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Disability and the Rise of Capitalism

The stressing of the need to provide a theoretical explanation of disability and the importance of developing a historical understanding of it, do not imply the endorsement of the theory of historical materialism, nor its applicability to a proper understanding of the nature of disability, for

It is not necessary to be a Marxist to recognise that economic conditions have a significant impact on social behaviour and on relationships between different groups of individuals in society. (Harbert, 1988, p. 12)

The previous chapters have suggested that the definitions and experiences of disability vary from society to society depending on a whole range of material and social factors. The crucial issue to be discussed in the next two chapters is why the view of disability as an individual, medical problem and a personal tragedy has been the dominant one in modern capitalist societies.

Given that no adequate social theory of disability has yet been advanced, it is necessary to draw upon the work of some earlier theorists whose main concern was to develop an understanding of the rise and progress of capitalism. Notwithstanding recent critiques of evolutionary approaches to human history (Giddens, 1984), it will be suggested that such approaches, derived particularly from the work of Marx, Comte and Weber, can at least provide a framework to facilitate our understanding of the present situation in respect of disability.

THE MODE OF PRODUCTION AND HISTORICAL CHANGE

A framework derived from historical materialism does, at least, add to our understanding of what happened to disabled people with the coming of industrial society. A general statement of this view of history is as follows:

In Marx's view, to understand the nature of human beings one must understand their relationship to the material environment and the historical nature of this relationship in creating and satisfying human needs. This material environment may, in the first instance, be the constraints of the physical environment. However, as societies develop and become more complicated, the environment itself will become more complicated and comprise more socio-cultural constraints. (Forder et al., 1984, p. 89)

These socio-cultural constraints may include the nature of the work environment, the living conditions of people in rural or urban environments and the relationships between institutions, groups and individuals, all of which are related to the socio-economic structure of society at particular points in history.

So an understanding of historical process makes possible an understanding of human nature and the social relationships which exist at any particular point in time. (Forder et al., 1984, p. 90)

But historical materialism is not just about placing social relationships within a historical setting. It also attempts to provide an evolutionary perspective on the whole of human history, and of particular relevance here are the transitions from feudal through capitalist to socialist society. No attempt has been made to apply this (or

indeed any other social theory) to the history of disability, though Finkelstein (1980) has located his account within a materialist framework and developed an evolutionary model, broadly along the lines of the three stages of the historical materialist model mentioned above, though without using the same terminology.

His model is couched in terms of three phases of historical development. Phase 1 corresponds to Britain before the industrial revolution; that is feudal society. Phase 2 corresponds to the process of industrialisation when the focus of work shifted from the home to the factory; that is capitalist society. This takes us up to the present day, and Phase 3 refers to the kind of society to which we are currently moving, though Finkelstein does not spell out the differences between Phases 2 and 3, nor does he comment on whether Phase 3 marks the beginning of the transition to socialism as predicted by historical materialism.

The economic base in Phase 1, agriculture or small-scale industry, did not preclude the great majority of disabled people from participating in the production process, and even where they could not participate fully, they were still able to make a contribution. In this era disabled people were regarded as individually unfortunate and not segregated from the rest of society. With the rise of the factory in Phase 2, many more disabled people were excluded from the production process for

The speed of factory work, the enforced discipline, the time-keeping and production norms - all these were a highly unfavourable change from the slower, more self-determined and flexible methods of work into which many handicapped people had been integrated. (Ryan and Thomas, 1980, p. 101)

As capitalism developed, this process of exclusion from the workforce continued for all kinds of disabled people.

By the 1890's, the population of Britain was increasingly urban and the employment of the majority was industrial, rather than rural. The blind and the deaf growing up in slowly changing scattered rural communities had more easily been absorbed into the work and life of those societies without the need for special provision. Deafness, while working alone at agricultural tasks that all children learned by observation with little formal schooling, did not limit the capacity for employment too severely. Blindness was less of a hazard in uncongested familiar rural surroundings, and routine tasks involving repetitive tactile skills could be learned and practised by many of the blind without special training. The environment of an industrial society was however different. (Topliss, 1979, p. 11)

Changes in the organisation of work from a rural based, cooperative system where individuals contributed what they could to the production process, to an urban, factory-based one organised around the individual waged labourer, had profound consequences. 'The operation of the labour market in the nineteenth century effectively depressed handicapped people of all kinds to the bottom of the market.' (Morris, 1969, p. 9)

As a result of this, disabled people came to be regarded as a social and educational problem and more and more were segregated in institutions of all kinds including workhouses, asylums, colonies and special schools, and out of the mainstream of social life. The emergence of Phase 3, according to Finkelstein, will see the liberation of disabled people from the segregative practices of society largely as a consequence of the utilisation of new

technologies and the working together of professionals and disabled people towards common goals. Whether this is likely to be so, is an issue which will be returned to in later chapters.

For Finkelstein, disability is a paradox involving the state of the individual (his or her impairment) and the state of society (the social restrictions imposed on an individual). By adopting a three-stage evolutionary perspective, he sees the paradox emerging in Phase 2. In Phase 1 disabled individuals formed part of a larger underclass but in Phase 2 they were separated from their class origins and became a special, segregated group, whereby the paradox emerged and disability came to be regarded both as individual impairment and social restriction. Phase 3, which is just beginning, sees the end of the paradox whereby disability comes to be perceived solely as social restriction.

Like historical materialism, this model has explanatory power particularly in helping us to understand what happened in Phase 2 or with the emergence of capitalist society. However, it does tend to oversimplify what was happening prior to this capitalist emergence. It implies that in Phase 1, some kind of idealised community existed and that disabled people, amongst other minority groups, were treated more benignly. While it is certainly true that the emergence of capitalism had profound effects on social relations generally and that many acceptable social roles and positions disappeared, and that this directly affected disabled people in many instances, it is difficult to assess whether these changes affected the quality of the experience of disability negatively or positively, largely because history is silent on the experience of disability.

A similar model has been advanced to explain variations in social responses to and personal experiences of

disability in the modern world (Sokolowska et al., 1981). They suggest that there are three kinds of society in the modern world; what they call developing, intermediary-developed and highly-developed or types I, II and III. Type I societies are characterised by the spontaneous participation of disabled people; type II societies are characterised by the separation of disabled people from the rest of society; and type III societies are, or should be, characterised by the integration of disabled people, made possible by the supply of 'necessary appliances'.

This contemporary model, like Finkelstein's historical one, is of considerable value in highlighting the importance of the mode of production in significantly influencing perceptions and experiences of disability. However, both models are over-simplistic and over-optimistic. They are over-simplistic in that they assume a simple relationship between the mode of production and perceptions and experiences of disability, without considering a range of other influential factors, many of which were discussed in the previous chapter. They are also too optimistic in that both assume that technological developments will liberate disabled people and integrate them back into society. The ambiguities of the role of technology in modern society will be returned to in Chapter 8, but for now, we need to consider some of the other factors which influence perceptions and experiences of disability.

THE MODE OF THOUGHT AND HISTORICAL CHANGE

Auguste Comte also provided an evolutionary model aimed at providing an understanding of the development of human history. He suggested that the human intellectual process could be understood in terms of three stages of development; the theological, the metaphysical and the positivistic stages. This model suggests that there has been a shift from a religious interpretation of reality to

a more naturalistic one and finally to a scientific way of understanding both the natural and social worlds:

each branch of our understanding passes through three different stages: the theological or fictitious stage; the metaphysical or abstract stage; and the scientific or positive stage. In other words, the human mind, by its very nature, employs successively in each of its fields of investigation three methods of philosophising whose character is essentially different and even radically opposed: first, the theological method, next the metaphysical method, and finally the positive method. This gives rise to three kinds of philosophy or of general conceptual systems about all phenomena which are mutually exclusive. (Comte, 1855, p. 2)

This evolutionary model has proved useful in developing an understanding of changing historical perceptions of deviance (Kittrie, 1971) including drug addiction, homosexuality, alcoholism and mental illness; each being regarded first as moral, then legal and now medical problems. As a result of these perceptions particular deviants were subjected to moral, then legal and now medical mechanisms of social control. Similarly, a recent review of the medicalisation of deviance suggests that three major paradigms may be identified that have held reign over deviance designations in various historical periods: deviance as sin; deviance as crime and deviance as sickness. (Conrad and Schneider, 1980, p. 27)

There have been few attempts to utilise this evolutionary model to develop an understanding of changing historical perceptions of disability. However, a recent analysis of the ideology of care underlying the development of services for mentally handicapped people suggests a similar approach (Soder, 1984). This analysis suggests that

initially the care provided was based upon a philosophy of compassion linked to religious and philanthropic perspectives; then services were provided based upon the philosophy of protection, both for the disabled individuals and society; and finally care was provided on the basis of optimism, linked to the development of new scientific and pedagogic approaches to the problem of, mental handicap.

Comte's model has also been used to illustrate changing patterns of prejudice in respect of people with epilepsy:

increasing rationalisation did not ameliorate social prejudice against epileptics - it merely caused one form of prejudice to be substituted for another. He was no longer isolated as unclean, as a ritually untouchable person, but instead he was isolated as insane, and placed in institutions where he was subjected to extremely substandard conditions of life. However later evidence suggests that further rationalisation and increasing knowledge of the causation of epilepsy, separating it from insanity, may lead to improvements in social conditions for epileptics - as the culture catches up with findings of the scientific community. (Pasternak, 1981, p. 227)

This optimism mirrors optimism found in the work of Comte and in Soder's analysis of mental handicap, but whether this is justified in respect of the medicalisation of disability will be returned to in the next chapter. For now we need to consider two criticisms of this evolutionary model and its application, one internal and the other external.

The internal criticism of these models is that the 'phenomena' are not 'mutually exclusive' as Comte implies. While one perception may dominate at a

particular point in history, it does not do so at the expense of the others. In modern industrial societies, people with epilepsy may still be perceived by some as possessed by demons, still subject to legal regulation (with regard to marriage, work or driving) and yet be the recipients of sophisticated medical treatments of one kind or another (Oliver, 1979). Similarly, the explanation for the birth of a disabled child will clearly be a medical or scientific one, but that does not mean that some parents may not feel that it is a punishment for some previous sin. Thus, while the model may add to our understanding of changing perceptions of deviance and disability, it cannot and does not explain them, in causal terms, at least.

The external criticism concerns this issue of causality and takes us back to the Marx/Weber debate and it is clear that changing perceptions of epilepsy cannot be accounted for solely in terms of the mode of thought for

The drift to the town and the growing complexity of industrial machinery at the time meant the development of a class of industrial rejects for whom it was clear that special provision would have to be made ... The problem of severe epileptics in a city such as Bradford, where the wool trade meant fast moving machinery, and crowded workshops, must have been particularly acute. (Jones and Tillotson, 1965, pp. 5-6)

Hence the nature of disability can only be understood by using a model which takes account of both changes in the mode of production and the mode of thought, and the relationship between them. What now needs to be considered is this relationship between the two, and the ways in which the economic surplus is redistributed through social policies which both meet the needs of the changing mode of production and which are

commensurate with current social perceptions about what are, and are not, appropriate ways of dealing with this problem.

STATE INTERVENTION IN THE LIVES OF DISABLED PEOPLE

The rise of capitalism brought profound changes in the organisation of work, in social relations and attitudes, and these changes had implications for family life. These factors, with the demographic explosion which accompanied them, posed new problems for social order and with the breakdown of traditional social relations, new problems of classification and control.

The main solution to this problem was the institution (Rothman, 1971), and while institutions existed in feudal times, it was with the rise of capitalism that the institution became the major mechanism of social control. Thus there was a proliferation of prisons, asylums, workhouses, hospitals, industrial schools and colonies. The institution was a remarkably successful vehicle in dealing with the problem of imposing order and it was in accord with changing social values consequent upon the 'civilising process' (Elias, 1977) and the switch from 'punishment of the body to punishment of the mind' (Foucault, 1977). The institution was successful because it embodied both repressive and ideological mechanisms of control (Althusser, 1971). It was repressive in that it offered the possibility of forced removal from the community for anyone who refused to conform to the new order. But it was ideological also, in that it acted as a visible monument, replacing the public spectacle of the stocks, the pillory and the gallows, to the fate of those who would not or could not conform.

Total institutions work their effects on society through the mythic and symbolic weight of their walls on the world outside, through the ways, in other words, in which people fantasize, dream and fear the archipelago of confinement. (Ignatieff, 1983, p. 169)

It was not just the prisons and asylums which operated as mechanisms of social control; the workhouse as well was crucial, and its ideological function was always more important than its repressive one:

the workhouse represented the ultimate sanction. The fact that comparatively few people came to be admitted did not detract from the power of its negative image, an image that was sustained by the accounts that circulated about the harsh treatment and separation of families that admission entailed. The success of 'less eligibility' in deterring the able bodied and others from seeking relief relied heavily on the currency of such images. Newspapers, songs and gossip, as well as orchestrated campaigns for the abolition or reform of the system, all lent support to the deliberate attempts that were made to ensure that entry to a workhouse was widely regarded as an awful fate. (Parker, 1988, p. 9)

In the institution, the state had found a successful method of dealing with the problem of order, and in the workhouse, a successful method of imposing discipline on the potential workforce. But it still faced the age-old problem of separating out those who would not from those who could not conform to the new order. Hence throughout the eighteenth and nineteenth centuries institutions became ever more specific in their purposes and selective in their personnel. This distinction between the deserving and the undeserving, which has shaped the

development of welfare policies throughout history, has never been satisfactorily resolved.

These developments then, facilitated the segregation of disabled people, initially in workhouses and asylums, but gradually in more specialist establishments of one kind or another:

the rise of specialist asylums signified an important shift in the way in which the poor, dependent and deviant were contained ... Public workhouses, as opposed to domestic relief, were increasingly used for all those who could not or would not support themselves economically. In these, idiots, lunatics, the chronic sick, the old and vagrants were mixed up with allegedly able-bodied unemployment. (Ryan and Thomas, 1980, p. 100)

However, it quickly became clear that workhouses could not simply function as residual dumping grounds for such disparate groups of people. A crucial issue was that of separating out those who could not work from those who could but would not; effective discipline and deterrence required these groups to be separated from each other. But further separation and specialisation was necessary within the former group in order to successfully manage and control this group in ways that were socially acceptable at the time.

The Poor Law Amendment Act (1834) played an important part in this process of increasing specialisation and the disability category was crucial in separating out those unwilling from those unable to work.

In the regulations of the Poor Law administration and thus in the eyes of the Poor Law administrators, five categories were important in defining the internal

universe of paupers; children, the sick, the insane, 'defectives', and the 'aged and infirm'. Of these, all but the first are part of today's concept of disability. The five groups were the means of defining who was able-bodied; if a person didn't fall into one of them, he was able-bodied by default. This strategy of definition by default remains at the core of current disability programs. None provides positive definition of 'able-bodied'; instead, 'able to work' is a residual category whose meaning can be known only after the 'unable to work' categories have been precisely defined. (Stone, 1985, p. 40)

It would be a mistake to imagine that the success of the institution meant that all or even a majority of disabled people ended up in one. In feudal times the family and the community were the places in which disabled people existed. With the coming of capitalism the family remained the setting where the majority of disabled people lived out their lives. What did change however, partly as a consequence of the ideological climate created by institutions setting people apart from the rest of society, was that disability became a thing of shame; the process of stigmatisation caught the deserving as well as the undeserving. But not all families could cope with difficulties of having disabled people segregated within them, particularly working-class families which were already under pressure in the new capitalist social order. Hence disabled people became segregated from their communities and wider societies and, only when the families were unwilling or unable to cope, did they become possible candidates for the institution.

Nobody wanted to go into an institution but not every relative found it possible to keep their dependent kin, especially so it seems, the mentally disordered and the aged. (Parker, 1988, p. 23)

Both the family and the institution, therefore, became places of segregation. But, as far as the balance between institutional and family provision for disabled people is concerned

We know next to nothing about this, but it is reasonable to suppose, for example, that the undoubted decline in domestic production in the outwork industries, the artisanal sector and the cottage economy of the agricultural labourer made it more difficult for poor families, particularly women, to provide domestic care for the aged and insane. (Ignatieff, 1983, p. 172)

Thus, as a consequence of the increasing separation between work and home, the boundaries of family obligations towards disabled people were re-drawn; so the new asylums and workhouses met a need among poor families struggling to cope with 'burdens which for the first time may have been felt to be unbearable' (Ignatieff, 1983).

This distinction between segregation in the family and in the institution remained into the twentieth century as the state became more interventionist and the foundations of the welfare state as we know it today, developed. As one commentator puts it

The provision of personal care and practical assistance to disabled people falls into two main divisions, that of residential care and that of support and assistance to disabled people in their own homes. (Topliss, 1982, p. 77)

What has changed in the twentieth century has been the balance between institutional and family care. To be sure,

there has been a 'de-institutionalisation' or 'decarceration' movement in the latter part of the twentieth century and undoubtedly many people previously in institutions have been returned to the community. The closure, initially of the workhouses and colonies and later the longstay hospitals has undoubtedly put many thousands of those previously incarcerated back into the community; but two points need to be made about this.

Firstly, within the different groups of people who are poor, old, sick, disabled, insane and so on, just as the proportions within each group who were institutionalised, were different, so too have been the rates of discharge back into the community. Secondly, while the numbers of people may vary significantly, the ideological shift from institutional to community care has been much more significant. As far as disabled people are concerned, the majority have always lived in the community, albeit sometimes segregated from it, and so perhaps the shift has been more apparent than real. A similar point has recently been made in an analysis of the historical development of social control with the rise of capitalism.

There have been two transformations - one transparent, the other opaque, one real, the other eventually illusory - in the master patterns and strategies for controlling deviance in Western industrial societies. The first, which took place between the end of the eighteenth and nineteenth centuries, laid the foundations of all deviancy control systems. The second, which is supposed to be happening now, is thought by some to represent a questioning, even a radical reversal of that earlier transformation, by others merely to signify a continuation and intensification of its patterns. (Cohen, 1985, p. 13)

Rather than consider here whether these transformations actually mean a loosening of the structures of social control or not, what now needs to be considered is why these changes took place.

EXPLANATIONS - BACK TO COMTE AND MARX

In seeking to explain, rather than merely describe, what happened to disabled people with the coming of capitalist society, it should be pointed out that both the movement to institutional care and the movement away from it will be incorporated within the same explanatory framework.

The first explanation draws heavily on the Comtean framework and suggests that what happened to disabled people, and others, can be seen as the progressive evolution of reason and humanity, and that the move from community to institution and back again, reflects changing ideas about social progress. This view is what Abrams (1982) calls 'the enlightenment theory of social welfare' and incorporates the establishment of segregated institutions in Benthamite terms as improvements on earlier forms of provision. Further it also incorporates variants of the anti-institution movement of the late twentieth century, sparked off by the work of Goffman (1961) and a number of damning public enquiries about the conditions in longstay hospitals, suggesting that the move back to community care reflects our changing ideas about the appropriateness of institutional provision in modern society.

What it fails to explain, however, is that many of those confined to institutions experienced this as punishment rather than treatment, and indeed, as recent studies have made clear (Scull, 1977), return to the community can also be an extremely punitive experience. Changing ideas

about the nature of the institution and of community incorporated in the enlightenment theory are thus

too one-dimensional to be altogether satisfactory. It recognises, one might say, that men make their own history but not the equally important fact that they do not make it just as they please. Of course men act on the basis of ideas but the ideas they have at any particular time and still more the influence of these ideas is not just an intellectual matter. Many good ideas never get a hearing; many bad ideas flourish for generations. (Abrams, 1982, pp. 11-12)

The success or failure of these ideas are dependent upon a whole range of other factors such as the economic and social conditions under which they develop and the support or resistance they encounter from people in powerful political positions and institutions.

The second explanation draws on the Marxian model and suggests that changes in policy and provision for disabled people were determined by changes in the mode of production. Thus

The asylums of the nineteenth century were ... as much the result of far-reaching changes in work and family life, and corresponding methods of containing the poor, as they were the inspiration of philanthropists and scientists. With other similar institutions of the period, they have remained the main alternative to the family ever since. (Ryan and Thomas, 1980, p. 101)

Similarly, the change back to community care was not simply the product of anti-institution ideas, which had been around in the nineteenth as well as the twentieth centuries, but also because 'segregative modes of social

control became ... far more costly and difficult to justify' (Scull, 1977, p. 135).

This explanation is what Abrams (1982) calls 'the necessity theory of social welfare' and incorporates not just the economic rationality underpinning much social provision but also the need to impose and maintain order in the changing industrial world. While this theory

forces us to pay attention to the ways in which social facts and conditions constrain and impel men to act in certain ways ... it corrects the bland tendency of enlightenment theory to detach ideas from their social context. But at the same time it tends to deny the equally important fact that what men do in the face of even the most constraining social conditions is indeed something they choose to do. (Abrams, 1982, pp. 12-13)

But neither the institution nor community care can be explained solely in terms of humanitarianism or necessity. The 'action theory of welfare' is also important and Parker (1988), in his historical review of residential care, suggests two factors of relevance. Firstly he suggests that the willingness, or otherwise, of families to care for their dependents was important and he cites historians like Ignatieff (1983) who have claimed that 'the working class family have played an active rather than a passive part, in the history of institutional development'. Thus he suggests that

the level of demand for institutional care seems to have been a function of (a) the acceptability of that care as perceived by relatives; (b) the costs which they consider they and their families bear in continuing to look after the dependent or disruptive

member; and (c) the number of dependent people without close relatives. (Parker, 1988, p. 24)

Some families have also played an active part in seeking to have relatives removed from longstay hospitals, special schools and children's homes, though as the defects in community care become more and more apparent, other families are actively campaigning for institutions to remain.

Secondly, he suggests that institutions have been important historically because of the role they have played in campaigns of rescue, notably of children in the latter half of the nineteenth century. This rescue mission was also an important factor in the development of residential care for disabled people after the Second World War, when the Cheshire Foundation supposedly 'rescued' many disabled adults from isolation in families, from longstay hospitals, from geriatric wards and other unsuitable provision. That history may subsequently reinterpret such action as incarceration rather than rescue does not invalidate the actions of individuals at particular historical points.

Thus while the 'action theory of welfare' may not explain the forms that provision may take when extracted from historical context, it is useful in developing an understanding of the precise nature and form of that provision, consequent upon the influence of individuals, families and groups at a particular point in time. However, what the action theory does not explain, according to Abrams (1982), is that some groups 'prove persistently more influential than others', necessitating the development of a 'power theory of welfare'. Undoubtedly the group that has been most persistently influential in the context of disability, has been the medical profession and this will be discussed more fully in the following chapter. Before that, there is one further explanation which needs

to be discussed and this draws upon Weberian notions of rationality, though it does also incorporate elements of the necessity theory.

RATIONALISATION - DISABILITY AS AN ADMINISTRATIVE CATEGORY

The work of Stone (1985) is different from that discussed previously in this chapter in that it takes disability itself seriously as a theoretical category and grounds its theorising in a discussion of the development of welfare policies in respect of disability in Britain, the USA and Germany. While making no reference to the work of Weber, the argument she presents can be located in his notion of the development of capitalism being accompanied by an increasing 'rationalisation' of the world. Weber's approach can be summarised thus:

By 'rationalisation' Weber meant the process by which explicit, abstract, calculable rules and procedures are increasingly substituted for sentiment, tradition and rule of thumb in all spheres of activity. Rationalisation leads to the displacement of religion by specialised science as a major source of intellectual authority; the substitution of the trained expert for the cultivated man of letters; the ousting of the skilled handworker by machine technology; the replacement of traditional judicial wisdom by abstract, systematic statutory codes. Rationalisation demystifies and instrumentalises life. (Wrong, 1970, p. 26)

In respect of provision to meet the changing needs of disabled people with the development of capitalism, this was done through the elaboration of ever more detailed systems of bureaucratic organisation and administration.

Stone's (1985) basic argument is that all societies function through the 'distributive principle' in that goods and services produced have to be allocated amongst the population as a whole. The major mechanism of distribution (and production) is work, but not everyone is able or willing to work. Thus a distributive system based on need will also exist and the 'distributive dilemma' centres on how to allocate goods and services based upon the very different principles of work and need. With the rise of capitalism, disability has become an important boundary category through which people are allocated either to the work-based or needs-based system of distribution. The increasing specialisation of both categorisation and provision is thus a function of the increasing rationalisation of the world.

This explanation incorporates elements of necessity theory, both in the need to redistribute goods and services and in relation to labour supply.

The disability concept was essential to the development of a workforce in early capitalism and remains indispensable as an instrument of the state in controlling labor supply. (Stone, 1985, p. 179)

However, it fails to acknowledge the contradictory aspects of rationalisation noted by Weber in the distinction he makes between formal rationality and substantive rationality (Weber, 1968) and the way the latter may contradict the former. It is possible to argue, as Stone does, that the formal rationality underpinning the disability category makes it the ascription of privilege, in that it offers legitimate social status to those classified as unable to work. But the substantive rationality, enshrined in the experience of disability, is much more concerned with the processes of stigmatisation and oppression.

Stone acknowledges the contradictions inherent in the development of capitalism discussed both by Marx and Weber, and discusses what she calls 'economic and political versions of contradiction theory'. In the economic version, the state experiences a fiscal crisis because it must constantly expand its expenditures while its revenues cannot grow fast enough to meet these expenditures. The political version stresses 'legal rights to social aid' which engenders political support from some sections of society but opposition from others. Both versions predict eventual system breakdown because of either economic crises or the erosion of political support. However, by concentrating on the boundaries between various parts of the capitalist system, rather than on its internal logic she concludes that

The interpretation of disability as a concept that mediates the boundary between two conflicting distributive principles offers a very different answer to the question of co-existence. (Stone, 1985, p. 20)

The answer, at least in the short term, therefore, is that the disability category, because it is socially constructed and flexible, can resolve any systemic contradictions that may occur.

By the late twentieth century, however, Stone notes that the disability category has become less flexible as the standards for eligibility get more and more detailed; once certain groups are accepted into the category they cannot be ejected from it; people become socialised into their role as disabled; and disability categorisation is legitimated by the medical and welfare bureaucracies. This has provoked a crisis in disability programmes which may not be subject to categorical resolution, for

Keepers of the category will have to elaborate ever more situations in which people are legitimately needy, until the categories became so large as to engulf the whole. (Stone, 1985, p. 192)

If such a situation were to occur, where the distributive dilemma was resolved on the basis of need, then that would surely mark the transition from capitalism to socialism predicted by Marx. But that is to go too far, too fast, and we need to resume the consideration of what disability under capitalism is actually like rather than consider what it might be like under socialism.

This chapter has attempted to discuss disability in the context of the rise of capitalist society and has suggested that economic development, the changing nature of ideas and the need to maintain order, have all influenced social responses to and the experience of it. The rise of the institution as a mechanism of both social provision and social control has played a key role in structuring both perceptions and experiences of disability, and facilitated the exclusion of disabled people from the mainstream of social life. Within this, the ideological dimension has been at least as important as the physical provision of segregated establishments and it is precisely this ideological dimension which is now being challenged with the development of community care. What needs to be considered next is the way the individualisation of life under capitalism has contributed to the individualisation of disability and the role of powerful groups, notably, the medical profession, in this process.