result was that people snuffed it. They had diseases that could have been cured, but they went on too far, so the population was beset with illnesses . . . . And they could not afford to get them treated, so it was the best thing since wearing boots when that [the NHS] came on.14

Helen Jones argues that the NHS benefited working-class women in particular. “The full extent of women’s ill health had never before been revealed. One woman doctor who qualified on the day the NHS came into operation recalled women queuing with thyroid deficiency, gynecological problems, painful varicose veins, or with menopausal difficulties. The biggest increase in visits to the GP came from the elderly and from women aged up to thirty-five.”15

In addition to addressing unmet needs, the NHS undermined previous class- and financially based differences in the ways general practitioners treated private and “panel” patients. Margot Jeffreys grew up in a small town near London. Her middle-class family consulted a GP who “lived in an elegant house in the High Street. As private, paying, patients . . . we went in through the front door and waited to see him in a well-furnished sitting room . . . . Our doctor also had panel patients. They were mainly working-class men, entitled to consult him by virtue of their compulsory NHI payments. They used a side entrance to his house, and waited to see him on benches along a passageway.”16 As indicated in chapter 3, oral history informants remembered friendly society (“club”) and NHI panel patients receiving less respect and possibly a lower quality of care from GPs than private patients.17 Recounting her mother’s memories of consulting the doctor before the NHS, Mrs. Harrison, born in Preston in 1945, said, “Dr. Simpson . . . was a mean Scotsman. He used to make you wash your

14. Mr. B4B, 30. See also Mrs. B2B, 54; Mr. K1B, 13; Mr. P6B, 31; Mrs. P6B, 121; Mr. S7L, 74.
17. See, for example, Mr. M1B, 17; Mr. F2B, 7–8.
bandages and those sorts of things then.” When asked what her mother thought of the National Health Service, Mrs. Harrison responded, “Bevan was her hero, certainly. Yes, she thought it was wonderful, you know, after experiencing the meanness of doctors like Simpson and others, the discretionary treatment.” By contrast with the past, because most private patients elected to join NHS panels in 1948, such distinctions faded in the postwar period when “going to the doctor” or requesting a home visit became a universal working-class experience for the first time.

The National Health Service also eliminated the stigma attached to requesting or receiving care paid for by public assistance. As we have seen, only the very poor who lacked adequate support from relatives and neighbors sought or accepted admission to a workhouse infirmary or treatment from a doctor compensated by the Poor Law guardians. Such pauperization risked individual and family reputations, as well as generating shame over personal inability to meet the normative role expectations of working and meeting one’s needs and those of close family members. The vestiges of the Poor Law were swept away by the advent of what some have termed the “classic welfare state” of the 1940s. Health care provided by the NHS was universal, not means-tested, and funded by general taxation. Mr. Morten, born in 1927 in Barrow, said his family thought the NHS was “First class. They had worked hard for it.”

Mr. Kirby, born in Barrow in 1921, remembered, “People thought, ‘Well, at least we can afford to be ill now,’ whereas before they tended not to go to the doctor’s unless they had to because they had to pay, that was the simple thinking behind it. If you were paying a contribution towards it, you felt as though it was an insurance, really.”

Citizens accessed NHS services by right, and increasingly were judged more harshly for not using than for using them.

After 1948, working-class willingness to consult general practitioners and use hospitals for in- and outpatient treatment grew, while reliance on traditional ways of dealing with health and illness declined. Mr. Lodge, born in 1919 in Preston, commented:

You see, before the war, if you went to a doctor, you had to pay. You had to pay for that treatment, there was no free medicine. Now, when the Beveridge plan came in, it was free, so naturally you relied more or less on the doctors, than your own remedies. Mind you, it came sometimes, when you wouldn’t be bothered going, you’d say, “Oh, I’ll do what my mother did.” Same as if I couldn’t sleep at night for coughing, I’d boil

20. See, for example, Digby, British welfare policy, 6.
22. Mr. K1B, 13.
some milk and get a spoonful of treacle and put it in and stir it round, and drink it, that would ease it, and you’d sleep all night, you see. Things like that.  

Mrs. Owen’s only daughter was born in 1940. While continuing her close relationship with her own mother, who lived nearby, Mrs. Owen transferred her reliance in medical matters to her GP. She said, “If something happened to her [the child], I used to take her to the doctor’s and get the proper thing.” She tolerated her mother’s home remedies, allowing “Mum to goose grease her if she had a bad chest. I used to say, ‘That child’s got a bad chest,’ and out would come the jar of goose grease. An earthenware jar with a piece of brown paper with a rubber ring round, and she would come down and rub her back and front. In the end, I took her [daughter] to the doctor, and he gave me some antibiotics, and it cleared up in no time.” These accounts illustrate the extensive overlapping of traditional and “modern” health cultures, which straddled the introduction of the National Health Service. They also remind us that, as was true in the early twentieth century, working-class people were selective about the formal services they sought and accepted after 1948, and did not operate as an undifferentiated cohort. There were continuing differences between the “rough” and the “respectable,” the more and less prosperous, the old and the young. As Virginia Berridge observes, relatives (particularly mothers and daughters) continued to support each other in times of ill-health, and certain forms of traditional behavior, including self-medication, continued. Nonetheless, the oral history evidence reveals an important shift in normative attitudes and behavior.

Elizabeth Roberts argues that after World War II, “There was a strong feeling that professional services were better than those provided by well-meaning amateurs. Mothers of babies and small children particularly sought professional help. Increasingly, the advice of doctors and health visitors was preferred to that of older women in the family or neighborhood.” As Mrs. Owen suggested, people who had experienced traditional domestic and community management of illness as children made different choices within their adult households. When asked where he and his wife obtained medical advice for their own children, Mr. Norton, born in 1931 in Lancaster, said “the doctor”:

23. Mrs. L3P, 35.
24. Mrs. O1B, 58.
If Mum had called, we would ask, but basically, no, we talked to the doctor.

_Interviewer:_ Why was there this change?

_Informant:_ Because, I think, the world had changed, the responsibility levels had changed, knowledge had changed. The doctors had got a lot more knowledge and were a lot more available.27

Other informants reported a similar change—higher levels of consultation of doctors combined with reduced confidence in informal health authorities.

This shift paralleled dramatic changes in the effectiveness of medical intervention. It is arguable that the development and growth of public health services before 1948 stemmed in part from comparative clinical helplessness, when prevention was regarded as the more powerful alternative. After 1948, with development of a growing range of successful interventions—from antibacterial and psychoactive drugs to increasingly ambitious surgeries and use of new technologies—despite institutionalization of social medicine, the policy focus shifted to treatment, with a special emphasis on medical specialists and the hospitals in which they were based.28 The hospitals and specialist consultants, and, to a lesser degree, the primary care services involving “independent contractors” (general practitioners, dentists, opticians, and pharmacists), attracted the lion’s share of public attention and resources. Although local-authority public health services continued and successfully administered immunization, midwifery, home visiting, social work, and family planning services, their status and influence declined from the high point of the 1930s. When working-class informants talked about “modern medicine,” they were more likely to mention clinical interventions than prevention and to refer to “doctors,” who were gatekeepers for the miraculous cures of the brave new postwar world.

After 1948, most health care moved from homes to offices, clinics, or hospitals. Although GPs continued to make house calls and until the 1970s a declining but significant percentage of Barrow, Lancaster, and Preston births occurred at home, the balance shifted in favor of institutional attention—whether for well care, diagnosis, monitoring (of a pregnancy or chronic condition), intervention, or nursing. This transition accompanied a change in the power dynamics of the relationship between patients and their families, on the one hand, and professional care providers, on the other. When most treatment and care took place in the home, although the GP, MOH, health visitor, qualified midwife, or district nurse might carry

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27. Mr. N2L, 58.

28. Webster, _The National Health Service_, 39. Regarding institutionalization of social medicine, see Dorothy Porter, “From social structure to social behavior.”
the weight of social class, professional, or official authority, patients and family members had significant control of the situation. They admitted or denied entry to the care provider, took or did not take medical advice, and followed or did not follow “orders.” The home environment was as much a part of the care provider’s culture as it was part of the patient’s; providers expected to work in private homes with patients and their families to achieve a variety of goals, including compliance, cure or amelioration of the condition occasioning the visit, and (sometimes) payment for services rendered.

By contrast, in offices, clinics, and hospitals, medical professionals were firmly in charge of interactions with patients, who were expected to defer to official authorities and comply with institutional rules. These rules quickly undermined traditional roles and relationships during times of ill-health: for example, mothers had access to hospitalized children only at the ward sister’s discretion, and fathers were not allowed to hold their newborn infants. Institutional environments contributed to the mushrooming cultural authority of professional medicine, which became spatially distant from sufferers’ home and neighborhood environments, and figuratively distant from lay knowledge and understanding.29 As health care moved to institutions, homes and laypeople became both unfit to provide it and increasingly dependant on occupational experts. Nonetheless, because of continuing social class distance from medical professionals, in the post–World War II era, working-class people were more deferent and less able to assert their own needs or question medical authority than their middle- and upper-class counterparts.

With hindsight, it is clear that inequalities in health and access to health services persisted after the introduction of the NHS.30 Furthermore, while life expectancy improved and death rates declined in the generation after 1948, these advances were slower than in the years before World War II and lagged behind those of many other European countries.31 This evidence indicates that the NHS did not accomplish the utopian goals its advocates set for it. However, it did complete the long process of cementing working-class “buy-in” to biomedicine and the formal health care delivery system. Because its services were universal and, with the exception of small fees charged for some services beginning in 1951, free at the point of use, the NHS converted professional treatment from a luxury (or quasi-punitive requirement) to a necessary, routine element of daily life. As a result of its philosophical and cultural distance from welfare, the NHS reduced barri-
ers to use of affordable medical services. Working-class women, continuing in their roles as family health care decision-makers, became enthusiastic patrons of the National Health Service, within a generation dropping their traditional positions as diagnosticians, makers and administrators of remedies, skilled nurses, and officiators at birth- and deathbeds.

MODERN LIFE, RESPECTABILITY, AND WORKING-CLASS HEALTH CULTURE

After World War II, social class remained an important component of identity, opportunity, health, and longevity in Britain. Class distinctions survive; people still identify themselves as working-class, however difficult it may be to define what that means. However, I will argue here that postwar changes in working-class standards of living, neighborhoods, access to a publicly provided social safety net, and consumption of popular media significantly influenced the ways people thought about and dealt with health and illness, contributing to decline of traditional working-class ways of managing ill-health and development of a national health culture.

Perhaps the most important contribution to working-class living standards was the transformation of housing that escalated with construction of local authority council houses and demolition of “slums” after World War I, and continued after World War II. For example, in 1964 Preston’s Medical Officer of Health reported that over 6,000 unfit houses had been eliminated in the postwar period. New housing updated standards and expectations regarding amenities, including private indoor sources of cold and hot water; private indoor toilets; plumbed-in baths; and domestic electricity and gas supplies for lighting, heating, and appliances. Council housing incorporated and projected these new standards, making them affordable for a growing number of working-class people. According to Alison Ravetz, “At its peak around 1975 council housing supplied nearly a third of the nation’s housing stock and (since it was primarily for families with children) the homes of something more than a third of the population.”

Built on the outskirts of towns, council estates were intended to

facilitate working-class moral and physical health by substituting light, space, and modern appointments for the poor sanitation, darkness, and crowding thought to breed disease and vice in old inner-city neighborhoods. Private home construction paralleled development of council housing, expanding owner occupation among all social classes. John Burnett points out, “In 1945 only 26 percent of all houses in England and Wales were owner-occupied; by 1966, the proportion was 47 per cent, and in 1983 63 per cent.”

Changes in housing paralleled changes in employment and income. After the war, working-class employment began its long shift from manufacturing to services. This change reduced the concentration of working-class wage earners in factories—often located within walking distance from where the workers lived—thus undermining the generations-old link between workplace, neighborhood, and household. Preston was particularly affected, with the cotton textile industry, after a brief postwar revival, shuddering to a halt by the late 1960s when “its era as a mill town was over.”

Lancaster’s more diversified factories, which boomed for twenty years after the war, began to contract and close in the late 1960s, while Barrow’s workforce continued to be disproportionately employed by Vickers’s shipyards throughout the study period. The shift toward nonfactory jobs did not damage working-class incomes overall. Indeed, nationwide the incomes of manual workers rose considerably during the twentieth century—over 400 percent between 1900 and 1981. Thus, in the second half of the twentieth century, working-class people could afford better housing and pay for the transportation required to commute longer distances to work.

With the dismembering of old neighborhoods by “slum clearance,” factory closures, council estate construction, and family mobility, traditional neighborhood relationships broke down. Many oral history informants remembered positive aspects of moving to better dwellings. For example, Mrs. Boyle was born in 1936 in a two-up-two-down rented house in Preston. When she was 16, the family moved to a council house on Preston’s Larches Estate, “which were like a palace then really, to us. Because it had three bedrooms, a back garden, a front garden, a hallway, a big kitchen, a wash-house, a big living room. Bathroom. We thought it were great.”

Similarly, Mrs. Hunter, born in Preston in 1931, said:

37. Burnett, Social history of housing, 282.
41. Mrs. B11P, 7. See also Mr. G6P, 2; Mrs. Y1L, 5, 7.
My first house I remember was a council house, which we apparently moved into when I was about one. . . . Well to me it was great, far superior to the houses of my friends, because they had the old-fashioned houses. One particular friend didn’t even have electricity, she went to bed with a candle. But we had three bedrooms and hot and cold water. We had a bathroom downstairs which was rather unusual and I don’t think we really liked. A little garden at the front and a big one at the back.

*Interviewer:* And at that point how big a family were you?

*Informant:* Just my mum and dad, and elder brother and myself.

The family had moved from a house that had been condemned.42

However, informants also recalled negative aspects of moving to council housing. Although the houses themselves were indisputably better than antiquated, bug-infested terraced homes, people missed the social closeness of traditional neighborhoods. In the 1950s and early ’60s, Mr. and Mrs. Boyle lived in a small house on a run-down Preston Street. Mr. Boyle said of his wife, “No, if you asked her could she go back to when we were first married, to when we were in that two-up and two-down in Allen Street, bugs dropping off the ceiling and one thing and another, she would go back to that tomorrow.” When the interviewer asked Mrs. Boyle, “Would you?” she replied, “Yes, to the neighbors.” She went on to recall mutual aid in her traditional neighborhood:

But like if you was ill or anything like that, you know they would come and help you, and it were good. They would take one another’s children to school for you, my mother would end up taking us to the park, but we would end up taking about twelve of us. Everybody joined in, do you know what I mean? Not like today, although we used to fight and fall out, but don’t get me wrong, because kids won’t be kids unless they did, but you could play together and nobody seemed any better than anybody, you know, nobody were upper-class. But nobody thought themselves any better than anybody, you know.43

Normative mutual aid was a casualty of the dissolution of older neighborhoods. With higher wages and the social safety net created by the post-1948 welfare state, the help of neighbors was neither needed nor trusted; instead, increasingly prosperous working-class women “kept themselves to themselves” and depended on professionals for expert assistance.44

Therefore, there was declining emphasis on family respectability to

42. Mrs. H3P, 1.
43. Mrs. B11P, 14–15. See also Mr. M7P, 19.
44. See, for example, Judy Giles, *Women, identity and private life in Britain, 1900–50* (New York: St. Martin’s Press, 1995), 101.
maintain access to neighborhood mutual aid. This does not mean that reputation no longer mattered to working-class people after World War II. However, its components and goals changed form. Before World War II, respectability was based in part on housekeeping standards—donkey-stoned front steps, gleaming white lace curtains, black-leaded ranges. With limited resources, working-class people’s ability to keep a respectable home depended on their capacity to improvise creatively, to “make do and mend,” and to “make a penny do a pound’s work.”45 With growing prosperity, these capabilities became comparatively less important than using new purchasing power and “do-it-yourself” skills to represent family respectability through home appearance and contents.

From the 1950s, working-class people could afford a proliferating range of domestic consumer goods. Andrew Rosen reminds us that “in 1956 only 8 per cent of British households had refrigerators and as recently as the 1960s the majority of British households did not possess telephones or cars and only slightly more than half had washing machines.”46 Thus, there was plenty of scope for consumption, consumer objects were expensive and desirable, and they arguably became the currency of new measures for family reputations. Mr. Goodwin’s comments about the Preston council estate he grew up in during the 1950s and ’60s are illustrative:

Even though it was a corporation, council estate, it was nice. Everybody knew each other, the kids were all, you knew all the kids. It was a nice street, it was. And everybody kept the gardens nice, these days the council estates seem to have let things go, but there everybody kept—and they had a pride with their gardens. Well, we had to look after and mow the lawns and things like that. Yes, everything was in nice condition, yes.

Interviewer: Do you remember the neighbors popping in to see your mum or her popping in to see them?
Informant: Usually with talking over the fence, I don’t think they popped in.47

The well-kept garden, the three-piece suite (sofa and two armchairs), and (ultimately) the automobile, together with the endless housework that homemakers performed with additional consumer goods (and status symbols) such as the Hoover (still a generic term for vacuum cleaner in Britain) and twin-tub washing machine, increasingly signified family providence, hard work, and independence. After the war, working-class respectability was commodified.

45. See, for example, Roberts, A woman’s place, 128–29, 150–51.
47. Mr. G6P, 5.
Similarly, while keeping children clean and well-dressed remained a mark of family and maternal respectability, these endeavors were assisted and represented by purchase of goods including expensive prams, clothing, shoes, and toys. Responsible childcare was also signified by dependence on experts—doctors, health visitors, teachers, and others—to guide development, identify and forestall problems, and enhance parents’ (read “mothers’”) knowledge and skills.

Since the goals of working-class respectability no longer included accessing mutual aid, what had they become? This question is difficult to answer. Perhaps the need to maintain standards before the neighbors was vestigial, with no real current objective except to distinguish one’s family as “respectable,” as opposed to the stigmatized “rough” other. Perhaps the new commodified respectability was constructed by the same middle-class social reformers who designed council estates, child welfare clinics, and state comprehensive schools to re-engineer a working class in their own image—and, thus, the primary goal of respectability was pleasing those same experts. Alternatively, perhaps postwar changes in components and functions of working-class respectability, like changes in health culture, were part of the larger processes of deindustrialization, the blurring of class distinctions, and the development of a national culture.

This process was aided by universal primary and secondary education, which after 1947 required attendance up to age 15. Working-class children spent increasing time in classrooms where they were taught approved lessons about personal hygiene, sex, and homemaking. They also took science courses informed by developments in biomedicine. They were given milk, meals, emulsion, and physical training to support their health and prevent disease. Classroom teachers, school doctors, and nurses inspected them, identified physical and mental “deficiencies,” and referred them for treatment. Above all, teachers and medical professionals encountered at school represented expertise, authority, and modernity, in direct contrast to the comparative old-fashioned ignorance of students’ parents. School encouraged adoption of officially endorsed health behavior—whether it be hand-washing, acceptance of diagnostic x-rays and immunization, or consultation of physicians. Public education is probably an important reason that oral history informants born after about 1920 tended to remember experiencing traditional informal home-based care as children but using formal institutionally based care in their adult households.

Another influential factor in this transition was universal exposure to an expanding range of popular media. Chapter 7 explored working-class consumption of magazines, radio programs, and films with content that glamorized and encouraged people to use professional institutional medicine. In the postwar era, this consumption continued, enhanced by the advent of television, which provided both informational and fictional programming about health, illness, hospitals, and medical personnel. Ann Karpf
observes that TV medical documentaries portrayed doctors as “scientific wizards with formidable technical skills,” while medical dramas emphasized physicians’ surgical flair, razor-sharp intelligence, and “superlative aptitude for handling emotions.” Programs such as Emergency Ward 10 (1957–67) helped relieve popular anxieties about hospital treatment, while in the late 1960s Marcus Welby, M.D. exemplified the idealized family doctor dwelling in both British and American mythology. An “exotic curiosity” in 1950, within the next half-century the television became “a normal part of virtually every household,” and “doctor shows” helped shape national health culture.

That culture was characterized by automatic normative consultation of professional health care providers for virtually all matters related to health and illness and internalization of the “cultural authority” of the physician:

Patients consult physicians not just for advice, but first of all to find out whether they are “really” sick and what their symptoms mean. “What have I got, Doc?” they ask. “Is it serious?” Cultural authority, in this context, is antecedent to action. The authority to interpret signs and symptoms, to diagnose health or illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume. By shaping the patients’ understanding of their own experience, physicians create the conditions under which their advice seems appropriate.

By 1970, the end date of this study, routine dependence on professional medicine extended beyond experienced symptoms to symptom-free ills, such as hypertension or the early stages of many cancers, which required knowledge and technology. This dependence also involved ingesting (or administering to children) large amounts of prescribed medication, routine attendance at health care facilities, and hospital admission for an ever-expanding range of ills and therapies. For members of all social classes—particularly for working-class women—this dependence also involved relinquishing personal knowledge of, discretion regarding, or participation in the medical care of self or loved ones. By 1970 the ideal patient was the compliant patient illustrated in the comments of Mr. Thornbarrow, born in 1949: “No, we knew the doctors very well, we had had the family doctor from the early forties, and no, we didn’t have any home cures. . . . It was one of them families where what the doctor said, that was it. You know,


50. Starr, Social transformation, 14.
it wasn’t open for negotiation.” And, although 1970 arguably marked a turning point, when middle-class patients in particular began to be critical of professional medicine and to demand greater participation in health care decision-making, processes, and environments, working-class patients continued, in general, to be dependent on and deferent to medical authority.

This transition involves both gains and losses. It is difficult to argue a downside to the eradication of smallpox and polio and the improvement of longevity and quality of life resulting from widespread access to bypass surgery for circulatory diseases and insulin treatment for diabetes. It would be churlish to attack the dedication and altruism of the medical practitioners who deal and have dealt with working-class health problems and people with imagination and good humor. However, it is fair to observe that dependence on medical expertise has undermined the traditional role and confidence of working-class women as health care authorities in their homes and neighborhoods, as well as invalidating their knowledge. With increasing costs of and decreasing resources for formal health care services at the beginning of the twenty-first century, it is ironic that people of all social classes are now being urged to be more active participants in prevention and treatment of illness, as well as to care for the ailing at home. Thus, perhaps we are in the midst of a new transformation of health culture.

**IMPLICATIONS**

This book has been a case study, firmly located in a particular time and place, of a phenomenon that has occurred in all industrialized nations and is now happening worldwide. While it is about Barrow, Lancaster, and Preston, it belongs more firmly to the history of public health and medicine than it does to local history. However, its local evidence reminds us that the shift from traditional to biomedical conceptualization and management of health and ill-health happens at different times in different places and differently among women, men, and members of different social classes. Although this study has not dealt with issues of race and ethnicity, these identifiers also affect transitions in health culture.

In most circumstances, these transitions are stimulated and enforced from the top down. Reformers know what should be done and are prepared to make people change for their own good. In the process, reformers tend to identify the evil with the victim and to be comparatively blind and tone-deaf to the wider environmental, political, and cultural circumstances of the people they are trying to help. Current global struggles with AIDS, malaria, overpopulation, malnutrition, and other killers are powerful reminders that elite knowledge and strategies rarely result in progress

51. Mr. T4B, 78. See also Mrs. M12B, 71; Mrs. P3L, 49–50; Mrs. S3B, 71.
or happiness unless sufferers are engaged and invested in solutions. Furthermore, the desired conversion of populations to modern western medicine carries the twin burdens of loss of lay ability to prevent and manage ill-health, on the one hand, and demand that political elites and medical professionals meet proliferating health care needs, on the other.

Working-class experience in Barrow, Lancaster, and Preston also reminds us that health culture touches almost every aspect of life—from housing, diet, and play to dress, sex, and death. As a result of their own heritage and the types of source materials they employ, the histories of public health and medicine have tended to be ghettoized within their associated professions and institutions. This isolation has conferred ownership of these histories on professional medicine and public health and ignored the expertise and agency of the people whose health and illnesses have, after all, been the foci of both endeavors.

This book has not been about doctor-bashing, although some readers may experience it in that way. Indeed, physicians have been comparatively peripheral to this study—as sufferers and patients often are in histories of medicine and public health. It is not that professional medicine is unimportant in the history of health and illness but that it is just one of many factors involved in the universal experiences of suffering, healing, prevention, and caregiving. By looking through another lens of the telescope, this study attempts to provide alternative perspectives about these matters.