Chapter 6
Resilience as an Asset for Healthy Development

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6.1 Introduction

This chapter examines positive adjustment and resilience as an asset, which can promote good health, even in adverse conditions. It presents a number of different models that have been put forward to explain how resilience works; compensatory, protective and challenge. Resilience is not a constant but is something moulded and shaped by the physical and social environment. Some people, depending on financial or social determinants, will have more freedom and capacity to make healthy choices.

A healthy diet is used as an example of a factor which can promote health resilience in some communities, even those where there are levels of socioeconomic disadvantage. Relative health inequalities in a number of Southern Mediterranean countries are used as an example of this. However, the authors argue that in these countries health advantage is conferred by a much more complex range of factors than diet alone. The role of social, religious and ethnic support following deindustrialisation is discussed. The paper concludes with an analysis of the largely unexplored impact of the contemporary removal of much unpaid female labour (both physical and emotional) from the domestic sphere and the untold impact of this on the physical and emotional development of the family. The changing roles and relationships of men and women within in the family have effectively, and perhaps unexpectedly, removed beneficial health assets.

As long ago as 1948, the World Health Organization defined health as a *"state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"* (WHO 1946; p. 28). Despite this affirmative definition of health, most subsequent studies over the past half century focused on health in terms of illness, disease, dysfunction and disability. A renewed call for attention to positive health

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and well-being by the WHO Venice Office has given rise to a pioneering focus on assets rather than deprivation and on strengths rather than deficits. The early development of this programme of work was part of the inspiration behind the Economic and Social Research Council's (ESRC) Research Priority Network on *"Human capability and resilience"*. In this chapter, members of the Network set out some of the ideas that have informed our research, and some of the ways in which these may inform the further use of the "assets paradigm" in public health.

Most empirical studies of individuals and communities experiencing serious adversity, such as severe family disruption or persistent poverty, reveal that such adversity usually has negative consequences on health. "The poorer a community is, the greater will be their level of poor health and mortality", is a generalisation which holds largely, but not wholly, true, and which drives the dominant focus on deficits and risk in public health. However, the practices and processes by which some individuals and communities do adapt to adversity, and "cope" or even "thrive", despite it, are less widely observed and considered, even if they are usually admired when brought to our attention. Attempts by social scientists to understand this capacity are, however, relatively recent, and even more recent are attempts to extend this research into the field of public health. The founders of resilience research such as (Antonovsky 1979; Garmezy 1985; Werner and Smith 1992), turned away from an emphasis on illness or maladjustment among hazard-exposed groups and towards *"the strengths of risk-exposed individuals as well, both in terms of adjustment outcomes (competence in addition to symptomatology) and in terms of characteristics that promote positive adaptation – assets or protective factors as well as 'liabilities' or vulnerability-enhancing ones."* (Luthar et al. 2000a; p. 574).

Most of our present understanding of resilience is drawn from studies of children brought up in severe adversity who prove to be "hardy survivors" and go on to *"live well, work well, and love well"* (Werner and Smith 1992). In many of these studies, the definition of positive adaptation has been rather limited, often confined to the avoidance of addiction to drugs or alcohol and of criminal or violent behaviour and high-risk sexual behaviour. Such definitions unfortunately turn us away from focusing on the processes by which resilience can be achieved and the individual or community assets which foster these processes. A limited definition of resilient outcomes also diverts attention from the possibility that many might deploy resilience practices as a response to adversity, even if they are not successful in adaptation.

A recent review of the field distinguishes three models of resilience: compensatory, protective and challenge models (Fergus and Zimmerman 2005). The authors define "assets" as characteristics residing within the individual such as competence, coping skills, and self-efficacy. Factors external to the individual such as parental support, adult mentoring, or community organisations are defined as "resources". Others have used the term "resources" as a synonym for assets, referring to the human, social, or material factors utilised in adaptive processes (Masten and Reed 2002).

According to the compensatory resilience model it is the joint influence of different assets or resources, i.e. their cumulative effect which compensates or counteracts the effects of adversity. A cumulative resilience model assumes a direct effect of resource factors on an outcome, which can be independent from the risk

factor (Fergus and Zimmerman 2005). The protective resilience model presupposes an interactive relationship between the protective factor, the risk exposure, and the outcome, whereby a protective factor shows its beneficial effects primarily for those exposed to the risk factor, but does not necessarily benefit those not exposed to the risk factor (Garmezy et al. 1984; Rutter 1985, 1987). The protection model of resilience assumes that the resource factors interact with (or, in epidemiological terms, "moderate") the risk factor and reduce the effect of a risk on an outcome. The third model of resilience, the challenge model, suggests that low or moderate levels of risk exposure may have beneficial or steeling effects, providing a chance to practice problem solving skills and to mobilise resources (Masten et al. 1999; Rutter 1987). The challenge model assumes a curvilinear association between a risk factor and an outcome, where the risk exposure must be challenging enough to stimulate a response, yet must not be overpowering (Garmezy et al. 1984).

Combining the existing approaches from social and developmental psychology with the new "health assets" approach requires some careful attention to terminology and definition of concepts. Fergus et al. conclude that: "A rich understanding of resilience processes ... necessitate including cumulative risks, assets, and resources studies over time." (Fergus and Zimmerman 2005; p. 13.9). In this way they create a clear link between the study of resilience and the increasing interest within social epidemiology in life-course processes in chronic disease (Kuh and Ben-Shlomo 1997), highlighting the need to examine the accumulation of both risks and resources or assets.

Up to the present time, life-course epidemiology has also tended to focus on the accumulation of "risk factors" only (Brunner et al. 1999; Bartley and Plewis 2002; Galobardes et al. 2004). Consideration of the possibility that health assets may also "accumulate", and that this may be expressed at certain times of life as resilience, requires more complex theoretical and methodological approaches (Schoon et al. 2002, 2003; Schoon 2006; Wiggins et al. 2004; Bartley et al. 2004).

Health assets are seen as being shaped by the social and physical environment. In agreement with this, Luthar and colleagues do not view resilience as a property of the individual, but as a set of conditions that allow individual adaptation to different forms of adversity at different points in the life course (Luthar et al. 2000b). Individuals are not born with resilience, nor do they develop it as a stable personal characteristic. On the contrary, levels of resilience may vary over time according to facets of the social environment (Schoon 2006). In this chapter we hope to show that resilient practices and processes may be regarded as health assets which need to be better identified and promoted by social and economic policies.

For example, research has consistently revealed the quality of social relationships, not just in the family but also in the school and neighbourhood, as promoters of resilience (Anonymous 2000; Masten and Coatsworth 1998). Having good-quality relationships with others is universally considered as being vital to positive health and optimal living (Ryff and Singer 1998). A full understanding of human health has to consider not only physical health but also psychological and social flourishing. Individuals with more positive social relationship histories show lower levels of allostatic load (defined by blood pressure, waist–hip ratio, cholesterol, haemoglobin, and "stress hormones" such as cortisol) – a stronger cardiovascular, metabolic and sympathetic nervous system (Ryff and Singer 2002).

The findings of the ongoing research of the Network is turning attention towards the importance of existing capabilities of individuals and communities who face adverse circumstances, even if these capabilities may be expressed in terms that do not fit with conventional ideas of "achievement". Young people growing up in harsh material circumstances and subject to negative attitudes may acquire a toughness that appears to middle class professionals as problematic behaviour in need of correction, when in fact these attitudes are protective given the realities of their lives. Ungar, in his book "*Nurturing hidden resilience in troubled youth*" (Ungar 2004) has challenged fixed boundaries between adaptive and maladaptive behaviours and emphasises the importance of experiences that enhance capacities, promote self-determination, and increase social participation. For example, young women in similar circumstances are more likely than their more privileged peers to become mothers early in life. These young mothers may not achieve as much in terms of education and later career success as their middle-class sisters, but early motherhood does not seem to damage their mental health over the longer term.

During the economic crisis of the 1980s, when mass youth unemployment emerged in the UK, suicide rates rose dramatically in young men, while they continued to decrease in young women, although rates of early motherhood increased. Research may reveal a range of "resilient practices" already embedded as health assets in communities which, if given support rather than discouragement, may be sufficient in themselves to meet a wide range of negative life events. It is better not to make assumptions about what is a "good" or a "poor" outcome over time. Such assumptions might, for example, enforce a definition of "living well" in terms of conventional career or family trajectories that might not be meaningful to all members of a population. This would be the equivalent to trying to force a river into a concrete channel that was pre-determined according to the interests and culture of a single interest group, which has been found to have suboptimal consequences. Rather, the research tends to indicate the importance of policies and services that leave open the maximum scope for different life-trajectories to be chosen without others being irrevocably shut off.

6.2 Resilience Capability and Freedom

Some of the literature on resilience seems to imply that the world might be a better place if no-one ever experienced adversity. And indeed, many of the case studies of, for example, extreme poverty, or alcohol or drug-related child neglect, describe circumstances to which no-one should be exposed. Does this mean that in an ideal world resilience would be an irrelevance? Not at all. Risk-taking is a normal and desirable feature of life for a very large number of individuals. Risks may be experienced involuntarily, but can also be voluntarily faced in order to follow a wider number of life choices, from the desire to exercise entrepreneurial skill to a wish to save the lives of others despite danger to oneself. By definition, any risk may result in a deterioration of life circumstances, whether this be financial, emotional or physical. The ability to adapt in the face of such negative change, and some degree

of confidence in this ability, is therefore a major feature in the individual's perception of their own freedom to lead a valued life, that is, in Sen's sense, *"resilience increases capability"* (Deneulin and Shahani 2009). In turn, research also indicates that the more time an individual has spent in a capability-producing environment, the greater the resilience they are able to carry forward to meet the next challenge they may face. In order to understand how we think this works, it is necessary to look more closely at the relationship between capability and health.

Health itself has been characterised as a basic capability, in that good health enables a person to function as an agent, and thus freely choose a valued life (Tremblay 1999). In this chapter, however, which focuses on health issues as they exist in developed and emerging European nations, we need to take a step back from this position. Rather, we regard it as important for the individual to possess the freedom to pursue health itself, and therefore to understand in some detail the sources of limitation to that freedom. Examples of such limitations are wide-ranging but include being forced by financial necessity to accept hazardous or stressful working conditions; to live in polluted areas; and psychological challenges such as addictions, and the addiction-like behaviours referred to as "health risk behaviour". Both of these are problems faced by many individuals in developed nations.

6.3 Sources of Resilience and "Healthy Choices"

How might the freedom to pursue health ("make healthy choices") be increased for people facing such challenges? Of course, different threats to this freedom will require very different policy responses. Working conditions can only be improved by protective policies; the obligation to work or to live in unhealthy conditions can only be removed by adequacy of income for both those with and without employment. But psychological vulnerabilities such as addiction have their roots in the combination of individual life history and present life circumstances. In all of the (rather few) studies that have been carried out on this topic, there are no differences in knowledge about health hazards of diet and smoking between the more advantaged social groups and those less advantaged groups whose members are more likely to engage in health risk behaviour (Blaxter 1990; Shewry et al. 1992). If anything, the evidence is that those who smoke, for example, are even more aware of the risks than those who do not. Research points to the conclusion that the reasons for social inequalities in health risk behaviours (and thus the most effective preventive measures) are not to be found in beliefs or knowledge, but rather in features of the relationship between the individual and the social environment. It is clear that some forms of social environment increase the freedom of individuals to follow the health behaviours that they themselves regard as most desirable, and other forms reduce this freedom.

Forms of resilience will be important in the face of both physical and psychosocial hazards that are encountered later in life, but in very different ways. An individual who has had a healthy childhood will be better able to survive periods of hazardous employment should they indeed be forced to follow such a path or chose it consciously aiming for an improvement in their situation.

Research shows that physiological resilience is increased by having been born to a healthy mother after a normal gestation and brought up in a clean, safe, warm and dry home where income is adequate to needs (Skuse et al. 1994; Baxter Jones et al. 1999; Parker et al. 1999; Heim et al. 2001; Power 2002; Seguin et al. 2003; Hemmingsson and Lundberg 2005). These are conditions that would be desirable for all young citizens. However, such conditions are in fact more important to those who face later physical hazard even than to those who do not. Those who enter a psycho-social environment that increases the risk of addiction may similarly be empowered by a sense of self-esteem, good coping and social skills that have been facilitated in earlier life.

However, there are also wider influences of social norms and institutions that weaken the relationship between material disadvantage, social inequality and health-damaging forms of behaviour. We know that in a wider international perspective, socioeconomically disadvantaged conditions are not universally correlated to all forms of health-damaging behaviours (Kunst 1997; Mackenbach et al. 1997a). While not in any way wishing to use this as a justification for lack of policy action on socioeconomic disadvantage, it is instructive to examine the situations in which health assets are found among less privileged social groups.

6.4 Diet as a Source of Resilience: the Importance of the Social Context

A major comparative study of health inequality in the European nations (Kunst 1997; Mackenbach et al. 1997b) has found similar or greater inequalities (depending on age) between social classes in mortality in wealthy and egalitarian Nordic nations such as Norway and Sweden than it found in Italy, Ireland and Portugal. Even more surprisingly perhaps, inequalities in mortality during the 1980s were found to be larger in Sweden than in the United States in men aged 30–44 and no different in men aged 45–59 (Kunst 1997). Kunst reflected that:

> There were good reasons to expect that egalitarian socioeconomic …policies resulted in a substantial and lasting reduction in inequalities in health. However, comparative studies do not provide support for this expectation. Socioeconomic differences in mortality in countries with more egalitarian policies are not small from an international perspective. The potential role of some circumstances, for example cultural factors, has been ignored too long in health inequalities research (p. 142)

In the terms we use in this chapter, it seems that in some nations there was a source of resilience that enabled less socioeconomically privileged groups to escape the same degree of health disadvantage as that experienced by those in similar situations in other nations. The nations with the more resilient population groups were, broadly speaking, the Mediterranean countries.

The explanation favoured by many for this phenomenon is diet. Social class differences in the most relevant aspects of the diet: consumption of fresh fruit, vegetables, unsaturated fats and oils differed between nations as one might expect from the observed differences in health inequality, that is, very little. In those Southern

European nations, such as Italy, with relatively large income inequalities but long life expectancy and less health inequality, the diet followed by the majority of people was a healthier one (Kunst 1997; p. 206). "Having a healthy diet" was not some special "lifestyle" associated with cultural or economic privilege.

This study has provided us with data highly relevant to the notion of resilience as an asset for health. The radical difference in the association between social and economic advantage and diet seen in the Northern and Southern European nations is a prime example of a "health asset". Whatever the circumstances are that break the link between healthy eating and socioeconomic position need careful study. It seems that there may be two aspects to this asset. The first is quite simply the cost, quality and availability of food items. In countries where fruit and vegetables (and perhaps wine in moderate quantities) are cheap and plentiful, they form part of everyone's diet and are affordable to all. Quality of fresh food also tends to be higher, and products are more likely to be bought from markets and smaller shops rather than supermarkets in comparison to the USA and UK (Glitsch 2000). The good health of Southern European populations is therefore evidence of the importance of affordable supplies of high quality fruit and vegetables; the salutogenic impact could perhaps even be quantified. Such a health asset would be endangered if, for example, economic forces resulted in the run-down of local farming practices that provide cheap and healthy food, in favour of more imported and highly processed food.

However, we do not believe this is the whole story. Although far more careful studies of diet would be necessary for a better understanding of diet as a source of health resilience, it is likely that attention needs to be paid to food preparation. A sociological analysis of health assets would, we will argue, need to be centrally concerned with questions of gender inequality. Diet as a source of resilience against socioeconomic disadvantage provides us with the first example of how important this may be. It is likely that more elaborate food preparation is more widely carried out in situations where many women do not have paid employment and therefore have no choice but to spend larger amounts of time in domestic labour. In this case, the healthy diet might be regarded as a consequence of inequality in social power between men and women. In fact, it is striking that some of the developed countries with low health inequality are those which have retained more traditional family arrangements, low levels of access to highly paid jobs for women, and low divorce rates such as Japan and the Mediterranean nations (Esping-Andersen 1999).

In the USA and UK, where women are increasingly involved in employment with long hours of work, but also often with high financial and social rewards, a higher proportion of meals are eaten outside the home, and more of the food eaten at home requires minimal preparation. Under these social conditions, diet quality will be heavily dependent on both knowledge about healthy eating and household income levels. Ready prepared "healthy" foods are increasingly available, but at a high cost. Where the long hours are being spent in a well-paid job, there may be no harm to health as a healthy diet can be bought. Where they are spent in low-paid "welfare to work" jobs, the health effects on women and their families could be severe. With no time or energy for elaborate cooking, people on low income are reduced to eating the cheapest, lowest quality instant foods.

So, although we may have located an important health asset which constitutes a source of resilience against socioeconomic disadvantage, this discovery also raises serious problems. Although some might think it desirable to somehow reimpose the obligation on women to remain in the home, and on men to support sexual partners financially, there is no historical precedent for this: once divorce and separation have become socially acceptable, there is no way to turn the clock back. It takes a political catastrophe such as those that have occurred in Afghanistan and may currently be occurring in Iraq to remove from women the rights to education and de jure access to all sectors of the labour market which have resulted in increases in female employment. So that although there is strong evidence that diet is a health asset that should be quantified and treasured, this does not automatically lead, in any simple manner, to policy prescriptions as to how this asset may be preserved.

One rare example that shows how access to employment by women need not result in increasing inequality in diet may be taken from experiences during the World War II in the UK. Women were employed in large numbers in "war work" to substitute for men serving in the armed forces. However, due to a combination of rationing and the availability of communal kitchens and canteens, diet quality for working-class people improved to levels previously unseen, and socioeconomic inequalities in diet were greatly reduced (Zweiniger-Bargielowska 2000). This is a case where policy measures were designed to fit a situation where women were needed in the workforce, but at the same time the protection of population health was of high priority.

6.5 Deindustrialization: Health Risks and Resilience

A very different example of the importance of understanding the sources of resilience can be taken from the consequences of deindustrialisation in Great Britain. Beginning in the 1980s, there was a drastic decline in the numbers of jobs available for men with little formal education, or whose skills were attached to traditional heavy industries such as mining, shipbuilding, iron and steel and assembly line production of household goods and vehicles. Much attention (though arguably not enough) has been paid to unemployment and its consequences for health (Iversen et al. 1987; Voss et al. 2004; Mattiasson et al. 1990; Korpi 2001; Martikainen 1990).

However, in the 25 years since the beginnings of this industrial decline, many have found alternatives to conventional work. Although what should be termed "non-employment" is now seen as a major policy problem in Great Britain, it does not seem to have been always harmful. In fact, as the numbers exposed to industrial hazards fell, life expectancy in men rose during this period at a faster rate than in the previous era of heavy industry. We know that many of those who lost their employment in the traditional heavy industries remained outside of the formal economic activity. However, far less is known about any alternative forms of activity that took the place of the old jobs.

Economic inactivity grew rapidly during these years, in all of the affected areas of the UK, but so did self-employment, and we know very little about the activities of those whose lives may have taken a new path. Being unemployed is, of course, a

long term risk factor for poor health in later life. But there is evidence to suggest that those who left employment early, as long as this was something over which they felt they had control, experienced an improvement in quality of life. Post-retirement activities have been found to include an increase in physical exercise and in further education and study. Some of these people will most likely have found a recipe for turning a smaller amount of money than they had previously earned into an amount of welfare that is at least equivalent – that is, of maximising the capability derived from their income. In former mining areas for example, coal was provided free of charge to those not working full time, equating to the means of keeping home and family warm in the winter. Evidence from one network project in fact showed that avoiding paid employment via claiming physical incapacity, or choosing not to take job offers was an important means of maintaining financial and community support.

Deindustrialisation seems to have had in some cases a far more severe effect on the health of younger men. Rates of both suicide and death by homicide in those aged 16–30 rose rapidly during the 1980s and have continued at a high level (Charlton et al. 1993; Crawford and Prince 1999). Such sustained rises in this kind of mortality illustrates that it was not only the circumstance of job loss and loss of prospects which adversely affected the younger adults in the 1980s but also that life as a young adult in the post industrial desolation during the 1990s and early twenty first century presents challenges. Boys in these areas present the education system with a series of intractable problems, and many leave school with no qualifications to help them take up the newer forms of employment (Nickell and Quintini 2002; Nickell 2004).

Addiction to hard drugs has become endemic in some pockets of the old industrial areas. Although the traditional manual jobs were extremely hard and hazardous, the availability of such jobs, and the community structures around them, seems to have provided young men with a significant health asset, whose disappearance has had serious impact on psychosocial well-being, but whose nature has never been fully clarified.

However, in one network project, in-depth studies of de-industrialised areas did find that not all of them experienced the adverse health consequences expected among younger people. It appears that whilst the original source of community coherence – a shared industrial experience and employment – was lost, the assets of close community cooperation established during the industrial era can sometimes be maintained in the post-industrial era where the common experience is now unemployment and a struggle against poverty. Those areas which retained a reasonably stable population in the wake of mine and factory closure, also sometimes retained their community structure and organisation. These assets have assisted such areas to build social stability, if not economic prosperity. In other areas, where community cohesion was founded on shared ethnic or religious identities, resilience to economic decline was also detected.

In some areas, such as the northern English town of Oldham, large numbers of people had emigrated from South Asia to fill a strong demand for labour in the textile industry. In the 1980s, this industry was one of those which declined sharply in the face of competition from countries where labour costs were much lower, and most of the textile workers, British and Asian alike, lost their jobs. In the Asian community, long-range social networks were revived in order to set up businesses

that went on to thrive. In fact, some of the unrest and inter-ethnic conflict in towns such as Oldham has been attributed to the great differences in the ways in which British and Asian ex-textile workers responded to the economic crisis.

These social and demographic trends are being repeated in several European nations, and in the new Europe. Below we put forward some reflections on the complex implications that may be drawn from these trends for understanding health assets and resilience.

6.6 Capability and the Production of Well-Being

We do not see it as our role here to advocate resilience as cheerful acceptance in the face of poverty or other forms of hardship. What has been highlighted importantly in the work of Sen, however, is the error involved in directly equating commodity (such as money income) with capability. We would like to argue that as nations modernise, they may become subject to processes that actually lower the capability-producing powers of money, or to put it another way around, make it necessary to spend increasing amounts of money for the same levels of perceived life satisfaction. This dilemma underlies much of the anxious preoccupation in some branches of economics with "well-being", pointing out that large increases in income per capita have not been accompanied by parallel increases in reported well-being.

The question of "reproductive labour power" is of great and wide ranging significance for both mental and physical health. The feminist economist Esther Boserup (1989) estimated that women carry out some 60% of all the work that is done in developing nations. There has been less attention to the unpaid work done by women in developed nations. However, a list could contain the essential activities of maintaining the hygiene of the home, and the health of its occupants by the provision of food and emotional support. The skills of the cook will also have a major impact on household budgets by determining how much will have to be paid for food as a "finished article" or how much can be saved by buying basic ingredients that can be transformed. Modernisation first saw the steady change from the provision of clothing by home production methods as mass production brings down the price of garments and shoes. At the present time, however, this process is extending to small-scale domestic food production with major implications for health. Yet very few health promotion campaigns regard knowledge about food and cooking skills as a valuable "asset for health".

As legal and political change opens all sectors of the education system and labour market to women, inevitably there will be a shift in time-usage from the home to the workplace, particularly by women who do well in education. Whilst we do not mean to argue that these roles *must* be carried out by women, it has been women who were previously contributing an enormous amount of "value-added" to more traditional economies. The shifting of their efforts away from home production has never, so far, been taken seriously as a policy issue. Although many societies now more fully embrace the value of women in the workplace, there is general

failure to equalise contributions to home production from men. Instead, several nations have indulged in moral panics around such issues as rising child obesity, the breakdown of relationship between pupils and teachers, and other similar issues, demonising children and childhood.

One may criticise current attacks on the behaviour of some children and youth. However, research shows that troubled young people often become troubled adults, with serious consequences for their own well-being and freedom of action. We therefore propose that the skills involved in the conduct of family relationships are a major neglected health asset. This conclusion is supported by research that indicates the importance of warm and supportive family relationships in child development, especially under conditions of relatively low material living standards (Schoon 2006). In other words, family relationships can both be health assets, and a source of resilience in the face of adversity.

It will not do, however, merely to advocate (in this case at least) the preservation of such an asset in its present form. Once social and legal norms have changed in such as way as to admit women to all sectors of the labour market, the genie cannot be put back into the bottle. The same could be said of the increasing promotion by advertising of "fast" foods with very poor nutritional content. Rather, the challenge is to preserve the asset of skilled domestic and emotional "reproductive" labour by spreading it further in demographic terms. We return here to the theme of freedom; women's freedom has no doubt been increased, (though perhaps not quite as much as might be imagined), by greater access to education and jobs. However, it is as important, we will argue, to increase the capabilities of both men and women to choose a way of life they can sustain themselves in terms of both physical and emotional self-care. One way in which this may be helped to happen would be by a revaluation of necessary skills. More careful attention to what is required for optimal growth and development, both physical and mental, and in both childhood and the adult years, would be a major step in this direction.

In Durkheimian terms, we might think here about yet further increases in the "Division of Labour", rather similar to the separation of more and more work from the home to the factory and office during the Industrial Revolution. Another way to look at these processes is in terms of what might be called the commodification of human relationships. We use this term here in a purely descriptive rather than an evaluative sense. As with many other important secular trends of modernisation, the commodification of relationships is largely a result of changes in the situation of women, and these are changes that have come about as a result of democratic processes. The domestic and emotional work previously done without payment by women in relation to husbands, sons and male co-workers was to a large extent constrained by women's inferior and less powerful economic and legal position. Once this situation changed as a result of political reform, however, the work involved did not begin to be shared more evenly by men and women.

As women began to work more hours in the formal economy, men only very slowly began to take up an appropriate share of domestic labour. As more women began to gain satisfaction from work that gave them power and influence, men did not rush to take up the roles previously played by subordinate women, either within

the home or within organisations. And as marriage became a more fragile institution, in part for many of these same reasons, the emotional ties between fathers and their children also became less secure.

Among those who could afford it, quite a lot of this emotional and domestic labour could be bought in the marketplace in various forms such as domestic servants and nannies, smaller class sizes in private schools, professional therapists and life coaches etc. Much of the emotional and domestic labour that had previously been done without payment was thereby comodified, and now requires to be bought in the market place, in a process similar to the movement of the production of clothing, bread and cheese out of the household in the nineteenth century. For this reason, access to forms of social relations that lie at the basis of important aspects of human health and development has become increasingly socially unequal.

The disappearance of "free emotional labour" spreads its effects far beyond the poorer social groups however. Like the infectious diseases that prompted some of the great social reforms of the nineteenth century, the effects of impoverished family relationships are pervasive. Children from families affected by financial or emotional hardship require a far higher input from their teachers, for example, leaving less energy to be spent on more psychologically stable children. The families of the latter are therefore forced to consider the expense of moving away to a more socially segregated area, or of private education. The more privileged family will therefore have a double demand on its income, ample though it may be: expenditure is necessary to provide care for the home (and perhaps home care for the children as well); and yet more is required in order to avoid the disruption at school caused by the children of the less fortunate. By this process, in a manner similar to that proposed in the work of Wilkinson, Kawachi and colleagues (Wilkinson 1996; Kawachi and Kennedy 1997), social inequality is increased and at the same time the well-being of even better-off families is reduced.

Rather similar processes take place in neighbourhoods. Here the loss is not of women's unpaid labour, but of the very presence in public space of citizens who are neither tied to the workplace nor too poor to take part in community life. The loss of the "civilizing" effect of the presence of retired people, adults with parental leave from work to look after children, municipal workers and others has been lamented by commentators on neo-liberal economic reforms. As many public spaces become more threatening, resources must be used to protect and transport children (and adults) to alternative locations, and to protect these locations themselves. The need to compete in the property market in order to "buy" access to an acceptable residential area takes an additional toll on the income of middle class households.

As the economic disparities become further etched in space, social and demographic inequalities between neighbourhoods get wider and wider. The dialectic relationship between neighbourhood and household incomes and identities ultimately serves only to widen the gaps between the richer and poorer. Those who cannot afford a secure and calm domestic life, tend also not to be able to afford a secure and calm residential neighbourhood, and their children grow up and learn in more dangerous, more difficult surroundings. The need for resilience in the face of these

adverse surroundings is then even greater, but the likely assets and capabilities of the young people to show resilience are reduced.

There are many aspects of human relationships whose vital role as assets for the health of both individuals and communities, because they are never given any monetary value, only become evident when they are lost. We do not think it would be accurate to characterise these assets as "social capital" (in any of the rather shifting meanings of this term). Rather, these assets arose from a historically specific combination of economic and social circumstances, some of which, such as the exclusion of women from many of the better paid and more influential forms of employment, have disappeared for very good reasons. The problem has been that the processes that produced these assets were never understood before being swept away, and their importance has only become evident in hindsight.

The WHO Assets for Health and Development programme seems to us a vital attempt to gain such an understanding, not in order to freeze history in its tracks, but to make sure that the development of these capabilities are pursued with the same amount of energy as economic and technological progress.

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