Citizenship, Rights, and Health Care

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Overview

- What is social citizenship?
- Is health care a basic right of citizenship? Is there a human right to health?
- Are health outcomes an effective measure of citizenship?

Citizenship is a collection of rights and obligations that regulates access to scarce resources. It also confers identity and expresses notions of civic virtue. Citizenship therefore demarcates the moral boundaries of society in terms of insiders and outsiders. This chapter argues that societies have to manage two contradictory pressures: scarcity and solidarity. Citizenship provides a form of secular solidarity as a response to social scarcities. The chapter develops a model of citizenship in order to explore health as a desirable, but scarce, resource in the context of political changes to the welfare state, including the rise of economic rationalism. It compares the social rights of citizenship and the individual rights of the United Nations Universal Declaration of Human Rights.

Key terms

capabilities approach  epidemiology  pluralism
capitalism    feminisation of poverty  rights
citizenship    Fordism  risk
class    gender  social capital
communism    Keynesianism  social closure
consumerism    neo-liberalism  social contract theory
cultural capital    market  social institutions
economic rationalism    patriarchy  state
Introduction

Human societies exist in the context of the impact of two contradictory social forces. First, they are confronted by systematic scarcities, which are produced by, and result in, exclusionary structures such as gender divisions, social classes, and generations. Second, they must also secure social solidarity in order to manage the social conflicts that are produced by scarcity. In the social sciences, these contradictory principles are described as the allocative and integrative requirements of social systems. The argument of this chapter is that health is a crucial example of a scarce resource (a good) and that, especially where social inequality is intensified by economic rationalism, social citizenship functions as a basis of social solidarity. It does so by alleviating the genetic legacy of disease and mitigating the social causes of illness. Health results from the adequate institutionalisation of the social rights of citizenship rather than from technical medical interventions. For example, because preventive health measures and social security measures improve the social environment of individuals, their health characteristics will also improve. The history of infections suggests that the health of populations improved as a result of improvements in the social environment before vaccination measures had a significant impact. This historical assertion that disease is a social product of poor housing, inadequate food, and low standards of education raises important policy questions about how a government should allocate funding between conventional medical practice and social policies that are designed to improve the social environment.

In modern sociology, there has been an extensive analysis of citizenship (Hoffman 2004; Isin & Wood 1999; Janoski 1998; Turner & Hamilton 1994). In this chapter, I discuss citizenship in terms of the legacy of T. H. Marshall (1893–1982), but I conclude by claiming that an adequate understanding of social rights in modern societies must go well beyond the Marshallian framework (Marshall 1950, 1981). Welfare citizenship is examined as a particular type of social right, and this chapter examines the sociology of health and illness from the perspective of welfare citizenship. More specifically, it provides an understanding of health issues in terms of the scarcity/solidarity distinction.

Models of citizenship

Citizenship is a collection of rights and obligations that gives individuals and social groups a formal legal identity. For example, citizens have a legal right to a passport and a legal obligation to pay taxes. These legal rights and obligations are constituted historically and sociologically as
social institutions (for example the jury system, parliaments, and welfare states). From a sociological point of view, we are interested in those social institutions that articulate the formal rights and obligations of individuals as members of a political community. Citizenship can be said to create the individual as a legal entity within the nation state. Figure 20.1 summarises the key components of contemporary citizenship.

This sociological approach is concerned with the social institutions of citizenship, including social identity, the nature of inequality, and access to socioeconomic resources. Sociologists attempt to understand how the institutions of citizenship protect individuals and groups from the negative consequences of the market in a capitalist society. This focus on the redistributive functions of citizenship institutions (the allocative processes) provides the basis for sociological approaches to questions about redistributive justice, as advocated by John Rawls (1970). Rawls equates justice with fairness; social arrangements are fair if there are no insupportable or unjustifiable grounds for discrimination among members of a society (Rawls 1970). The achievement of equality will require some redistribution of existing wealth from the very rich to the very poor. Such a redistribution may conflict with individual rights (to inheritance, for instance). Social arrangements are just if the basic liberties of individuals are compatible with the individual liberties of other members of society, and socioeconomic inequality may exist only if it can be reasonably expected to benefit the position of the least advantaged. The institution of citizenship attempts to reconcile individual rights (rights to free speech, for example) with collective rights (such as freedom from racial discrimination) within a democratic framework. In terms of health rights in a democracy, individual liberties (personal sexual preferences, for instance) have to be reconciled with collective health safeguards (from the unanticipated spread of AIDS). The right to health care must be negotiated within these parameters of redistributive justice. While most commentators (Daniels 1985) have concentrated on the right to health care, I want to treat health itself as a scarce resource, in the same way that we might treat housing as a scarce good.
cultural capital
A concept that suggests the possession of valued cultural traits can be treated like an economic asset that provides a basis for social privilege.

Citizenship, as a set of institutional mechanisms, controls the access of individuals and groups to scarce resources in society because it determines both membership and eligibility. Social rights and obligations, once they are institutionalised as formal status positions in a political community, give people entitlements to scarce resources. I approach the issue of scarcity from the perspective of Max Weber’s political sociology, in which the principal variable is power. By ‘resources’ we mean primarily economic resources, such as property and liquid assets, but ‘resources’ can also include access to culturally desirable goods such as education. Cultural goods are cultural capital (Bourdieu 1984). Political resources themselves are related to access to the media of influence and authority in society: rights to vote, rights to participate politically, and so forth. Health is a scarce good that is unequally distributed in society along the fissures of social stratification and which, from an individual’s point of view, diminishes inevitably with the wear and tear of ageing and the vicissitudes of the lifecycle.

It is conceptually useful to think of three generic types of resources (or power): economic, cultural, and political. Alongside these resources, we typically find three forms of rights: economic rights relating to the basic needs for food and shelter; the cultural rights of cultural capital (primarily education); and finally, political rights of liberal philosophy (such as freedom of assembly). These rights may be collectively designated as social rights, as distinct from human rights, because they presuppose membership of a political community—namely a nation state (James 1996).

The first thing to emphasise about citizenship is that it controls access to the scarce resources of society, and as a result, this allocative function is the basis of a profound conflict in modern societies over citizenship membership criteria. Morbidity and mortality rates can be treated as an index of citizenship. For example, certain complaints relating to industrialisation, such as ‘miner’s lung’, repetitive strain injury, asbestosis, or hypertension, are indicative of the quality of industrial relations legislation and the economic rights of workers. To take an extreme example, the health of slaves and servants may not be taken seriously where the supply of labour is elastic and where slaves and domestic servants, as in classical Greece, are not fully regarded as members of society. Social membership is obviously a precondition for sharing in social resources.

The process of, and conditions for, naturalisation and denaturalisation tell us a great deal about the character of democracy in society, because these processes relate fundamentally to the basic notions of inclusion and exclusion. The willingness or otherwise of communities to share access to health care is a sensitive measure of the universalism of citizenship values. In legislative terms, nation states are generally reluctant to embrace new citizens without some checks of their age, health status, and health histories. These inclusionary and exclusionary processes mark both the political and moral boundaries of society. Moral panic about the international spread of AIDS through tourism and other means is an indicator of cultural risk in global societies (O’Neill 1990). In Australia, limitations on migration have historically been related to attempts to control access to resources by selective control of migration and naturalisation. The ‘White-Australia’ policy is a typical illustration of citizenship as a form of social closure (Parkin 1979).
Social closure is an elementary form of group solidarity, producing both social bonding and an inevitable alienation and stigmatisation of ‘outsiders’. The boundaries of the state produce an enduring crisis of belonging for marginal communities in an ethnically plural society, and in this negative sense, citizenship is about the policing of normative borders (Connolly 1995). Any benchmark of citizenship would have to include some notion of egalitarian openness to difference and otherness as an essential ingredient of liberal democracy. Who gets citizenship clearly indicates the prevailing formal criteria of inclusion and exclusion within a political community, and how these resources are allocated and administered following citizenship membership largely determines the economic fate of individuals and families. From a historical perspective, the normative boundaries of society are, in practice, defined by tolerance of ‘otherness’—a tolerance that is typically limited and in which otherness is often defined by reference to disease categories. In the medieval period, this boundary was determined by bubonic plague; the risks of modern society are indicated by the spread of new ‘superbugs’ and old infections, such as malaria, by global tourism. Other illustrations of risk in modern technological societies would include ‘mad cow disease’ and the effects of thalidomide on offspring (Beck 1992).

The next important aspect of citizenship is that it confers, in addition to a legal status, a particular cultural identity on individuals and groups. The notion of the ‘politics of identity’ indicates an important change in the nature of contemporary politics. In the early stages of industrialisation, much of the conflict over citizenship was related to class membership and struggles in the labour market, where battles were fought over retirement, health insurance, and health benefits. Citizenship struggles in contemporary society, however, are often about claims to cultural identity. These struggles have been about sexual identity, gay rights, gender equality, and Aboriginality. Many debates about citizenship in contemporary political theory are about the question of contested collective identity in a context of radical pluralisation (Mouffe 1992). The health status of individuals is also related to their identity and membership. For example, disability often determines one’s social identity, and struggles over the definition of ‘disability’ indicate the cultural and historical relativity of disease categories. Disability is ultimately about difference and personhood, and is shaped by political contestation that articulates the underlying values of society—that is, what society respects (Barnes et al. 1999). This cultural dimension of citizenship also includes the notion of ‘civic virtue’, of which obligation, or ‘the principle of duty’ (Selbourne 1994), is the cornerstone. In a context of economic rationalism, there is a growing assumption that we are responsible for our own health and that we should not depend, as Mrs Thatcher argued, on the ‘Nanny State’. Preventive-health philosophy now includes the assumption that we should practise ‘safe sex’, especially with strangers, and that we should avoid behaviours such as smoking or excessive dependence on alcohol, which have a negative impact on our health. With the increasing longevity of the populations of Western societies, the burden of dependency (the ratio of young and elderly to the working population) has a major impact on national budgets. These changes in public-health philosophy have encouraged ‘voluntarism’ and inevitably promote the idea that the family should be more involved in the care of its members (especially as health costs increase with the ageing of the population). This preventive ethic places, however, an increasing burden on private health care, in which those providing the care are often unemployed women and single mothers. Against such a trend, some sociologists argue that we have a right not to depend on the traditional charity of the family (Finch 1996).
This question of family obligation raises a particular issue in relation to the changing forms of social involvement: the early stages in the development of citizenship appeared to depend on the unrecognised contributions of women, who were outside the formal labour market but involved in domestic labour. Feminist political theory notes that conventional patterns of citizenship depend upon Fordism, which assumes that men go to work to generate an income to sustain their own domestic arrangements and also to provide, through superannuation, for the future of their household. According to this model, women were assumed to be domestic labourers who serviced their men and reproduced society through child-bearing within the nuclear family. Social contract theory reproduced the dominant assumptions of patriarchy, which reproduced the public/private division (Pateman 1988). Women’s unpaid domestic labour was thus essential to the maintenance of the external political structures of citizenship. These Fordist assumptions have been transformed by changes in the labour market (such as de-regulation), by the increase in female employment, by changes to the family (which have often been associated with the feminisation of poverty with the growth in single-parent families), and by changes to retirement legislation. The conventional and simple division between the private and public realms has been transformed by changes to both. For feminist political theory, the historical relegation of women to the private domain of the nuclear family creates permanent dependency (Pateman 1989).

The final component of this sociological model of citizenship is the idea that a political community is the basis of citizenship; this political community is typically the nation state. When individuals become citizens, they not only enter into a set of institutions that confer upon them rights and obligations, they not only acquire a social identity, they are not only socialised into the civic virtues of duty, but they also become members of a political community with a particular territory and history. In order to have citizenship, one has to be, at least in most modern societies, a bona fide member of a political community. Generally speaking, it is unusual for people to acquire citizenship if they are not simultaneously members of a political community—that is, a nation state. One should notice here an important difference between human rights and citizenship. Human rights are typically conferred upon people as humans, irrespective of whether they are Australian, British, Chinese, Indonesian, or whatever. But, because human rights legislation has been accepted by the nations of the world, people can claim human rights, even when they are stateless people or dispossessed refugees. Children, including unborn children, are believed to have human rights before they are recognised as members of a state. In general, citizenship is a set of rights and obligations that attach to members of formally recognised nation states within the system of nations, and hence citizenship corresponds to legal membership of a nation state.

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It is important to understand this relationship between the social rights of citizenship, which are enforced by the state, and the human rights of the Universal Declaration of Human Rights (1948). Whereas the rights of citizens are tied to their obligations (such as the duty to pay taxes), human rights are enjoyed, without specific duties, by every human being. Human rights have become increasingly important in the defence of health rights. For example, Article 25 says that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services’. Further declarations announced the rights on ‘mentally retarded persons’ (UN 1971) and the rights of disabled persons (UN 1975) (Bickenbach, 2001). Human rights are often used to compel nation states to provide adequate protection to their own citizens, and occasionally the human rights of individuals may clash with the legal provisions of nation states. However, it is difficult to enforce human rights, because there is no global government to ensure they are justiciable. The enjoyment of human rights depends on the willingness of national governments to ensure their citizens have the benefit of such rights. Another way of expressing the difference between human rights and citizenship is to say that, while the latter is historically the outcome of democratic processes, the former are not. Nevertheless, human rights conventions are increasingly important in establishing benchmarks for rights to health care. Governments cannot easily guarantee a right to health, because they cannot, for example, protect us against every contingency, such as the SARS outbreak of 2003. Nation states can, however, be made accountable for rights to health care—that is, an entitlement, as the Declaration has it, to ‘a standard of living adequate for the health and well-being’ of citizens.

This discussion of the relationship between citizenship and human rights, and between health rights and rights to health care, can help us to understand some of the difficulties and issues that have surrounded Aboriginal health in Australia. Racial exclusion from the dominant political community has produced cultural exclusion, resulting in poor education, and inadequate housing and welfare provision. The low and problematic health status of Aboriginal communities is a clear reflection of their inadequate citizenship status in Australia. The failure to secure an adequate standard of living for Aboriginal peoples is a clear indictment of past health policies (see chapter 6).

**Scarcity and solidarity**

One can conceptualise all human societies as divided or organised along two contradictory principles: solidarity and scarcity. All human societies, in order to exist, have to find some common basis, some form of solidarity, which—while it will not overcome them—will at least cope with the problems of difference, diversity, and conflict. All human societies must have some basis in solidarity in order to exist, but precisely because they are human societies, they are also characterised by scarcity. What do I mean by scarcity? The resources of society can never be wholly or systematically distributed to everybody in an egalitarian fashion because there are fundamental scarcities of an economic, cultural, and political nature. Scarcity is a very difficult notion to define. It is the basis of all economic theory; economics is about the management of
scarcity of resources in matching means to ends, but it is wrong to think that scarcity exists in only primitive or simple societies. Indeed, Marshall Sahlins (1974) argues in his economic anthropology that scarcity is institutionalised in modern economies, whereas so-called ‘primitive economies’ were ones of abundance. One can easily imagine a hunter-gatherer society in which access to food was limited by the actual difficulties of hunting wild animals and gathering natural produce. But scarcity is always relative to demand as well as to need, and thus scarcity is a fundamental element of the most advanced and prosperous societies.

This argument is brilliantly analysed in Nicholas Xenos’s *Scarcity and Modernity* (1989). Scarcity in wealthy societies is a function of growing expectations about assets, wealth, and success, and hence it is possible to date this form of scarcity to the rise of mass consumerism.

Scarcity is as much a function of prosperity and wealth as it is of poverty. Scarcity is manifest in social inequality, and the typical forms of social inequality that we experience in modern societies are, obviously, differences of social class or access to wealth. However, scarcity also follows the contours of gender, age, and ethnicity. This tension between scarcity of perceived means to desired ends and the need for social solidarity in a context of pluralism is the focal point of citizenship.

Having outlined a general model of citizenship, we will now look more specifically at the issue of health as a scarce resource and at health care as a social right. In employing health as an index of social rights, we need to distinguish between morbidity (the statistics on illness and disease, in both acute and chronic conditions) and mortality rates (the pattern and causes of death over time). There is a strong sociological argument that the improvement in mortality rates (especially from infectious diseases among children) in the nineteenth and early twentieth centuries was a result of improvements in the standard of living (diet, water supply, education, and housing), rather than a consequence of medical intervention (McKeown 1979; Turner & Samson 1995). Population growth in the industrial societies resulted from a decline in infant mortality, which was in turn followed by a reduction in family size through increased control of reproduction, made possible by improvements in contraception. These historical illustrations can be used to argue that an increase in life expectancy from birth is a general index of citizenship, because we know that an improvement in the social environment reduces infant mortality. These debates are part of the legacy of the work of nineteenth-century health reformers such as Rudolf Virchow, whose work on typhus epidemics in the 1840s brought him to the conclusion that democracy is the best social response to disease (Gerhardt 1989). In other words, he concluded that improvements in social conditions were the most significant lasting basis for good health.

There is a significant amount of sociological research on the relationship between social class and health to confirm this general argument (Kawachi et al. 1999). In the United Kingdom, the Black Report in 1980 (Townsend & Davidson 1982) and *The Health Divide* (Whitehead 1987) demonstrated an almost perfect match between socioeconomic position and mortality. Similar
data demonstrate the relations between class and health in Australia (see chapter 4). The research of Richard Wilkinson (1986, 1996) has been important for showing the persistence of class inequalities and illness, and the comparative importance of the welfare state in explaining better health outcomes in Scandinavian societies. There is a broad consensus that social class is crucial in understanding inequalities in morbidity and mortality, but there has been considerable debate about how this relationship between socioeconomic deprivation and illness should be understood. For example, it can be argued that this relationship is produced over time by the downward mobility of the physically and mentally sick. In this regard, it has been asserted that the over-representation of schizophrenia in the lowest social class is a product of downward mobility. The second alternative is that illness is a result of personal behaviour; for example, the high rates of lung cancer among working-class men result from their excessive use of tobacco. Against these arguments, sociologists have favoured a materialist explanation, which accounts for illness in terms of poor housing, inadequate education, dangerous working conditions, industrial pollution, and low incomes (Turner 2004).

Of course, these class and health relationships are complicated by gender and age structures. Women generally live longer than men but experience higher levels of morbidity (see chapter 5). There are important gender divisions in terms of both physical and mental health; these differences are primarily connected to different patterns of employment and lifestyle. Some differences between men and women may be related to variations in sickness-reporting behaviour, but feminist theory also points to the role of patriarchy in explaining such phenomena as anorexia nervosa. Improvements in female health have been associated with a decline in female fertility, improvements in the management of reproduction, and changes in education. In short, health in women is associated with the women’s movement and the achievement of social rights. However, there is also evidence that, as women enter the labour force in significant numbers and leave traditional nurturing roles, they acquire the health profile of men. There is a convergence of lifestyles; one illustration of these changes has been the increasing use of alcohol and tobacco among employed women.

A similar set of arguments applies to ageing. There has been a significant increase in life expectancy for both men and women in Australia throughout this century. These improvements point to a general expansion of social-welfare provision through the institutions of citizenship. However, the paradox is that, while we live longer, morbidity data show a corresponding increase in patterns of chronic illness. There is a significant increase in the prevalence of disability for men and women over the age of 65 years, and in America 22 per cent of this age group require some form of assistance to accomplish daily tasks (Albrecht 1992).

There is also a significant change in the epidemiological profile of society, with a distinctive increase in deaths from degenerative disease (in particular from cancers, strokes, and heart failure). Whether an improvement in citizenship alone can extend life expectancy and reduce chronic morbidity is a crucial question for public health in the next century. Epidemiological research suggests that, once a certain level of affluence has been achieved, then genetic legacy plays a crucial role in individual experiences of illness and disease. There are also puzzling and

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**epidemiology**

**social epidemiology**

The statistical study of patterns of disease in the population. Originally focused on epidemics, or infectious diseases, it now covers non-infectious conditions such as stroke and cancer. Social epidemiology is a sub-field aligned with sociology that focuses on the social determinants of illness.
persistent inter-ethnic variations in terms of disease prevalence. For example, prostate and breast cancers are much lower in Japan than in the USA and Australia. These variations may be accounted for by differences in living conditions, dietary practices, and genetic legacy.

We have seen that citizenship provides access to resources that are important in protecting individuals and families from illness. The relationship between health, well-being, and social resources has been expressed by Martha Nussbaum (2000, pp. 78–80) in terms of ‘central human functional capabilities’. The basic idea behind this model is that we should be able to develop universal criteria in play and to enjoy leisure

the ability to engage in critical reflection on one’s life

the capacity to sympathise with other species and exercise stewardship over their lives

the ability to enjoy leisure

the capability to exercise some control over one’s political and material environment.

Nussbaum believes that these capabilities are universal and that they form the basis of human rights—that is, a range of rights that universally protect and enhance these capabilities. Recognition of these fundamental capabilities provides a moral framework for democratic governance and the dignity of human beings. This capabilities approach throws further light on the importance of citizenship as a collection of social rights, and hence as the framework within which people can expect a basic level of good health. Those governments that fail to respect basic capabilities will necessarily undermine the health and well-being of their citizens. Her theory of capabilities has also been used to establish a basic legal framework for the protection of women and to insure that women’s capabilities are given equal respect by society. Where extreme forms of social inequality exist in a class or caste society, the capabilities of individuals cannot be equally achieved. Nussbaum has developed this approach to provide a general set of values that can direct policy and strategy for development, but her criteria of capability would be equally valuable in assessing the success or failure of social policies designed to enhance social citizenship.

Conclusion: future directions

These historical relationships between health and citizenship—which were established by the expansion of welfare in the postwar period and by a general expansion of the economies of postwar industrial societies—have been challenged since the early 1980s by economic ration-
alism, privatisation, commodification, and changes in electoral philosophy. It is no longer assumed by the contemporary governments in Australia, for example, that full employment is the principal goal of economic policy. It is, however, increasingly assumed that:

- individuals will pay for welfare services (the 'user-pays' doctrine)
- the voluntary sector (such as the large charities) will contribute significantly to the national welfare effort
- there will be a significant level of privatisation in welfare and education
- welfare will be subject to the same controls and philosophy as industry itself (in the use of quality-control processes, 'out-sourcing', and competitive funding models), and
- individuals will take responsibility for their own health by embracing an appropriate and healthy life-style such as regular exercise, healthy diet, abstinence from tobacco, and moderation in alcohol consumption.

It is unclear how great the impact of these changes on social rights will be in the long term, but it is clear that state provision of welfare will be increasingly relocated to the private sector. In this respect, there are interesting parallels between welfare strategies in the USA, Canada, and Australia, each of which have adopted versions of neo-liberalism and welfare-for-work strategies (Redden 2002).

We have seen that in the postwar period in the majority of industrial societies, there was a period of social reconstruction. After the ravages of warfare, many governments adopted social Keynesian policies for stimulating the economy through investments in health, education, housing, and other so-called infra-structural expenditure. Following the social policies of J. M. Keynes (1883–1945), governments attempted to control the level of unemployment through investments in public works such as road building. Keynesianism can be seen as part of a more general philosophy arguing that the state rather than the market should be pivotal in providing for the needs of its citizens. In Britain, for example, the Beveridge reports such as *Full Employment in a Free Society* (1944) provided a framework for the development of a health system that would cover the health needs of the nation as a right. In the USA, there were similar developments during the twentieth century in the New Deal and Progressive Era, when Federal governments attempted to regulate industry and to improve the health of workers through legislation on social security measures (Eisner 1993). In the 1970s and 1980s, the Keynesian philosophy of public support for health and welfare became unpopular with governments who sought to reduce public expenditure, reduce personal taxation, and rely on market competition to drive down inflation.

The idea behind neo-liberalism is to increase the profitability of economic corporations by reducing their tax burden and removing legal constraints on their activities. At the same time, neo-liberal policies argue that individuals should take more responsibility for their own health care and, in particular, provide for their own retirement needs through personal investments. Because these policies attempted to
reduce state expenditure, there has been a variety of experiments to transfer responsibility for the provision of health and welfare services to community groups and voluntary associations. Although these partnerships between the voluntary and state sectors can reduce welfare bureaucracy and bring services directly to the client, the voluntary sector cannot produce a uniform or universal service, and many critics have argued that the voluntary sector is driven by the same logic as the market, namely by the principle of resource maximisation (Brown et al. 2000). Neo-liberalism arose because of fears that corporate profitability had been eroded by taxation, government regulation of the economy, and by the greying of the population. It has been estimated, for example, in Germany and Italy, that by 2030 for every person in employment there will be one person who is retired (Peterson 1999). Partnerships between the voluntary sector and the state are often promoted, not because they will create ‘active citizenship’, but because some measure of voluntarism will reduce the public cost of welfare services. The burden of voluntarism tends to fall primarily on women.

The consequences of neo-liberalism are thought to be incompatible with the values of social equality that underpinned the creation of the postwar welfare state. We have already noted that, while welfare improved the health of the population as a whole, it did not eradicate social class differences (the ‘class gradient’) in mortality and morbidity. In fact, social class differences, as measured by infant mortality rates and standardised mortality rates, remained remarkably constant. While the health benefits of welfare state expenditure were often disappointing insofar as they failed to remove the effects of class inequality, it has been argued that neo-liberalism will have profoundly negative consequences for health.

The negative features of global neo-liberalism were spelt out in an influential article by David Coburn (2000) on ‘income inequality, social cohesion and health status’. Coburn has argued that neo-liberalism diminishes the authority of the state, and makes it difficult for governments to achieve their welfare priorities. At the same time, it increases social inequality and reduces the level of social cohesion (or social capital) in society. These structural changes lower the level of social trust in a society and diminish self-respect among those sectors of the community that are exposed to growing social inequality. Low self-respect and declining social trust have a direct effect on health by lowering immunity to illness. Coburn’s approach is important because it allows us to make a direct connection between the global growth of neo-liberalism, the decline in social cohesion, and the erosion of the health of individuals.

These changes suggest an important insight into the history of citizenship: social rights are not evolutionary and cumulative. Because Marshall argues that the rights of citizenship are cumulative, he also assumes that once one has achieved legal rights, won the political battles of parliamentary democracy, and won social welfare rights, then these rights will not be eroded by subsequent social struggles. Marshall asserts that each of these historical stages represents a successful accumulation of citizenship. This is a very optimistic picture of the historical evolution of rights. One of the important debates emerging in contemporary democracies is whether previous rights can be sustained in a society that is increasingly dominated by the needs of the marketplace and the rhetoric of economic rationalism. In a market-driven society, young people find it very difficult to enter the labour market and gain access to resources because of the nature of the
modern economy. If we regard full employment as an entitlement, social rights may be obliterated or at least weakened as a consequence of economic rationalism. One can identify many societies that have highly developed social and economic rights, but they do not have adequate legal and political rights. In traditional debates about communism and capitalism, one criticism of the former communist regimes of Eastern Europe was that, while they had institutionalised social and economic forms of citizenship, these societies were often weak in terms of legal and political rights. They had economic rights without a comprehensive civil society, because they had achieved industrialisation without a liberal-bourgeois revolution against feudal privilege. It is not clear how societies will manage the social conflicts that result from a failure to respect social rights entitlements. Citizenship provides a form of solidarity—a kind of social glue, if you like—that binds societies that are divided by social class, gender, ethnicity, and age. The solidarity of the political community of modern societies is provided by citizenship, which works as a form of civic religion. This model of the history of citizenship has either optimistic or pessimistic implications. The optimistic view is that, through the United Nations, and through agreements about human rights, modern societies can manage the problem of interstate violence, terrorism, and conflict. The alternative view is that we do not, in fact, have cumulative citizenship; what we have is a breakdown of citizenship. Nation states no longer adequately provide citizenship for their members, and instead we can observe an escalating war in which mega-cities and mega-economies are pitted against each other. Human rights will not be protected, because the so-called ‘new world order’ operates in the interests of a small number of powerful economies through the mechanisms of the World Bank, the International Monetary Fund, and the World Trade Agreement (Stiglitz 2002). The future of health in Australia, therefore, depends on how citizenship rights survive in a global economy and cope with a partial erosion of national sovereignty.

socialism/communism

Socialism is a political ideology with numerous variations, but generally refers to the creation of societies in which private property and wealth accumulation are replaced by state ownership and distribution of economic resources. Communism represents a utopian vision of society based on communal ownership of resources, cooperation, and altruism to the extent that social inequality and the state no longer exist. Both terms are often used interchangeably to refer to societies ruled by a communist party.

Summary of main points

- T. H. Marshall’s theory of citizenship—in terms of legal, political, and social rights—is a valuable framework for approaching health inequalities.
- To Marshall’s model, we can add the notions of access to scarce resources (as forms of power), cultural identities, the political community as a product of social closure, and civic virtues (as obligation).
- Health can be analysed as a desirable good (that is, as a scarce resource).
- The health resource is distributed along the contours of social class, gender, and generations (or age cohorts).
- The notion of functional capabilities can provide a universalistic framework for evaluating citizenship programs.
It is possible to use data on health as a measure of effective citizenship.

Governments cannot readily ensure health as a right, but adequate citizenship requires effective health care.

Recent shifts in public policy reflect post-Fordism, and a new emphasis on preventive health and voluntarism in welfare delivery.

These changes on a macro or global level can be collectively referred to as ‘neo-liberalism’.

Discussion questions
1. What are the main criticisms of T. H. Marshall’s theory of citizenship?
2. What are the social and economic consequences of the ‘greying of the population’ for government policies on health, retirement, and pensions?
3. What do you understand by the notion of ‘social closure’? Can it help us to understand health inequalities?
4. Is illness best explained by ‘material factors’ (such as social class differences) or by ‘cultural factors’ (such as lifestyle) or by a combination of both types of factors?
5. Assume that people understand, through anti-smoking campaigns, that smoking causes lung cancer and various respiratory diseases. Can continuing to smoke be explained by rational models of economic behaviour such as consumer preference?
6. Do we have a right to health or a right to health care or both?

Further investigation
1. ‘The most significant cause of illness is poverty.’ Discuss.
2. ‘There are no such things as universal human rights or capabilities.’ Discuss.
3. Having read this chapter, what do you think are the crucial problems facing the federal government in terms of reducing class differences in health?
4. How successful has the advance of citizenship been in reducing class differences in health?
5. Compare and contrast Australian and Swedish data on mortality. Can you draw any conclusions about citizenship in the two societies?
6. ‘Despite advances in citizenship for non-Aboriginal Australians, Aboriginal health statistics show that the enjoyment of citizenship rights is uneven.’ Discuss.
7. ‘Infant mortality data are the best guide to the effectiveness of citizenship.’ Discuss with special reference to Australian social trends.
Further reading and web resources


Web sites

Australian Human Rights Centre (AHRIC): <http://www.austlii.edu.au/other/ahric>


Center for Economic and Social Rights (USA): <http://www.cest.org>

Human Rights Council of Australia: <http://www.hrca.org.au>


Human Rights Watch: <http://www.hrw.org>

Human Rights Web: <http://www.hrweb.org/resource.html>