Alfons Labisch

Doctors, Workers and the Scientific Cosmology of the Industrial World: The Social Construction of 'Health' and the 'Homo Hygienicus'

Germany's transition from an agrarian to an industrial society (c. 1870–1914) coincided with a change from extensive to intensive use of labour: instead of short-term exhaustion of the proletariat by work (the Manchester School), it became necessary to secure permanently a labour reserve of sufficient quality and numbers.[1] Towns and factories grew apace during industrialization. The industrial towns were swamped by unforeseen social problems: apart from infrastructural needs such as drainage and water-supply, towns wrestled with the massive problems of housing shortages, lack of food and clothing, infectious disease and malnutrition (especially among mothers and children) and last, but not least, the inadequacy of the workers' own behaviour as a response to the new structures of their lives.

For the 'freed' and 'alienated' working population, industrialization meant a hitherto unimaginable change in their traditional pattern of life. While the new life in the industrial towns offered new chances and new freedoms, it also held new dangers. Workers and their families abandoned the 'natural' behavioural guidelines of their country origins and their 'natural' knowledge in their encounters with sickness, invalidity, old age and death. In addition, they lost the systems of bonds and supports previously represented by relatives, landowners, co-operatives and villages. Large existential communities were reduced to small industrial family units. At the same time, the worker was thrown back on his labour as his only means of subsistence, with the result that for more and more people health and productive strength assumed ever greater importance. On the other hand, the dangers to health in the industrial areas were high:[2] tuberculosis, which was rampant in the towns and cities, was known as a 'proletarian disease', pure and simple.

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To bourgeois observers, the workers' behaviour appeared as 'drunkenness, slovenliness and debauchery' – their inability to postpone satisfaction and control emotion being the outward sign that workers had not yet adjusted to the pursuit – as had the civilized bourgeoisie – of remote goals. Traditional support-systems, community life and patterns of behaviour had, as a result, to be complemented and replaced by artificial and institutional equivalents. New profiles and standards of normality were now required: the normality profile 'wage-earning' dictated to the worker the standards of 'wage-labour and work-preparedness'; the normality profile 'family life' imposed on the worker's wife the standards of 'house-keeping and motherhood'.[3]

In this process of civilization, rationalization and social disciplining, 'health' became a multi-valent term of the greatest political potential – from its importance as a guide to living and behaviour, to its importance as the existential basis of wage-dependent sections of the population and finally its socio-political importance.[4]

Here, bacteriology had a liberating effect in that it destroyed the ecological justifications of experimental hygiene and its liberal-bourgeois socio-political context.[5] The new scientific basis of 'health' seemed to mean that its political connotations could be abandoned. 'Health' provided a scientific, neutral concept by which to assist the colonization or assimilation of peripheral social classes – that is the proletarians, who had to be integrated into industrial society. What had become the personal life-style of the bourgeois was now to become an obligatory life-style for all: the homo hygienicus, the man for whom health is life's supreme goal and who subordinates his manner of life entirely to principles of health derived from medicine. It was now possible for the problem of health to be politically channelled, individualized and made into a therapeutic problem. Traditional forms of help could be destroyed, along with the worlds of significance that attached to them – 'health' thus offered an instrument both for a neutral controlling of behaviour and for a socially pacificatory way of dealing with social problems.

What, then, were the sociogenetic and psychogenetic processes by which the industrial working class came to adopt this construct? In other words, how did this apparently medical construct of 'health' become a generally binding and accepted social construct? We shall trace this multi-form process at three different levels: in the institutionalization of state social insurance as an instrument for the long-term implementation of standards of normality and the forcible socialization resulting therefrom, carried out by medicine as the monopoly form of help and definition; then, in the way the social element in medicine was made

scientific by social hygiene and the corresponding effect of communal health care on the reproductive life of the working-class family; finally, reversing, so to speak, the angle of vision, we shall go on to examine how the worker's need to assimilate led him to adopt the universe of the 'homo hygienicus'.

The Law concerning Workers' Sickness Insurance, passed in the Reichstag in 1883 over the opposition of the SPD (Social Democrats), continued the existing principle of compulsory insurance. Initially, statutory health insurance applied exclusively to workers employed in manufacture, to ancillary staff in the legal professions and insurance institutions – precisely the groups amongst whom the social democrats and trade unionists were recruiting.[6] The first social-hygienic criticisms of statutory health insurance showed that from the hygienic point of view its provisions were meaningful only in limited ways:[7] it did not cover older workers who, already burnt out, slid into invalidity because of their failing ability to work; nor did it include other family members, either women, particularly at risk from labour and childbirth, or babies and infants.

As far as internal social control was concerned, there was scarcely any difference between the assistance schemes operated largely by the workers themselves and the state schemes. In fact, the non-state schemes tended to be even more rigid. The health insurance schemes accepted only skilled workers who had passed a stringent preliminary medical examination by a doctor and they did not cover certain risks that carried a social stigma – alcoholism, for example, or injury resulting from fighting. Claims for health insurance payments were closely examined. Even in workers' aid schemes, the doctors who carried out the initial examinations and issued sick notes acted as social screeners.[8]

Thus for 'health' as a social construct the introduction of compulsory state health insurance was not initially a qualitative but a quantitative problem: in the longer term, the state would cover larger and larger sections of the productive and politically active working population. But there was a qualitative leap concealed here, too. In the self-aid schemes, the checking of claims for assistance was a co-operative affair, experts only being called in when necessary; through the compulsory state scheme, this checking system became a public affair, a means of 'social normalization' (E. Pankoke). From the institutionalization of the socio-political defusing of the risk of 'illness', there followed the

institutionalization of the imposition of standards of normality in this sphere, through a para-state agency.

After a legal reform of 1892, the continual transfer, as a result of social and insurance legislation, of health services to the compulsory state scheme opened up entry into its administration for the Social Democrats. Bismarck and Theodor Lohmann had in fact deliberately prepared the ground for this machinery of social integration. The health service administrations became the 'NCO training schools of Social Democracy'. At the turn of the century, one trade union member in five was on the board of a *Krankenkasse* (sick fund), and local *Krankenkassen* were employing staffs of between four and five thousand.[9] A further long-term side-effect of compulsory health insurance was to create the 'progressive economic guarantee of the "medicalization of society" (I. Illich), thereby contributing to the liberal-capitalist expansion of the "health sector"'.[10] Doctors and doctors' associations were, initially, taken completely by surprise by the new insurance legislation, for all at once they were being obliged to treat a clientele they had previously largely only encountered as poor-law doctors. As the Prussian Medical Association wrote, as late as 1899:[11] 'By far the largest number of members of health and accident insurance schemes receiving treatment had hardly ever consulted a doctor before, without ever having suffered any lasting damage to their health.' The panel doctors acted not only as therapists but as expert medical judges of whether social services should be provided or not. 'The doctor was initially consulted only as an authority, to certify the commencement and duration of an incapacity to work, the effect of an accident on fitness for work and the commencement of invalidity,' wrote Adolf Gottstein, the social hygienist, in 1920.[12]

The process of civilization is associated with a differentiation and monopolization of life expectancy, and these monopolies in turn react on psychogenetic processes, regulating individual affects and individual behaviour. At the turn of the century, this process was enacted in overcoming the mass problems of sickness, invalidity and age, which were monopolized in the form of social security systems and community health care.[13] The form the socially organized life expectancy took was the creation of a general right to assistance in certain defined situations in life, a right evaluated by doctors as the experts appointed by society. However, inextricably tied up with the monopolization process is another question – apart from questions concerning the assessors of life expectancy – namely, that of vetting access to these offers of aid. The

claim for assistance is thus also subjected to monopolized and institutionalized vetting. This vetting follows objectifiable systems of thought and legitimation and is left to the judgement of appropriate experts; rather as the judge (through the medium of jurisprudence) lays down objective law, so now the doctor (through the medium of medicine) decides about 'objective' health or sickness and hence about how justified is a claim for assistance.

But socially organized monopolies of survival chances are not only automatically bound up with 'experts' and the monopolization of definition and control; they also have psychogenetic side-effects which appear at the moment the proffered assistance is accepted. An application for medical assistance simultaneously involves indirect or direct manipulation of behaviour: indirect through positive and negative stimuli, direct through orders and prohibitions. Not following instructions can lead to sanctions being imposed or a machinery of exclusion being set in motion. For the compulsorily insured section of the population, the only remaining way out of the working life is by means of the 'healthy/sick' definition. It is here that the problems of 'malingerers', 'medical examiners' and medical certificates as a legal requirement begin.[14] In this way, the compulsorily insured working population is led by means of state health insurance to 'compulsory socialization'.[15]

Socio-politically, then, health insurance aimed at the social pacification of the workers by means of the newly upgraded goal of 'health'. In the process, it succeeded in subjecting this crucially productive section of the population to compulsory socialization. The demand for behaviour regulation through the social construct of 'health' was supplied by the monopoly medicine had over service and definition. The determination of the reality of the 'homo hygienicus' was thus reinforced by the doctor.[16]

Demand for preventive health measures and for assistance during sickness grows with the complexity of society, on the one hand, and the functional alteration of primary communities on the other. By its generalization of claims, the monopoly arouses needs which either do not arise in small social units or could never be satisfied there. Demand is heightened by an increasing dependence on a monopoly of forms of assistance, induced in the last resort by the professions as agents of the monopoly. The result is a violent struggle against folk medicine, lay healers ('quacks') and traditional interpretations of health, as outmoded ways of seeing things. From the socio-political and professional points of view, what was needed, therefore, was either for collective and individual forms of medical aid to be absorbed or for them to be marginalized and ultimately destroyed.[17] Through their new function both as official

universal experts and as practitioners of social technology, doctors achieved a position that endowed them with a power hitherto unknown. Julius Petersen predicted in 1877:[18] 'The fanatical mysticism of theology and the apathetic formalism of jurisprudence will gradually cede ground to a third authority, the human science of anthropology. The time will come when representatives of medical practice will be as indispensable as functionaries of state and society as preachers and judges are now.'

Through social insurance, it is true, the Reich tried to depoliticize the risks of invalidity, illness and old age. Quantitavely speaking, however, this insurance only went a certain way towards eliminating such risks, being unable, even with the individual therapeutic approach, really to get to grips with them. Thus the industrial towns could not escape the problems of mass illness and health risks. Moreover, the hopes placed in bacteriology had proved exaggerated. This was especially true of tuberculosis and cholera. A cholera epidemic broke out in Hamburg in 1892 despite the bacterium having been known since 1883. Wide-ranging investigations into tuberculosis revealed that everyone actually had the infection, but that only a small proportion fell ill – and this small proportion was distinguished by identifiably poor living conditions.

Social hygiene developed from various sources. Adolf Gottstein, originally a convinced bacteriologist, learned – as he himself tells us – at the sick-bed that the last cause of an epidemic is the virus itself: the real causes lay in the field of the development of the masses and of social conditions.[19] Alfred Grotjahn can be seen as a spokesman of a largely theoretical social hygiene, arising from the combination of medicine and the new social sciences; a major influence on Grotjahn was the national economist Gustav Schmoller.[20] Alfons Fischer, by contrast, advanced social hygiene both theoretically and practically (by, for instance, supporting mutual maternal assistance).[21] In short, social hygiene was as heterogeneous as the personalities who exerted the most influence on it. Nevertheless, it was through social hygiene that the social element of medicine became scientific.[22] The mass health problems of the industrial towns could now be handled scientifically and transformed into new forms of intervention tailored to the industrial working class.

The earlier bourgeois ethical appeal to the proletarian to live a clean and healthy life was made scientific by the combination of medicine and the social sciences, and in the concept of 'hygienic culture' it became binding in a new way. Social hygiene provided local politicians and

communal and poor-law doctors with scientifically based guidelines as to which prophylactic measures to take against health problems. Out of this there emerged a new – and necessary – dimension, that of shaping the behaviour of the lower orders through medicine. There was now no need at all for religious or moral appeals of any kind. Moreover, not only did the raising of health to a scientific level now apply in the individual sphere, a process begun by the first generation of hygienists and made irreversible by bacteriology, but the social explanations of 'health' offered by social hygiene also appear in value-free, scientific dress. Where, a generation earlier, health had become the scientifically justified life-style of the bourgeoisie, it now finally becomes the life-style of the industrial world, binding on all and unchallengeable because scientifically proven. Social hygiene directed its attention to social conditions and in so doing legitimized the structuring of social behaviour.

Through the 'general spread of hygienic culture'[23] the 'hygienic person', 'hygienic family' and the 'hygienic housing estate' – the chapter-headings in Grotjahn's 'Hygienic Challenge' – are all gripped in the total embrace of a scientifically-based mode of life. Where hygiene is the morality of the bourgeois, social hygiene is the morality of the industrial worker and of society at large. 'Homo hygienicus' was to live in a 'societas hygienica'. 'Social hygiene alone,' says Grotjahn (1921), 'can teach us how to deepen, simplify and spread hygienic culture. It will be the ruling star of the health doctrines of the twentieth century.'[24] Our aim should be 'to take hygienic awareness into the dwellings of even the poorest workers'.[25]

Under the slogan 'popular hygiene', bacteriology had developed its own programme of health education, but one based on altering behaviour through rational understanding, not on altering social conditions. This individual enlightenment was organized by the various kinds of association then springing up everywhere, with their particular specialized areas – mothers, babies and infants, alcoholics, etc. Conservatively inclined and often organized by doctors, these associations worked hand-in-hand with politicians, civil servants, members of the upper classes and with industry.[26] However, as an organization of hygiene and bacteriological enlightenment and advice covering the whole Reich, the German Society for Popular Hygiene had only limited success in reaching the working class.[27] At the same time, the 'health educational' effects of experimental hygiene and bacteriology were considerable. The new estates, new houses and flats, the supply of water, public baths, clean clothing and the

more sanitary and health-conscious organization of the supply and preparation of foodstuffs – all had an indirect effect through the normative power of facts.[28] Furthermore, because changes in an individual's behaviour within the civilization process take place not rationally but in social imitation of the behaviour of integrated strata, hygienically correct behaviour also spread through being fashionably correct behaviour.[29]

Over and above these efforts and developments, the industrial towns were obliged to face up to the new mass-health problems. After the turn of the century, a new type of public health practice emerged in the towns: in local health services, doctors, female health workers, national economists, civil servants and social reformers all worked together.[30] It was the scientific concept of social hygiene which provided the direction to such effort. Two different groups at risk were identified: those who because of age, social position or occupation were exposed to special dangers – for example, mothers, babies and young children – and those with social diseases who put their own and their environment's health at risk – those suffering from tuberculosis, venereal diseases, alcoholism, mental illness, etc. In the application of its ideas, social hygiene was able to count on the support of existing social movements: municipal leaders and numerous humanitarian and charitable organizations were already engaged in trying to improve health conditions; the bourgeois women's movement was looking for new fields of activity for women no longer tied to their families; and, lastly, the political workers' movement was also already getting organized in the towns.

Comprehensive programmes of health education were also developed alongside these group-related efforts, whose aim was to provide people with opportunities for fruitful action of their own.[31] The prohibitions and unmistakable behavioural controls of 'defensive' hygiene were to be abandoned in favour of life-enhancing attractions opening up new possibilities – 'positive' hygiene in other words. So, a clean bright home was not only healthy but also modern and beautiful. This new method of encouraging the spread of health-conscious behaviour – replacing instruction with education – was publicized in campaigns through the new means of mass communication: the 1911 'Hygiene Exhibition' in Dresden, the 'Great Exhibition of Health Care, Social Welfare and Physical Exercise' held in Düsseldorf in 1926, and the National Health Week (also 1926) are major examples.[32]

Health care as social hygiene in practice was threefold in character: constant medical observation of groups whose health was at risk; the identification of illness and predisposition to illness and the arrangement of treatment; and hygienic counselling, education and training.[33] As far

as medical practice went, this meant that in schools, for instance, health care would confine itself to serial examinations and monitoring of those children identified as being health risks. Precise diagnosis and therapy remained the task of the medical poor-law officer and later the panel doctors. At the same time, the school medical service saw itself 'as a tool for educating parents, through explanation and checks on behaviour, to be more health-conscious in how they looked after and brought up their children'.[34] As a consequence, there emerged in local health care a new type of doctor, oriented towards neither the traditional professional image of the practitioner nor that of the state board doctor, but one acting according to the principles of group-related health care. These community doctors were motivated by a strong sense of social responsibility and saw their activity as political work.[35] Alongside these community doctors there arose a new professional group, the health workers or visitors, representing the female involvement in welfare work, the main thrust of which was in the direction of health care. In the 'professionalization of the maternal instinct', women from the middle classes found a vocation that seemed suited to their social origins.[36] The care these female health visitors provided covered both the economic and the medical. As in the case of the social-hygienic concept of health education (and of social hygiene generally), there was no specific concept involved; rather, economic assistance on health grounds, health care itself and health education were all united in one person and one positive intervention. Thus the health visitor would also hand out food and clothing for babies and small children and on her own initiative would seek out mothers in need in their homes, checking simultaneously whether the home was clean, the nappies washed and the baby's bottle boiled. Thus non-specific health measures, instruction and control were merged together, in a manner intelligible to all, in the immediate environment of the lower classes, the family home. The working sphere of communal health care turns out, therefore, to have been centred on the normality profile 'family life', and thus on the worker's wife and her performance as housekeeper and mother.

'Health' and 'health-conscious behaviour' were only one aspect of the process by which the working class was integrated into the world of industrial society. The decisive regulating factor for the worker was undoubtedly the compulsion to become a wage-labourer, along with the industrial form of work itself and its scientific and technical organization – the determining element of work was the machine.[37] Wage differentials,

extra benefits, factory and work rules, group pressure and collective consciousness were other contributing factors.[38] Nor should the state's open or concealed agents of socialization be forgotten: the army, first and foremost, that 'excellent institution of popular education',[39] which affected both the general subordinate pattern of behaviour and – through compulsory vaccination, food and clothing – behaviour in matters of hygiene as well.

On the other hand, the role of 'health' should not be underestimated, especially in the extent to which it shaped the reproductive life of the working-class family. There was in fact 'a real hunger...amongst the lower classes for knowledge on questions of hygiene'.[40] How ought they, in their changed living conditions, to react when there were risks to health, accidents or illness? How should they adapt their lives, homes, clothing, food and so on from the health point of view?[41] One movement in particular saw itself as the avant-garde of a scientifically organized mass society, and that was the political labour movement. Thus health and the safeguarding of health loomed very large not only among the workers but in the programmes and policies of the social-democratic labour movement.[42] The offer of value-free 'health' as a scientifically-based mode of life was therefore eagerly accepted by a working class in the process of assimilation. While the naturopath-inclined workers were perfectly aware of its ideological character,[43] one further reason why the medical profession became more widely accepted was because its assistance was requested and its advice taken. The reason why the working classes became integrated into industrial life was that the scientific construction of the productive sphere was paralleled by the scientific construction of the reproductive sphere.

This process, by no means automatic or free of conflict, was consciously encouraged by the workers' doctors and the health insurance employees and self-governing bodies.[44] Thus, in 1896, the large local *Krankenkasse* for the Leipzig area had 184 voluntary health visitors who made 79,332 visits and 13 professional health visitors who made 149,899 visits.[45] One of the visitors' duties was to check that the doctors' directions were being followed and medicines and remedies taken as instructed – an obligation on members written into the statutes of the *Krankenkasse*. The ultimate proof 'health' as a social construct was thus provided, not only by experts but in the patients' immediate sphere of life by people of the same background and class and sharing the same language as themselves. Both communal health care in the form of preventive regulation of behaviour and the supervision of medical therapy took place in the worker's immediate reproductive

sphere of life, in his home and among his family – and, as they entered his home without being asked, there was no escaping these visitors.

To some degree, the health visitors personify the problems of transition from external to internalized control. After the turn of the century, the 'health insurance movement' (Tennstedt) provided a framework within which the insurance societies' administrations worked out rather more subtle models of control and means of influencing behaviour. By 1903, Paul Kampffmeyer was speaking of the 'mission of the German *Krankenkassen* in the field of public health': the workers' health insurance societies were to be entrusted with an ambitious programme of social hygiene.[46] For, despite its bourgeois rather than socialist origins, social hygiene and social democracy were pursuing partially the same goals – the 'general spread of hygienic culture', the aim of social hygiene, gradually converged with a greater practical and reformist tendency among the social democrats.

Thus it was that health insurance and communal health services became the entry-gates through which medico-hygienic ideas percolated among the workers and their political representatives. The function of expert in this assimilation process fell to the worker's doctor. It was he who wrote the health books, brochures and leaflets, he who held courses for the public and advised politicians, health insurance staff and associations, and even, in some cases, he who sat in parliament (like Ignaz Zadek).[47] These doctors also penetrated into the workers' immediate living environment, into their homes and families – for instance, the housing inquiry conducted, under Zadek's leadership, by the Berlin shopkeepers' *Krankenkasse* in 1901.[48] A similar case had occurred earlier, after the 1892 Hamburg cholera epidemic, when, again inspired by Zadek, the workers' health committee in Berlin went so far as to organize a boycott of the royal 'Charité'.[49] Their activities were not limited to documenting poor hygienic and health conditions for the outside world or to politicizing them: housing inspectors, advised by socialist doctors, also gave working-class women practical instruction in how to air and clean the home, how dust and dirty curtains helped to transmit tuberculosis, how foodstuffs (summer diarrhoea for the babies!) should be kept, and so on. Here, too, there was fertile ground for utopian plans: 'Every Saturday, one workers' housing quarter should be flooded with health inspectors, the women observed as they wash and clean their steps, rooms and houses, and instructed about the main risks they are exposing themselves to in the process, and reports on all this should then be made to the centre, the *Krankenkasse*; where there is resistance, there must be further inspections and calls, so that in the course of a year the whole of

Berlin will have been visited and educated in hygienic culture.'[50] Thus it was the workers' doctors and the *Krankenkassen*, committed on the one hand to the scientific concept of social hygiene and on the other to the political concept of social democracy, who formed the personal and institutional link between the scientific idea of 'health' and the world of the working class. And it was with eager enthusiasm that the workers adapted themselves to this new form of life.[51]

In this cursory and by no means complete analysis, using sources and texts from the Wilhelminian Empire, we have outlined the social constitution and function of 'health' and its personification, the 'homo hygienicus'. At the height of industrialization, 'health' became a value of the greatest political relevance: the single existential basis of the wage-dependent classes; a generally binding guideline as to how to live and behave; and finally, because it was scientific and therefore value-free, 'health' became a seemingly depoliticized pillar-concept of national, communal and industrial social policy. Health, as a value- and class-neutral scientific construct was implicitly personified in the 'homo hygienicus'. It became life's supreme goal; the way people led their lives was subjected to norms of health derived from medicine. The two constructs – 'health' and the 'homo hygienicus' – made it possible for the risks of endangered health/sickness and their social conditions and social consequences to be, apparently, depoliticized; they also made it possible, in the long term, for the behaviour of the working class to be regulated. For in the 'homo hygienicus' the workers found in the reproductive sphere a medico-scientific construct comparable to the scientific-technical construct they encountered in the productive sphere. Thus, the scientific construct 'health' became a social construct, because in it quite divergent interests and reference systems were neutralized in a new interpretational world – neither the aim nor that world were disputed, only the means and forms of its organization. Hence it was by means of the concept of 'health' that the proletariat was introduced into the scientifically organized industrial world and transmuted into industrial workers.

This psychogenetic process by which the industrial working class was colonized and assimilated into the industrial world was realized by 'medicine', a monopoly of forms of assistance and of definition that had likewise taken on a separate existence. As official universal expertise, the medical sciences were the theories of the new interpretational world and the doctors were the practitioners of the corresponding social

technology. Subordinate functionaries, such as district nurses and health visitors and so on, were added. But the medical sciences and the doctors do not appear in the civilization process as agents or agencies of 'social control'. Medicine and the doctors are rather mediators in a new interpretational world and new existence.

In the formation of a service monopoly of medical aid, the doctors became professionalized. Simultaneously, there fell to them as a task indivisibly linked to that monopoly the vetting of both the demand for aid and the form of behaviour on which its supply would depend. The generalization of vetting and of expectations of behaviour followed inevitably from this generalization of claims on, and the monopolization of, the general supply of aid. 'Protection by control, control through protection' was the general mechanism, and in particular: the greater the supply of aid society puts on offer, the less avoidable and more coercive becomes the demand for 'health-conscious' behaviour; thus an 'obligation towards health' became synonymous with the 'right to health'. In this process, individual interpretations and evaluations of health, specific to particular worlds of experience, were first overwhelmed and then annihilated as provincial worlds of meaning that were no longer relevant: from being a pattern of behaviour related to the existence of the bourgeois, the 'homo hygienicus' became a compelling behavioural obligation on everyone. In the process, it becomes evident how the reality of the 'homo hygienicus' is defined in the medical monopoly of advice and aid – the definition of the new reality is thus mediated and reinforced by the doctor.

The new social reality of the interpretational world of the 'homo hygienicus' was spread over a number of different constituent processes. The social justificatory bases of medicine that had been destroyed by bacteriology were raised to the scientific plane by social hygiene; group-related health care as social hygiene in practice was carried out in the industrial towns and cities by communal doctors and female health workers. Health care was directed particularly at the family, as the new basis of the workers' reproductive life. On the other hand, the individual risk of 'illness' was covered, for the politicized industrial working class, by statutory health insurance – thus the external benefit of health insurance and the general socio-political objective was not medical aid but social integration. The sick-fund doctor directed his attention, therefore, to the productive section of the population.

Behind these various processes, it was the general civilization and rationalization process which imposed the pattern of behaviour: it was necessary to colonize new, peripheral lower strata, in order to guarantee

the long-term supply of usable labour – and here the social force emerged which fuelled the process. 'Health' obscured the real institutions and centres of power. But the constituent processes were only able to unfold so rapidly, so comprehensively and so successfully because the lower social strata found themselves in an active process of assimilation. Thus the demand was not only for aid but for a new interpretational world which could satisfy the demand for new, appropriate modes of behaviour. Thus social imitation, social learning and enforced socialization all worked in the same direction. In Germany the second phase of industrialization, including the Weimar period, was a 'golden age of health education', because, as it took form, the new industrial working class grasped hold of the construct 'health' as a component part of its general social movement.

'Health' thereby reveals itself as the construction of an interpretational world adequate to industrial societies: it provides the legitimation for the socio-technological shaping of conditions *and* behaviour.

Notes

1. Cf. inter alia C. Sachsse, F. Tennstedt; *Geschichte der Armenfürsorge in Deutschland. Vom Spatmittelalter bis zum 1. Weltkrieg* (Stuttgart 1980).

2. Cf. R. Spree, *Soziale Ungleichheit vor Krankheit und Tod. Zur Sozialgeschichte des Gesundheitsbereichs im Deutschen Kaiserreich* (Göttingen 1981); idem, 'Zu den Veränderungen der Volksgesundheit zwischen 1870 und 1913 und ihren Determinanten in Deutschland (vor allem in Preussen)' in W. Conze and U. Engelhardt (eds.), *Arbeiterexistenz im 19. Jahrhundert. Lebensstandard und Lebensgestaltung deutscher Arbeiter und Handwerker* (Stuttgart 1981), 235–92.

3. E. Pankoke, 'Gesellschaftlicher Wandel und soziale Dienste. Voraussetzungen und Entwicklungsperspektiven' in E. Kerkhoff (ed.), *Handbuch Praxis der Sozialarbeit und Sozialpädagogik*, vol. 1 (Düsseldorf 1981), 3–30.

4. The theoretical conception of the present study derives from Norbert Elias, Max Weber, Peter L. Berger and Thomas Luckmann; see, more fully, A. Labisch, 'Die soziale Konstruktion der "Gesundheit" und der "homo hygienicus": zur Genese einer sozialen Kategorie' in *Österreichische Zeitschrift für Soziologie*, 10 (1985), no. 4. For the period from the Reformation to the industrial revolution, see A. Labisch, 'Hygiene ist Moral – Moral ist Hygiene'. Soziale Disziplinierung durch Ärzte und Medizin' in C. Sachsse and F. Tennstedt, *Soziale Sicherung als Soziale Disziplinierung* (Frankfurt 1985).

5. Cf. E. H. Ackerknecht, 'Anticontagionism between 1821 and 1867' in *Bulletin of the History of Medicine*, 22 (1948), 562–93.

6. Cf. F. Tennstedt, *Sozialgeschichte der Sozialpolitik in Deutschland. Vom 18. Jahrhundert bis zum Ersten Weltkrieg* (Göttingen 1981); idem, *Vom Proleten zum Industriearbeiter. Arbeiterbewegung und Sozialpolitik in Deutschland 1800 bis 1914* (Köln 1983).

7. I. Zadek, *Die Arbeiterversicherung. Eine socialhygienische Kritik* (Jena 1895).

8. Cf., besides Tennstedt's pioneering work (n.6, above), G. Stollberg, 'Die gewerkschaftsnahen zentralisierten Hilfskassen im Deutschen Kaiserreich' in *Zeitschrift für Sozialreform*, 29 (1983), 339–69, and for a full account, U. Frevert, *Krankheit als politisches Problem 1770–1880. Soziale Unterschichten in Preussen zwischen medizinischer Polizei und staatlicher Sozialversicherung* (*Kritische Studien zur Geschichtswissenschaft*, 62) (Göttingen 1984).

9. Tennstedt, *Sozialgeschichte*, 172; idem, *Vom Proleten*, 430f.

10. Tennstedt, *Sozialgeschichte*, 173.

11. *Ärztliches Vereinsblatt* 28 (1899), No. 407, 365; quoted in F. Tennstedt, 'Sozialgeschichte der Sozialversicherung' in M. Blohmke et al (eds.), *Handbuch der Sozialmedizin*, vol. 3 (Stuttgart 1976), 385–492, ibid. 388.

12. A. Gottstein, *Die neue Gesundheitspflege* (Berlin 1920), 24.

13. Cf., in general terms, N. Elias, *Über den Prozess der Zivilisation. Soziogenetische und psychogenetische Untersuchungen*, 2 vols. (Bern 1969); for the significance of Elias for the sociology (and history) of medicine, cf. C. v. Ferber, 'Zur Zivilisationstheorie von Norbert Elias – heute' in *Lebenswelt und soziale Probleme. Verhandlungen des 20. Deutschen Soziologentages* (Frankfurt 1981), 355–68.

14. For a systematic treatment see H. Leithoff, 'Die Duldungspflicht ärztlicher Behandlung als Möglichkeit medizinischer und sozialer Disziplinierung' in *Zeitschrift für Rechtsmedizin* 83 (1979), 27–38.

15. C. v. Ferber, *Soziologie für Mediziner* (Berlin 1975), 9–48; cf. further Spree, *Soziale Ungleichheit*, 156–62.

16. In modified form, from P. L. Berger and T. Luckmann, *Die gesellschaftliche Konstruktion der Wirklichkeit. Eine Theorie der Wissenssoziologie* (Frankfurt 1977), 128.

17. Cf. G. Gockenjan, *Kurieren oder Staat machen. Gesundheit und Medizin in der bürgerlichen Welt* (Frankfurt 1985).

18. J. Petersen, *Hauptmomente in der geschichtlichen Entwickelung der medicinischen Therapie* (Kopenhagen 1877), 395.

19. Adolf Gottstein, *Allgemeine Epidemiologie* (Leipzig 1897), v; cf. more fully 298–316, for Gottstein's discussion à propos tuberculosis. There exists no biography of Gottstein; see his autobiography in L. R. Grote (ed.), *Die Medizin der Gegenwart in Selbstdarstellungen* (Leipzig 1925), 53–91.

20. A. Grotjahn, *Soziale Pathologie. Versuch einer Lehre von den sozialen Beziehungen der Krankheiten als Grundlage der Sozialen Hygiene* (Berlin ^{1}1912, ^{2}1915, ^{3}1923); idem, *Erlebtes und Erstrebtes. Erinnerungen eines sozialistischen Arztes* (Berlin 1931); for Grotjahn, see D. Tutzke, *Alfred Grotjahn* (Leipzig 1979).

21. A. Fischer, *Grundriss der sozialen Hygiene* (Berlin ^{1}1913, Karlsruhe ^{2}1925); for Fischer, see K. D. Thomann, *Alfons Fischer (1873–1936) und die Badische Gesellschaft für soziale Hygiene* (Köln 1980).

22. Grotjahn, *Erlebtes und Erstrebtes*, 136.

23. Grotjahn, *Soziale Pathologie*, 446.

24. A. Grotjahn, *Die hygienische Forderung* (Königstein/Ts. 1921), 179.

25. Fischer, *Grundriss*, 12.

26. For the links between politics, administration and hygiene/social hygiene as the transmission belts of socio-political aims, cf. the writings of Paul Weindling; for instance his 'Die preussische Medizinalverwaltung und die "Rassenhygiene". Anmerkungen zur Gesundheitspolitik der Jahre 1905–1933' in *Zeitschrift für Sozialreform* 30 (1984), 675–87.

27. Cf. Tennstedt, *Vom Proleten*, 462.

28. Cf. for instance, G. Heller, *'Propre en ordre'. Habitation et vie domestique*

1850–1930: l'exemple vaudois (Lausanne 1979), and idem, 'Idéologie et rituels de la propreté aux XIX^e^ et XX^e^ siècles' in A. E. Imhof (ed.), *Leib und Leben in der Geschichte der Neuzeit* (*Berliner historische Studien*, vol. 9) (Berlin 1983), 193–202, and also the other contributions by B. Hermann, J. Brüggelmann, C. Honegger and E. Fischer-Homberger in the same volume, on 'Verdrängung, Medikalisierung, Hygienisierung des Körpers'.

29. J. Goudsblom, 'Zivilisation, Ansteckungsangst und Hygiene. Betrachtungen über einen Aspekt des europäischen Zivilisationsprozesses' in P. Gleichmann, F. Goudsblom and H. Korte (eds.), *Materialien zu Norbert Elias' Zivilisationstheorie* (Frankfurt 1979), 215–53.

30. For the development of public health services in Germany c. 1830–1940, see A. Labisch and F. Tennstedt, *Der Weg zum 'Gesetz über die Vereinheitlichung des Gesundheitswesens'. Entwicklungslinien und Entwicklungsmomente des staatlichen und des kommunalen Gesundheitswesens in Deutschland* (*Schriftenreihe der Akademie für öffentliches Gesundheitswesen*, vol. 13) 2 vols. (Düsseldorf 1985; forthcoming).

31. Cf. M. Vogel's survey 'Hygienische Volksbildung' in A. Gottstein, A. Schlossmann and L. Teleky (eds.), *Handbuch der Sozialen Hygiene und Gesundheitsfürsorge*, vol. 1 (Berlin 1925), 303–90.

32. On the Dresden exhibition, out of which the hygiene museum grew, see besides Vogel, 'Hygienische Volksbildung', (Vogel was later the director of this famous institution), R. v. Engelhardt, *Zur Einführung in die Sammlung 'Der Mensch'* (Dresden 1921). For Düsseldorf, cf. A. Schlossmann (ed.), *GE-SO-LEI. Grosse Ausstellung Düsseldorf 1926 für Gesundheitspflege, soziale Fürsorge und Leibesübungen*, 2 vols. (Düsseldorf 1927). For the national health week, cf. D. S. Nadav, 'Zur Einberufung der Ersten Reichsgesundheitswoche im Jahre 1926' in *Med. Welt*, 27 (1976), 1069–72.

33. Gottstein after I. Kaup; 'Abgrenzung der Sozialhygiene von der übrigen Medizin', in *Zeitschrift für Schulgesundheitspflege*, 42 (1929), 248–51.

34. A. Gräfin zu Castell-Rüdenhausen, 'Die Überwindung der Armenschule. Schülerhygiene an den Hamburger öffentlichen Volksschulen im Zweiten Kaiserreich' in *Archiv für Sozialgeschichte*, 22 (1982), 210–26, esp. 205.

35. See, e.g., the recollections of W. Hagen, *Auftrag und Wirklichkeit. Sozialarzt im 20. Jahrhundert* (München 1978); cf. also G. Loewenstein, *Kommunale Gesundheitsfürsorge und sozialistische Ärztepolitik zwischen Kaiserreich und Nationalsozialismus – autobiographische, biographische und gesundheitspolitische Anmerkungen* (Bremen ²1980).

36. Cf. C. Sachsse, 'Zur Entstehung sozialer Arbeit in Deutschland', in *Zeitschrift für Sozialreform*, 28 (1982), 267–96; cf. also idem, *Mütterlichkeit als Beruf* (Frankfurt 1985).

37. The first collective works on the social history of the relationship between work and medicine will be appearing shortly; see D. Milles and R. Müller (eds.), *Beiträge zur Geschichte der Arbeiterkrankheiten und der Arbeitsmedizin in Deutschland* (Bremerhaven 1985); P. Weindling (ed.), *The Social History of Occupational Health* (London 1985).

38. B. Flohr, *Arbeiter nach Mass. Die Disziplinierung der Fabrikarbeiterschaft während der Industrialisierung Deutschlands im Spiegel von Arbeitsordnungen* (Frankfurt 1981).

39. Hygienist Ferdinand Hueppe; see his autobiography in L. R. Grote (ed.), *Die Medizin der Gegenwart in Selbstdarstellungen*, vol. 2 (Leipzig 1923), 77–138, esp. 81.

40. Tennstedt, *Vom Proleten*, 462.

41. For a treasure trove of further sources, see the chapter 'Soziokulturelle Auswirkungen der Krankenkassenbewegung: die "Veredelung des Arbeiters" durch "Gesundheitsverhalten"', in Tennstedt, *Vom Proleten*, 448–70.

42. A. Labisch, 'Die gesundheitspolitischen Vorstellungen der deutschen Sozialdemokratie von ihrer Gründung bis zur Parteispaltung (1863–1917)' in *Archiv für*

Sozialgeschichte, 16 (1976), 325–70; idem, 'Das Krankenhaus in der Gesundheitspolitik der deutschen Sozialdemokratie vor dem Ersten Weltkrieg' in *Medizinische Soziologie. Jahrbuch 1*, 1981, 126–51.

43. Cf., for instance, H. Wolf, *Kapitalismus und Heilkunde oder Doktor und Apotheker* (Dresden 1893).

44. Apart from Tennstedt (see n. 41), cf. G. Göckenjan's forthcoming 'Medizin und Ärzte als Faktor der Disziplinierung der Unterschichten: Der Kassenarzt' in C. Sachsse and F. Tennstedt (eds.), *Soziale Sicherung und soziale Disziplinierung* (Frankfurt 1985).

45. Tennstedt, *Vom Proleten*, 451.

46. P. Kampffmeyer, *Die Mission der deutschen Krankenkassen auf dem Gebiete der öffentlichen Gesundheitspflege. Programmatische Gedanken zur Reform des Krankenversicherungsgesetzes* (Frankfurt 1903), 4.

47. Ignaz Zadek, for instance, was involved in almost every activity of the Berlin social democratic labour movement in the field of health policy, around the turn of the century; apart from much else, he edited an *Arbeiter-Gesundheits-Bibliothek* which ran to forty-one numbers. For Zadek, see F. Tennstedt, 'Arbeiterbewegung: Familiengeschichte bei Eduard Bernstein und Ignaz Zadek' in *IWK. Internationale wissenschaftliche Korrespondenz zur Geschichte der deutschen Arbeiterbewegung*, 18 (1982), 451–81.

48. Cf. the many pictures, documents and contributions in G. Asmus (ed.), *Hinterhof, Keller und Mansarde. Einblicke in Berliner Wohnungselend 1901–1920* (Reinbeck 1982).

49. For the Workers' Health Committee, cf. A. Labisch; 'Selbsthilfe zwischen Auflehnung und Anpassung: Arbeiter-Sanitätskommission und Arbeiter-Samariterbund' in *Argument-Sonderband*, 77 (1983), 11–26.

50. Quoted from Tennstedt, *Vom Proleten*, 459.

51. Kampffmeyer, *Mission*, 29f.

Alfons Labisch
is Professor of Health Policy at the Gesamthochschule Kassel. He is the co-author, with Florian Tennstedt, of the forthcoming *Der Weg zum 'Gesetz über Vereinheitlichung des Gesundheitswesens' vom 3. Juli 1934. Entwicklungsmomente des staatlichen und des kommunalen Gesundheitswesens in Deutschland.*