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# Editorial Board



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# Table of Contents

Volume 1, No. 1, 1999

## Editorial



## Articles



## Archives

# Why Hygiea Internationalis?

Jan Sundin

Is there a need for a special journal for the history of public health? And, if so, why in electronic form? There are at least two answers to the last question. First of all, new journals in traditional form are expensive to produce and to distribute. Much more substantial support would have been needed from our sponsors to establish the journal on the market and to test its economic potential. We all know the difficulties in convincing our university libraries to subscribe to new journals, a condition necessary for their survival.

Secondly, the electronic medium offers a number of possibilities not easily available for traditional journals. One is the easy access at no other cost for the consumer than time. A second advantage is the possibility to cut the time – just a few months – between the submission of the manuscript and its publication, which shortens the interval between the first expression of new ideas and findings and the moment they reach the rest of the scholarly world.

We have met colleagues who are doubtful about the value of an electronic medium for the spread of high-quality research in the humanities and social sciences. Besides the arguments already mentioned, we would also like to point out that:

- Linköping University guarantees that each issue of the journal will be available – unchanged – on the Internet for 25 years according to the terms of the contract with Linköping University Press.
- hard copy of the journal is available for institutions and private persons at a reasonable cost.
- authors can order off-prints of their own articles.

Having been the co-ordinators of the International Network for the History of Public Health for some years, we are convinced that there is an audience for a special journal within our particular field. Two years ago the network's second international conference, arranged in conjunction with the Society for the Social History of Medicine in Liverpool, gathered more than 100 participants. So did the

third conference, held in co-operation with the European Association for the History of Medicine and Health. It was organized admirably in Almuñécar by the University of Granada. Public health issues already appear in many traditional journals, which will certainly also be the case in the future. *Hygiea Internationalis* sees its role as one of a complement to established journals. It may also serve as a place where information in the field may be found and new material tested.

The study of public health and its history is a truly interdisciplinary field. Not only does it include the study of the health of populations and groups within the population (men, women, children, adults, elderly, social classes, ethnic and occupational groups, etc.) by historical demographers and epidemiologists. It also means the study of ideological, professional and popular perceptions about health and disease and the ways and means to promote health and prevent disease in time and space by collective efforts – sanitary reforms, environmental control, vaccination, eradication of risks at work, campaigns for personal hygiene and healthy lifestyles. Thus, this field attracts the medical profession as well as historians, philosophers, ethnologists, anthropologists, geographers, sociologists, economists and political scientists, to name a few.

Just a couple of decades ago, it seemed as if modern science was on its way to solving most of the major health problems, at least in the industrialized part of the world. Then came the discovery that the almost unlimited potential of medical technology in a society with limited resources created a number of ethical questions, one of them being how to make priorities. HIV and AIDS have taught us that the fight against infectious diseases is not over yet. The outcome of the race between resistant germs and new antibiotics seems uncertain. Tuberculosis is a major problem in less favoured regions of the world. Ethnicity, class, gender and other social variables still manifest themselves in health differences. The re-emergence of infectious diseases among children and the increased mortality rates among adults, especially men, in parts of Eastern Europe show what happens when collective institutions break down in modern societies.

When society changes, the health of its population changes too. New forms of society face new types of health problems. One example is the growing concern about the connection between everyday life (work, family and other arenas) and the potential for human beings – as individuals and collectives – to cope with the situation in a way that preserves health and prevents mental and physical disorders. 'Social stress' has emerged as a term describing mental conditions that destroy health and create diseases of different types among unemployed as well as among relatively prosperous but over-worked groups on a labour market that demands flexibility and high performance under new conditions.

Comparative studies – both qualitative and quantitative – in time and space can provide us with a better understanding of these processes, biological as well as social, cultural, ideological and political. *Hygiea Internationalis* will be open for con-

tributions that can help us to exchange research results from different countries and different stages of development. Our first issue contains contributions from two distinguished scholars who have approached public health from different angles, as well as a guided tour through sources for studying public health in London from another.

*Dorothy Porter* provides a survey of the historiography of public health history from the 'grand narratives of progress' of the 1950s to today's post-modern analyses of discourses and the many approaches to what she defines as 'the history of collective action in relation to the health of populations'. She argues that this history must also be studied in relation to the general systems of welfare provision and the welfare state. She concludes by calling for a dialogue across both methodological, conceptual and chronological boundaries 'from the ancient past even perhaps to speculation upon possible futures'.

*Virginia Berridge's* article 'History *in* Public Health' reflects upon the use of public health history by non-historical practitioners from the point of view of a historian who has been working side-by-side with the medical profession, at present at the London School of Hygiene and Tropical Medicine. She describes her role as 'living among the tribe' or as 'a stranger and a friend'. Her article shows how history in public health can shed light upon a number of issues presently debated in public health policy, even if historical experience cannot provide prescriptions for the future.

*Andrea Tanner's* contribution to the 'Archives section' provides an invaluable guide to available sources for the study of London's public health history. No one authority was responsible for all public health measures, but her article shepherds us through the labyrinth of materials preserved in various archives.

Our next issue will be prepared during the autumn of 1999. In the year 2000 we hope that we will have established routines which will allow us to publish up to four issues per year. It is our sincere hope that we will be able to attract the interest of our colleagues all over the world as readers and as contributors. In addition to complete articles, we will keep the door open for serious comments and replies in order to promote discussion.

We would like to remind you that the journal also has the section 'Research and commentaries', where preliminary research notes/reports of a limited size can be displayed for discussion during six months. Hopefully, this section can become a kind of electronic symposium. There is also a 'workshop' where longer working papers on a single topic may be displayed for comment. In addition, the 'news' section will announce scholarly events and distribute other messages that our INHPH members wish to send out. For information, check the buttons on the homepage.

We kindly ask all of our readers to send – by e-mail or otherwise – remarks and comments about this first issue of the journal so that we can provide you with the best possible forum for scholarly communication.

We are deeply indebted to Professor Erik Sandewall, Department of Computer and Information Science, who provided us with the software system and who has generously offered his invaluable time and advice. This project could never have been launched without his support. We also thank all members of the editorial board, who have offered their experience during the preparation of the journal. Personally I feel profound gratitude to my co-editor Marie Clark Nelson and our technical editor Peter Berkesand for their enthusiastic, dedicated and skilful work in bringing this first volume to fruition. The following Swedish research foundations have provided financial support for the project: The Bank of Sweden Tercentenary Foundation, Swedish Council for Research in Science and the Humanities, and Swedish Council for Social Research.

Jan Sundin
co-editor, co-ordinator of the INHPH

# The History of Public Health: Current Themes and Approaches

Dorothy Porter

## Changing Definitions of the History of Public Health

Public health history flourished after the Second World War within the historiographical interest in the administrative growth of modern states and the development of social welfare systems. In the histories written in the 1950s, the concept of public health was largely equated with the nineteenth-century 'sanitary idea' of environmental reform and methods of preventive medicine, such as vaccination. The limitation of infectious diseases by the turn of the twentieth century through environmental and preventive regulations was represented in these accounts as the triumphant culmination of a long tradition stretching back to biblical times. In 1952, René Sand, professor of social medicine at Brussels University, wrote a comprehensive account of what he called *The Advance to Social Medicine* from ancient to modern times.[1] Similar themes were subsequently explored by George Rosen in 1958 when he wrote what became a definitive textbook on the history of public health.[2] Both Sand's and Rosen's works were imposing, erudite surveys of health regulations from pre-Socratic times to the early years following the Second World War. Both accounts were written at a time when public health appeared to be victorious in achieving massive reductions in mortality rates in the Western world, when scientific medicine seemed to have almost eliminated the menace of pestilence. As a result, Sand and Rosen both wrote grand narratives of progress, arising from the technological advance of science and medicine and its capacities to combat endemic and epidemic disease. This heroic

1 René Sand, *The Advance to Social Medicine* (London, 1952).

2 George Rosen, *The History of Public Health* (New York, 1958).

vision was reinforced in 1976 by the conclusions of Professor of Social Medicine Thomas McKeown, that clinical medicine had played no part in the *Modern Rise of Population,* which had, he claimed, largely resulted from improved nutrition and environmental reforms such as the creation of clean water supplies.[3]

When the parameters of public health history were confined largely to sanitary reforms and the control of infectious diseases, it was possible to argue that, although public health was invented in the nineteenth century, it had been preconfigured in technological developments stretching back through time, such as the Mosaic Code and Roman baths and aqueducts.[4] In the three decades following the 1960s, social historians of health, illness and disease began to challenge such a view. In 1961 the eminent social historian of nineteenth-century Britain, Asa Briggs, suggested that the story of cholera had been overlooked as a major factor in historical change in Victorian society.[5] Subsequently historians began to explore not only cholera, but also the impact of epidemic and infectious disease on historical transformations in early modern and modern European and North American societies. Historians such as Margaret Pelling, William Coleman, Charles Rosenberg, Carlo Cippola, Paul Slack, James Riley, Richard Morris and Richard Evans used the economic, social, political and ideological responses to diseases to explore the complex ways in which change both caused and was determined by the impact of epidemics.[6] This new historiography investigated the differential experience of epidemics by social classes, professionals, scientific and religious communities and political states and oligarchies.[7] The scope of public health history expanded by the 1980s to include the social relations of ideas and actions taken collectively and individually in response to epidemic disasters. In addition historians such as William McNeill

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3 Thomas McKeown, *The Role of Medicine – Dream, Mirage or Nemesis* (London, 1976); Thomas McKeown, *The Rise of Modern Population* (London, 1976).

4 George Rosen, *The History of Public Health* (New York, 1958).

5 Asa Briggs, 'Cholera and Society in the Nineteenth Century', *Past and Present*, 19 (1961), 76–96.

6 Margaret Pelling, *Cholera Fever and English Medicine 1825–1865* (Oxford, 1978); William Coleman, *Yellow Fever in the North: The Methods of Early Epidemiology* (Madison, Wisconsin, 1987); William Coleman, *Death is a Social Disease* (Madison, Wisconsin, 1982); Charles Rosenberg, *The Cholera Years 1832, 1849 and 1866* (Chicago, 1962); Carlo M. Cippola, *Faith, Reason and the Plague: A Tuscan Story of the Seventeenth Century* (Brighton, 1979); Paul Slack, *The Impact of Plague in Tudor and Stuart England* (London, 1985); James C. Riley, *Sickness, Recovery and Death: A History and Forecast of Ill Health* (London, 1989); Robert J. Morris, *Cholera 1832: The Social Response to an Epidemic* (London, 1976); Richard J. Evans, *Death In Hamburg: Society and Politics in the Cholera Years 1830–1910* (Oxford, 1987).

7 Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease* (Cambridge, 1993).

and Alfred Crosby began to indicate how disease could influence, not only the relations between classes, ruling orders and political states, but also the way in which disease influenced the processes of imperialism and colonisation.[8] Studies of the relations of health and imperialism have subsequently proliferated, revealing fascinating new insights into the role played by bio-politics in economic, military and political oppression.

At the same time, the changing epidemiological and demographic structure of past populations began to be probed by quantitative historians who tried to account, like McKeown, for the modern rise of populations. While numerous studies found McKeown's reasoning about 'hunger and history' to be flawed, the debate continued to rage about the causes of population growth.[9] Quantitative historians added greatly to our knowledge of the social and economic relations of the past, however, by mapping the distributions of health and disease, differential patterns of height and weight between social strata, identifying factors encouraging increased fertility and trying to highlight a wide range of determinants of mortality decline.[10]

From the late 1980s, a new world-wide pandemic stimulated yet further directions in public health history. The experience of a contemporary epidemic in times when lethal infections had almost become a lost memory provoked powerful responses amongst historians, semiological analysts and literary theorists.[11] AIDS revived the historical study of stigma, encouraged new directions in inquiries into the meanings of representation and forcefully added to new debates about the social construction of everyday life.[12] Often stimulated by concerns to understand the

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8 W. McNeill, *Plagues and Peoples* (New York, 1976); Alfred W. Crosby, *Ecological Imperialism: The Biological Expansion of Europe. 900–1900* (London, 1986).

9 Population Studies; Journal of Interdisciplinary History.

10 Theo Barker and Michael Drake, eds., *Population and Society in Britain 1850–1980* (London, 1982); Simon Szreter, 'The Importance of Social Intervention in Britain's Mortality Decline c.1850–1914: a Re-interpretation of the Role of Public Health', *Social History of Medicine*, 1 (1988), 1–37; Simon Szreter, *Fertility, Class and Gender in Britain 1860–1940* (Cambridge, 1996); E. Anthony Wrigley and Roger S. Schofield, *The Population History of England 1541–1871* (London, 1981).

11 Sander L. Gilman, *Sexuality an Illustrated History* (New York, 1989); Sander L. Gilman, *Disease and Representation* (Ithaca, N.Y., 1988); Sander L. Gilman, *Health and Illness: Images of Difference* (London, 1995); Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830–1980* (New York, 1986).

12 Charles Rosenberg, 'What is an Epidemic? AIDS in Historical Perspective', in Charles Rosenberg, ed., *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, 1992); Elizabeth Fee and Daniel Fox, *AIDS: The Burdens of History* (Berkeley, CA., 1989); Elizabeth Fee and Daniel Fox, *AIDS – the Making of a Chronic Disease* (Berkeley, 1992); Virginia Ber-

historical meaning of AIDS, art historians and literary theorists added their skilful analyses to what sociologists had been interrogating from the late 1970s, that is the cultural significance of the body in comparative societies.[13] In the 1990s, the historiography of health, disease and illness existed within a vastly expanded intellectual discourse on the relations between biology and culture, living and dead bodies.

A range of important philosophical and theoretical movements dating from the 1930s significantly influenced intellectual developments in public health history in the 1990s. In the 1960s the French 'archaeologist of knowledge', Michel Foucault, and a variety of Hegelian-Marxist thinkers from the 1930s, such as the Frankfurt School of Critical Theory, highlighted contradictions in the Enlightenment tradition in Western thought.[14] Such a view fundamentally undermined any heroization of public health as a great achievement of Enlightenment rationalism. Historians influenced by these theoretical perspectives cross-examined the ways in which public health regulation contributed to the rise of a 'disciplinary culture' which Foucault argued was the defining characteristic of modern society.[15] Equally, the role played by public health reform in facilitating the development of authoritarian bureaucratic government and the rise of professional power has been interrogated by leftist and Marxist critiques of the repressive nature of modern states.[16] These concerns fed into a wide variety of new perspectives brought to bear upon what constitutes the history of public health which now embraces diverse subjects and enquiries from the multicultural politics of the body to examinations of the dramatically changing structure of modern welfare states and social policies.

Over the last four decades or so historians, social scientists and scholars from a range of intellectual disciplines have broadened the study of the economic, social and political relations of health and society extensively. Accounts of the progressive 'rise of civilisation' have long since gone out of fashion and 'grand narratives' them-

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ridge, *AIDS in the UK: the Making of a Policy, 1981–1994* (Oxford, 1996); Virginia Berridge and Philip Strong, eds., *AIDS and Contemporary History* (Cambridge, 1993).

13 Bryan S. Turner, *The Body and Society: Explorations in Social Theory* (Oxford, 1984); Bryan S. Turner, *Regulating Bodies: Essays in Medical Sociology* (London, 1992); Dorrinda Outram, *The Body and the French Revolution: Sex, Class and Political Culture* (New Haven, 1989); Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London, 1996).

14 Michael Foucault, *The Order of Things: An Archeology of the Human Sciences* (London, 1970); Max Horkheimer and Theordor Adorno, *The Dialectics of the Enlightenment,* trans. John Cumming (London, 1972).

15 David Armstrong, *The Political Anatomy of the Body* (Cambridge, 1983).

16 Dorothy Porter, ed., *The History of Health and the Modern State* (Amsterdam and Atlanta, 1994); Paul Weindling, Health, Race and German Politics Between National Unification and Nazism 1870–1945 (Cambridge, 1989).

selves have never been more outcast than in the contemporary intellectual climate of postmodernist relativism.[17] Heroic accounts of the triumphant emancipation of modern society from the primitive bondage of ignorance can no longer be sustained in a world in which many voices contribute to the reconstruction of the past who have different interests to identify within it.[18] History writing is no longer dominated by one ideological vantage point even within Western societies where a new multicultural mix ensures that a huge variety of historical perspectives has been able to gain legitimate authority.[19]

The attention drawn to philosophical relativism by post-modernist theory is, however, only the most recent of many new intellectual and philosophical approaches to the writing of history which have developed since Sand and Rosen wrote their great works. The history of health, medicine and disease has profoundly reflected many different historiographical and intellectual directions between the 1960s and 1990s. As a result, what constitutes public health has been redefined beyond the predominantly nineteenth-century concept used by Sand, Rosen and their contemporaries and now concentrates on *the history of collective action in relation to the health of populations*.

## The History of Collective Action in Relation to the Health of Populations

The broadest history of ideas, beliefs and actions in relation to health and illness would consider traditions of individual health regimens and the experiences of individuals themselves.[20] While individuals and their behaviour are not ignored in current public health histories, they are a subsidiary analytical category to collective social action in relation to populations and groups. That is, public health history is concerned largely with social, economic and political relations of health between

17 Joyce Appleby et al., eds., Knowledge and Postmodernism in Historical Perspective (London, 1994).

18 Terry Eagleton, *The Illusions of Postmodernism* (Oxford, 1996); Joyce Appleby et al., eds., *Knowledge and Postmodernism in Historical Perspective* (London, 1996); Jerry Topolski, ed., *Historiography Between Modernism and Postmodernism: Contributions to the Methodology of Historical Research* (Amsterdam, 1994).

19 George L. Clark, Dean Forbes and Roderick Francis, eds., *Multiculturalism, Difference and Postmodernism* (Melbourne, 1993).

20 Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-century England* (Cambridge, 1989); Roy Porter and Dorothy Porter, In *Sickness and In Health: the British Experience 1650–1850* (London, 1988).

classes, social structures and organisations, pressure groups, polities and states. The focus on collective social action does not mean that the behaviour and beliefs of individuals are ignored. They only appear, however, to the extent that the actions, ideas and beliefs held by individuals bleed into the sphere of collective social action. This can mean discussing William Petty's methods of assessing the health of the mercantilist state through 'political arithmetic' in the seventeenth century or examining the role that socio-medical reformers such as Louis René Villermé played in public health reform in France in the nineteenth century. Sometimes the crucial actions of political rulers such as Bernabo Visconti in fourteenth-century Milan, or influential civil servants such as the Secretary to the first British Central Board of Health, Edwin Chadwick, have been analysed in detail.[21]

An exploration of the health of populations can avoid being limited by preconceptions which underlay examinations of 'public health' as defined in nineteenth-century terms.[22] For example, we can explore how the concern of ruling elites in some ancient Mediterranean societies with their own comfort generated political actions derived from abstract theories and practical codes of health behaviour. This form of collective action needs to be differentiated, however, from comprehensive public health systems developed in much later periods that aimed to reform the conditions of existence and levels of mortality of all the social strata within a society. Collective actions explored in different chronological periods need to be identified according to their significance for expanding discourses on population health. For example, if we are to accept the conclusions of some historians of late antiquity that the hegemonic expansion of Christianity through institutionalised charity assisted the administrative development of social welfare provided for the sick,[23] then to what extent did this create a grammar for plague regulation in a later period?

Just as an older historiography argued that 'public health' was invented in the nineteenth century, it could be equally legitimate to argue that 'population' was invented in the seventeenth and eighteenth centuries. Historical demographers and historians of statistics have revealed the social and historical malleability of the concept of population.[24] As Karl Marx suggested, however, population needs to be in-

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21 Coleman, *op.cit.* (ref. 6); Richard Palmer, 'The Control of Plague in Venice and Northern Italy, 1348–1600' (Ph.D. diss., University of Kent, 1978); Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick* (Cambridge, 1997).

22 William Frazer, *History of English Public Health 1834–1939* (London, 1950); S. Finer, *The Life and Times of Edwin Chadwick* (London, 1952).

23 Peregrine Horden, 'The Byzantine Welfare State: Image and Reality', *Society of the Social History of Medicine Bulletin* 37 (1985), 7–10.

24 Lorraine Daston, *Classical Probability in the Enlightenment* (Princeton, N.J., 1988); Karin Johannisson, 'Why Cure the Sick? Population Policy and Health Programs Within Eight-

vestigated as the social relations between classes, status groups, nations and societies. In this context, the concern with collective social action involves an analysis of the structural operation of power, which makes the political implications of population health in different periods and in different societies a central issue of historical research into the subject. In pre-modern societies this means paying attention to a wide variety of different theatres of power including city states, fiefdoms and dukedoms, monarchical realms and large institutional organisations of power such as the Church. In the modern period the study of the operation of power in relation to population health involves an examination of the rise of the modern state as an autonomous political sphere, the implications of health citizenship, and the different interpretations that have been made of the 'social contract' of health between the state and civil society.

The subject of the history of population health is distinct from the history of the theory and practice of therapeutic medicine. However, the history of public health cannot ignore the influence of biomedical theories and conceptual development of medicine. For example, in ancient Mediterranean societies medical theory reflected the emergence of rational, material beliefs about health and illness which allowed hygiene regimes to influence practical codes of settlement and colonisation of what were perceived to be healthy environments. Equally, the history of population health cannot ignore the influence of access to clinical medicine and the organisation of health and medical services. In the modern period, for example, the economic and political organisation of access to medical care has become crucially significant to health levels amongst populations which have increasing numbers of longer living, yet chronically sick, individuals. Because of changing demographic structures in advanced or post-industrial societies, social policies aimed at providing welfare to relieve social and economic disadvantage have become inherently linked to the costs of medical care. The mechanisms developed for meeting the costs of care need to be compared in a variety of national contexts.

Population health has not only been intimately linked to access to medical care, it has always depended upon collective provision of social welfare and needs to be discussed, therefore, within the broader history of welfare provision from ancient to industrial and post-industrial societies in the twentieth century. The history of social welfare has frequently been undertaken not only by social and political historians but also by social policy theorists examining the origins of their own discipline. As a result, the historiography of welfare has undergone a number of different 'paradigm shifts' which the history of collective action in relation to population health needs to take into account.

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eenth-century Swedish Mercantilism', in Anders Brändström and Lars-Göran Tedebrand, eds., *Society , Health and Population during the Demographic Transition* (Stockholm, 1988).

# Population Health, Welfare Provision and the Civilizing Process

At one time the historiography of welfare states conceptualised them as comprehensive systems of social security, funded and administered by centralised political organisations which first emerged in northern Europe in the first half of the nineteenth century following the French Revolution.[25] More recent studies have begun to explore changing forms of welfare provided by a myriad of agencies, from self-help and mutual aid to various types of collective distribution organised by political, voluntaristic, or commercial institutions, in communities with or without a centralisation of power.[26] The current challenge to the history of public health is to examine health care provision utilizing both of these conceptualisations by examining what determined change within mixed economies of welfare and how health care and social welfare have been influenced by ideologies of what might be called 'the civilizing process'.

In 1939 Norbert Elias attempted to investigate the sociological basis of belief by studying the long-term transformations in social structures and personality structures in European societies which defined their 'civilizing process'. He argued that 'the order of historical changes, their mechanics and their concrete mechanisms' could reveal the structural roots of changing standards of behaviour that determined social actions and formed social institutions.[27] He tried to investigate the sociogenesis and pyschogenesis of what different societies identified as civilised behaviour. Elias' work stimulated what might now be called the historical sociology of feelings and experience. He focussed, for example, on historical transformations in the social construction of shame, delicacy and fear and the pyschogenesis of the experience of ageing. He asked: how did the process of 'growing up' in Western societies change? But primarily Elias explored how historical transformations in these processes affected structural differentiation and integration within different societies. Contemporary history of public health needs to investigate how health figured within the construction of belief in society and the way in which this determined social integration and differentiation. Comparing narratives of population health is one way to approach this task; examining the influence of health regulation on the process of state formation is another. Elias was especially concerned with the way in which historical transformations in the sociogenesis of civility were linked to the

25 Douglas Ashford, *The Emergence of Welfare States* (Oxford, 1986); Peter Flora, ed., *Growth to Limits: the Western European Welfare State Since World War II* (Berlin, 1986).

26 Jonathan Barry and Colin Jones, eds. *Medicine, Charity and the Welfare State* (London, 1991).

27 Norbert Elias, *The Civilising Process* (London, 1994, 1st edition 1939), xv.

formation of the state, or the centralisation of power, in European societies.[28] The history of public health needs also to examine how collective actions which aimed to regulate or improve the health of populations were involved in changing the historical relationship between the civilizing process and state formation. In this context, the links between the history of public health and the history of social welfare are vital.

Until recently, far more attention has been paid to the history of state as opposed to voluntary welfare. One reason for the extensive focus given to state welfare has been the interest taken by social policy theorists in the modern history of their own subject. Analysts of contemporary welfare states consistently contextualize their investigations within the history of social policy in the nineteenth and twentieth centuries,[29] and frequently cite the influence of the British model on other systems. Britain has thus been given prominence within the context of comparative accounts.[30] Consequently the literature on the history of British welfare has expanded with numerous historians providing sometimes overlapping, if alternative, interpretations of the same events.[31]

The historian, the late Geoffrey Finlayson, argued however, that the historiography of the British Welfare state created an intellectual distortion of the subject as a whole. Finlayson suggested that most accounts of British welfare history offered Whiggish linear descriptions of progressive state expansion working its way teleologically toward the establishment of what Anne Digby and others have identified as the Classic Welfare state.[32] This has influenced writing on the history of other welfare systems which also give tacit acknowledgement to the existence of a classical model of welfare experiencing a 'golden age' in the first two decades following the Second World War. Finlayson claimed that this linear historiography was not challenged until the integrity of the Welfare state itself was threatened by the political rhetoric of the New Right in the 1980s, which also questioned the pa-

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28 *Ibid.,* 335–421.

29 Vic George and Peter Taylor-Gooby, eds., *Squaring the European Welfare Policy Circle* (London, 1996).

30 Gösta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge, 1990); Gösta Esping-Andersen, 'After the Golden Age? Welfare State Dilemmas in a Global Economy', in Gösta Esping-Andersen, ed., *Welfare States in Transition. National Adaptations in Global Economies* (London, 1997), 1–31.

31 Rodney Lowe, *The Welfare State in Britain Since 1945* (London, 1993); Nicholas Deakin, *The Politics of Welfare: Continuities and Change* (London, 1994); Howard Glennerster, *British Social Policy Since 1945* (Oxford, 1995); N. Timmins, *The Five Giants. A Biography of the Welfare State* (London, 1995).

32 Anne Digby, *British Welfare Policy. Workhouse to Workfare* (London, 1989).

rameters of democratic citizenship. The New Right brought attention upon the historical alternatives to statutory welfare provision and began to highlight the role of contributory citizenship in achieving a citizenship of entitlement, the necessity for rights to be earned through the undertaking of social and economic responsibilities. A New Right political consensus emphasised the value of individualistic resolutions to the provision of welfare through voluntarism, self-help and mutual aid.

Whether Finlayson's interpretation of the political motivations underlying an historiographical shift were correct or not, his observation that from the 1980s, historians began to pay increasing attention to voluntarist welfare certainly had merit. To begin with, new investigations were undertaken on health care and welfare provision 'Before the Welfare state'.[33] Perigrine Horden revealed the intricate networks of social provision amongst early medieval European communities.[34] The expansion of this complex web of charity provision has been explored in the late medieval and early modern periods.[35] Jonathan Barry and Colin Jones edited a seminal collection of essays that documented the mixed economies of welfare in Europe up to the beginning of the twentieth century.[36]

One of the themes of the historiography of voluntary welfare was the public rather than the private nature of charity. Sandra Cavallo demonstrated the intricate nature of the relationship of charity hospitals in early modern Italian city-states with local governments.[37] Anne Borsay illustrated the growth of associative charities in England, such as the voluntary hospital movement and charity schools, that were set up on the model of publicly owned joint stock companies, made possible by financial reforms enacted in the early eighteenth century.[38] Alan Mitchell and Paul

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33 Jonathan Barry and Colin Jones, eds., *Medicine, Charity and the Welfare State* (London, 1991).

34 Peregrine Horden, 'The Byzantine Welfare State: Image and Reality', *Society of the Social History of Medicine Bulletin* 37 (1995), 7–10.

35 Richard Palmer, 'The Church, Leprosy and Plague in Medieval and Early Modern Europe', in W. J. Shiels, ed., *The Church and Healing: Papers Read at the Twentieth Summer Meeting and the Twenty-first Winter Meeting of the Ecclesiastical History Society* (Oxford, 1982), 79–101.

36 Jonathan Barry and Colin Jones, eds. *Medicine, Charity and the Welfare State* (London, 1991).

37 Sandra Cavallo, 'The Motivations of Benefactors: An Overview of Approaches to the Study of Charity', in Jonathan Barry and Colin Jones, eds., *Medicine, Charity and the Welfare State* (London, 1991), 46–62.

38 Anne Borsay, 'Patrons and Governers: Aspects of the Social History of the Bath Infirmary, c. 1739–1830' (Ph.D. diss., University of Wales, Lampeter, 1999).

Weindling have shown how mutual aid organisations set up in Germany and France in the nineteenth century were collectivist 'communities' of skilled workers and artisans founded on the principles of self-help.[39] The public nature of charity highlighted the role of a wide range of social groups in the organisation of health care and charity. Borsay illustrated the way in which associative charity revealed the emergence of a middle class in eighteenth-century English society. Cavallo brought attention to the role of women as both benefactors and recipients in hospital charity in early modern Italy and England.[40] Other feminist historians discussed the participation of women in 'active citizenship' or in a 'citizenship of contribution' through the voluntary organisation of health and social welfare in the nineteenth and early twentieth centuries.[41]

Finlayson was right, therefore, to suggest that the dismantling of the older historiography of the welfare state created new opportunities for a new generation of historians living in a new era. He was wrong, however, to dismiss the need for further investigation into the history of what he called political collectivism and the provision of welfare because throughout its history population health, at least, depended on the collectivist operation of power. In the history of public health in the early modern and modern periods this is especially crucial because the social contract of health has been inherently linked to state formation and the development of citizenship. The investigation of health citizenship justifies continued attention to the history of political collectivism for two reasons.

First, the creators of the classic welfare state based upon the principle of universalism believed that the expansion of central government was the route to increased egalitarianism in the social and economic relations of industrial capitalist society.[42]

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39 Alan Mitchell, *The Divided Path: The German Influence on Social Policy Reform in France After 1870* (Chapel Hill, 1991); Paul Weindling, 'The Modernisation of Charity in Nineteenth-Century France and Germany', in Jonathan Barry and Colin Jones, eds., *Medicine and Charity Before the Welfare State* (London, 1991), 190–206.

40 Sandra Cavallo, 'The Motivations of Benefactors: An Overview of Approaches to the Study of Charity', in Jonathan Barry and Colin Jones, eds., *Medicine, Charity and the Welfare State* (London, 1991), 46–62.

41 Jane Lewis, *Women's Welfare, Women's Rights* (London, 1983); Jane Lewis, *Women and Social Action in Victorian and Edwardian England* (Brighton, 1991); Susan Pedersen, *Family Dependence and the Origins of the Welfare State: Britain and France 1914–1945* (Cambridge, 1993); Anne Digby, 'Poverty, Health and the Politics of Gender in Britain, 1870–1948' in Anne Digby and John Stewart, eds., *Gender, Health and Welfare* (London , 1996), 67–90.

42 Martin Daunton, 'Payment and Participation: Welfare and State Formation in Britain 1900–1951', *Past and Present* 150 (1996), 169–216; Alan Deacon, 'The Dilemmas of Welfare: Titmuss, Murray and Mead,' in S. J. D. Green and R. C. Whiting, eds., *The Boundaries of the State*

As a result they assumed that the statutory universal guarantee of minimum living standards without stigma would act as a counter force to structural inequality produced by free market economies and would create a citizenship of entitlement for all. But in doing so, the architects of the modern welfare state did not lose sight of an equally long tradition within the concept of democratic citizenship in which entitlements were earned through the fulfilment of social obligations.[43] In order to explore the complexities of the rights and obligations of health citizenship, it is impossible to ignore the history of political collectivism and the history of central state expansion. The history of the active citizenship of contribution in voluntaristic and charity organisations needs to be examined in relation to the 'active' fulfilment of obligations and social responsibilities required before health citizenship as a citizenship of entitlement is granted by the state. Nowhere is this more profoundly reflected than in the history of conflicts between the liberty of the individual and the rights of the community in relation to the health of populations and, in the modern period, specifically the rights and obligations of democratic citizens to the provision of medical care.

Secondly, the history of political collectivism and central state expansion has yet further value for historians of population health, especially those concerned with the influence of scientific rationalism upon ideological and cultural transformations. Here the task is to explore the cultures of politics and the narratives of government as they were constructed and deconstructed through the languages of natural philosophical rationalism and positivistic scientism. This subject is intimately connected to the relationship between scientific rationalism and the social construction of expertise. In the modern period, for example, this is a subject which needs to explore the relationship between scientific research and the construction and application of public policy.[44]

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*in Modern Britain* (Cambridge, 1996), 191–213; Nicholas Deakin, *The Politics of Welfare: Continuities and Change* (London, 1994).

43 Dorothy Porter, *Health, Civilisation and the State. A History of Public Health from Ancient to Modern Times* (London, 1999).

44 See for example, Virginia Berridge, Jenny Stanton, Stuart Anderson, Mark Bufton and Kelly Loughlin, 'Science, Policy and the Healthy Life', Session at the European Association for the History of Medicine and Health and the International Network for the History of Public Health, *The Healthy Life: People, Perceptions and Politics* (Conference, Almuncar, Spain, 2–5th September, 1999).

# Conclusion: Population Health and the Operation of Power

The history of collective actions in relation to the health of populations is a broad study requiring an interdisciplinary mixture of investigative methods and acknowledges no chronological boundaries. One unifying theme, however, is that the history of population health is inherently linked to the history of the operation of power. This means examining population health as a political phenomenon in all chronological periods and in different national and international contexts. On the one hand, as a political phenomenon the history of collective actions in relation to population health has been intricately bound to the history of the provision of welfare both in the context of centralised welfare states and within the context of welfare provided by voluntaristic and market agencies. On the other hand, the history of population health has been bound to the politics of knowledge and the practice of expertise. In the latter context it is necessary to examine the relationship between the history of ideas and political actions, for example in the relationship between science and public policy.

The launch of the new journal comes at an especially important moment, offering the opportunity for a rich enhancement of the subject through dialogue across methodological and conceptual boundaries. It also offers the opportunity to explore the history of public health beyond any chronological or territorial boundaries from the ancient past even perhaps to speculation upon possible futures.

# History in Public Health: a New Development for History?

Virginia Berridge

Historians, by and large, operate among their own kind. Most professional historians work in departments which are discipline-based, although often with contacts and networks among a wider range of interests relevant to their research speciality. Medical and other health-related schools, where they draw on history, as in teaching, tend to look within their own ranks. The history of public health might well be the responsibility of a non-historical staff member with an interest in the subject. It is rare for historians, in the UK at least, to cross the boundary and to be located in a medical or public health setting.[1] This is the position of the history group at the London School of Hygiene and Tropical Medicine.[2] Operating across the boundaries in this way requires a complex balancing act of interests. This paper reflects on the history of public health and possibilities for future development both from the perspective of that unusual location, but personally from that of a research career which has partially been spent in other non-historical

1 Apart from the London School of Hygiene and Tropical Medicine (LSHTM) group, I could only think of Elizabeth Fee, formerly at John Hopkins. I am not including groups of medical historians who operate as separate departments, or historical demographers, who sometimes have a closer relationship. Nor am I including groups of medically qualified historical workers, as for example in the German history of medicine institutes, now under threat.

2 The group is primarily based on the 'Science speaks to Policy' programme, funded by the Wellcome Trust, and includes work on smoking, medical technology, nutrition policy and the postwar rise of media processes in facilitating the science/policy relationship. There is further work on community and hospital pharmacy in the twentieth century. It is located in the Department of Public Health and Policy at LSHTM, a department of around 150 staff from a variety of medical and social science backgrounds.

contexts elsewhere as well.[3] I aim to consider three related but different areas of interest – public health history (by which I mean the current state of play of historical research in this and allied subjects) and history in public health (by which I mean the interest in and use of that history by non-historical practitioners and the role of historians in non- disciplinary settings). So I will first consider the current focus of historical interest within public health, and then offer some suggestions of how, in the British context, a more extensive 'history in public health' could develop. I will finally consider the role of historians in such developments.

## The Historical Consciousness of Public Health

Nobody could accuse public health interests of lacking an interest in history. In recent years, new developments in public health policy have regularly been justified by reference to the past. Key policy documents, for example, the Acheson Report on the Public Health Function in 1988, used the history of public health as a subtext. For AIDS, the history of the liberal and non-punitive British response to sexually transmitted disease was cited as a model for the types of policy which should be adopted. AIDS was seen initially as a foretaste of the revival of epidemic disease against which public health had battled in the nineteenth century. Public health could again fulfil this role in the 1980s, so it was argued. AIDS was an 'epidemic waiting to happen' in many senses – but particularly for public health, which was potentially rejuvenated through its role in dealing with the new syndrome.[4] The 'new public health' has justified its broader mandate in health matters through reference to the public health past. John Ashton's paper in the BMJ, 'Sanitarian becomes ecologist', gives a flavour of that linkage.[5] The concerns of nineteenth century public health have been drawn on for lessons in the response to health problems in the Third World today. Sir Donald Acheson, former Chief Medical Officer (MOH), remarked in a lecture, 'If Chadwick were alive today, he would not have limited his attention exclusively to the health of British people. Chadwick would have taken a global view...'. [6]

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3 I also worked at the beginning of my career at the Addiction Research Unit, Institute of Psychiatry, with a specific interest in drugs and their history.

4 For some discussion of this, see Virginia Berridge and Philip Strong, 'AIDS and the Relevance of History', *Social History of Medicine* 4:1 (1991), 129–138.

5 John Ashton,' Sanitarian becomes ecologist: the new environmental health', *British Medical Journal*, 302 (1991), 189–90.

6 Sir Donald Acheson, 'Edwin Chadwick and the world we live in', Edwin Chadwick lecture, *Lancet* (15 December 1990), 1482–90.

The history of public health these spokespeople draw on here is the nineteenth century 'heroic age' of environmentalism and the battle against vested interests of dirt and disease. In the British context, they lament the demise of the local government-based Medical Officer of Health (MOH). The revival of annual local public health reports in the 1980s was a nod to the role of the MOH in the nineteenth century. The recent Labour government's greater focus on public health as an activity within central and local government has also led to a looking back as well as looking forward. The 1848 Public Health Act celebrated its 150th anniversary in 1998, accompanied by a rash of discussions about whether Britain needed a new piece of similar legislation.[7]

Among public health researchers, there is also historical consciousness. They acknowledge the history of nineteenth century epidemiology. Teaching exercises use those well-known maps of the areas round the Broad Street pump. It is the John Snow Society, which holds meetings on contemporary epidemiology with recourse to the John Snow pub in Soho afterwards. There is some acknowledgement of the role of controversy and the mutability of historical 'fact' through the demographic debates. Everyone knows Thomas McKeown's work and its historical basis, and Simon Szreter's modification of that thesis – to the advantage of public health – needs no introduction from historians.[8] That classic debate in economic history, the standard of living debate, is integrated into the revived discussion on inequality through the newer field of anthropometric history. This area of economic history is one where past and present data perhaps most easily intermingle.[9]

The historical model most drawn on is the tradition of nineteenth century public health, the era of the broad environmental mandate. Seeing the past – or parts of it – as a 'golden age' is common; the invention of tradition, so historians have told us, is widespread. A speaker at the Liverpool public health history conference referred to 'a package-able and mythologised past'.[10] In my experience, many public health researchers, if they used a public health history text, would turn to Rosen rather than

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7 For several years now, the Chief Medical Officer's annual conference has invited a historian along. I attended in 1996, although there was no specific historical component on the agenda. In 1998, the discussion focussed on whether 1848 could be a model for a new overall Act, and Sally Sheard from Liverpool was called on for advice.

8 These comments are based on observation at LSHTM.

9 A historical conference just before the recent Public Health Forum on inequalities at LSHTM attracted a good number of main conference attendees. Amartya Sen's keynote address at the main forum effortlessly mingled historical and contemporary data, with reference to the work of historians such as Jay Winter.

10 Paul Laxton, speaking at the Liverpool conference 'Health in the City: a history of public health', September 1997.

more recent work.[11] History in public health has two main practical functions. At the policy level, it is a matter of the 'lesson of history', of historical 'facts' giving specific historical messages for the present, often implicitly justifying what current policy interests want to do. Among researchers, it is this – but also a matter of 'folk tales', the professional equivalent of family history, tracing origins back to people in the past, looking at current practice in terms of lineages, tracing the origins of 'what we do now' in the light of what people did in the past. This, of course, is common practice within medicalized areas, among which professional public health still has to be included. There is little recognition of the interplay of 'fact' and interpretation in history, with the exception of Szreter's reinterpretation, which, it could be argued, fits with public health's conception of its revived role. It is noticeable that the most sophisticated integration of history within public health is through the standard of living debate, where the historical 'data' is quantitative, historical epidemiology more akin to the conventions and techniques of contemporary public health research.[12]

## Expanding Historical Consciousness in Public Health

Like the late Raphael Samuel, I think family history and the interest in heritage is potentially a 'good thing'; anything which brings people to a sense of their past should be encouraged. But the historical consciousness of history in public health could be developed further. It seems that the understandings of processes and ideological/policy change are less well integrated than historical quantitative data. In this section of the paper I will first discuss some themes which emerge from historians' work in this area which could be drawn on by public health practitioners and researchers, but which mostly are not. I will also suggest some areas of further research, which could be developed, drawing on my own experience as a contemporary historian in a public health location.

If we look at the potential public health historical 'tool kit' available, it is clear that the nineteenth century environmentalist period was more complex than the heroic accounts would allow.[13] Concern was indeed for poverty and ill health, but this arose out of a particular set of economic and social ideals. Edwin Chadwick came to public health from his involvement in the reform of the Poor Law. In his view, ill health caused poverty and therefore reliance on poor relief. The connection was with

11 Personal observation by author.

12 This is also the case with the historical epidemiological approach of the 'Barker thesis' which has influenced epidemiologists with work on the foetal and early origins of disease.

13 This section of the paper draws on Virginia Berridge, 'Historical and policy approaches' in Margaret Thorogood and Yolande Coombes, eds., *Evaluating health promotion* (Oxford, 2000, in press).

economic efficiency and the securing of a functioning working population. Public health had its rationale in the human capital theories of the time. Nevertheless public health reform did serve as a surrogate in the nineteenth century for more general social reform. Christopher Hamlin's work stresses its role as an alternative to wider reform; and other research has stressed the importance of activity at the local level in securing those ends.[14] This tension between central direction and local initiative marked much of later nineteenth century public health. In 1840s Liverpool, the local/central relationship was a symbiotic one, with public health officials in both locations using the tensions in the relationship to advance their own objectives.[15] Eyler's recent study of Newsholme shows, through a study of his work as the MOH for Brighton, how much a determined local official could achieve by working within local political structures.[16]

It is important to recognise, too, how public health efforts were informed by fear. Towards the end of the century, fear was focussed on what was seen as the growth of a 'residuum', a race of degenerates, physically stunted and morally inferior. Public health historians are beginning to relate this larger ideological climate to the concern for environmental pollution in the late nineteenth century – fear of contamination, which found expression in imagery such as that of the fog shrouded East End – or in the concept of the opium den. The focus of pollution concern was both environmental and individual.[17]

But public health has also had a history since the nineteenth century. Public health historians such as Jane Lewis have drawn attention to broad stages in the development of public health, which were also delineated by early writers on public health.[18] The era of environmental sanitation gave place at the end of the century to an emphasis on isolation and disinfection under the impact of germ theory. The individual patient became the locus of infection. Some historians have argued that

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14 Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick, Britain, 1800–1854* (Cambridge, 1998). Hamlin spent several months in 1998 as Health Clark Lecturer in LSHTM, a valuable cross-fertilisation exercise. An in-house conference on history in public health, organised by the history group, brought discussion between current researchers and public health historians.

15 Gerard Kearns, 'Town hall and Whitehall. The roles of local and central government in sanitary reform. The Liverpool case, 1847–1863'. Paper given at the Liverpool conference 'Health in the City: a history of public health', September 1997.

16 John M. Eyler, *Sir Arthur Newsholme and State Medicine, 1885–1935* (Cambridge, 1997).

17 Bill Luckin, *Pollution and control: a social history of the Thames in the nineteenth century* (Bristol, 1986). See also Gareth Stedman Jones, *Outcast London. A study in the relationship between classes in Victorian Society* (Oxford, 1971).

18 For a good survey of this argument see Jane Lewis, 'The origin and development of public health in the U.K.' in Walter W. Holland et al., eds., *The Oxford Textbook of Public Health.* 2nd ed. (Oxford, 1991).

these theories gained such widespread acceptability quickly at the political level precisely because they provided such a circumscribed notion of appropriate intervention. Others argue that bacteriology had a less significant impact on the implementation of policy. Its importance lay in preparing the way for the rise of what has been called 'surveillance medicine'.[19] The new public health of the twentieth century was indeed founded on the concept of 'personal prevention'. Stimulated by concerns about national efficiency and the 'deterioration of the race', the concern was with education and personal hygiene. After local government took over the old Poor Law hospitals in Britain in the interwar years, public health doctors turned their attention to running hospitals rather than to securing the health needs of the community. Historians have pointed to Britain's resultant slowness in adopting diphtheria immunisation, and to the failure to draw the health consequences of unemployment to government during the 1930s.[20]

The establishment of the National Health Service (NHS) in 1948 saw public health marginalised when the nationalisation of the hospitals rather than public health in the local authorities formed the bedrock of the new system. The 'new vision' for public health in the 1960s was community medicine – the public health doctor as health strategist', but with the health service and the structures of clinical medicine rather than the local authority, using epidemiology and statistics for 'community diagnosis'. The new public health was to be the lynchpin of the reformed NHS, and doctors were to be advisers as well as managers. At the same time, the technical tools of epidemiology underpinned a new change in ideology to personal prevention, drawing on the turn of the century ideas, and the concept of individual lifestyle, epitomised in government prevention documents of the 1970s. Individual habits were identified, but examined via epidemiology at the population level. It was smoking, alcohol consumption, and eating which epitomised the new public health concerns. Fiscal and media strategies – taxation, mass media campaigns – underpinned the standard patterns of response established at this time. In practice the dual role for public health proved difficult to manage. After health service reorganisation in the 1980s, community medicine was sidelined and in some areas virtually disappeared. The coming of AIDS stimulated another revival. More recently, the Conservative government's Health of the Nation (1992) policy document and the unintended consequences of NHS reforms, which saw public health playing a central role in purchasing, seemed to mark another 'new beginning'. The advent of the Labour government in 1997 has seen a greater stress on public health.

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19 Dorothy Porter, *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times* (London, 1999). See also David Armstrong, *Political Anatomy of the Body. Medical Knowledge in Britain in the Twentieth Century.* (Cambridge, 1983).

20 Work by Webster and Weindling, surveyed in Lewis (1991), *Oxford Textbook, op. cit.*

For historians, this broad historical survey would be nothing new. We are reasonably familiar with the debates and the interpretations advanced by fellow workers. But it is not internalised as history in public health in the way in which the Chadwickian 'heroic' period is. Advising recently on the compilation of a brochure to mark the centenary of LSHTM, I was struck by how little of the interwar UK history of public health was known to practitioners. The recognition of the history of UK public health in particular seemed to end with the nineteenth century. Yet the School in the interwar years and after had been the location for important moves which helped structure postwar public health, not least statistical and epidemiological developments and the role of its staff in policy making. For example its Dean, Wilson Jamieson, was CMO in the Ministry of Health during the war. So certain dimensions of 'historical fact' are missing. But there is also a more fundamental problem. Change over time in the ideology, location and practice of public health are important dimensions of historians' analyses, but these are difficult concepts for contemporary practitioners. It is more difficult to integrate the conceptual side of historical research. The interplay of 'fact' and interpretation in history is barely recognised. There is an added complication in that the other social science disciplines, which are located within public health, are also often unaware of historical research and its conclusions.[21] When one European public health journal ran a historical special issue, it drew on the work of sociologists rather than that of historians of public health.[22] Nor do the contemporary policy discussions of public health appear to take much account of this historical mutability of the concept of public health. At the policy level, public health is used as some kind of universal absolute, without recognition of historical developments in ideology. One recent policy report on health promotion remarked in its summary, 'Health promotion and public health are intricately linked concepts which overlap considerably. Greater clarity is needed on how they relate to each other'.[23] These are important historically determined issues.

## The Public Health Consciousness of Historians

There is also another way of looking at history in public health. It is easy to be patronisingly superior. Public health practice could expand its understanding of history and of the greater complexities of historical interpretation. But historians of

21 Here Armstrong's work would be used, but rarely a range of historical work. e.g. of Judy Green and Niki Thorogood's recent book *Analysing health policy: sociological approaches* (London, 1998).

22 This was the *European Journal of Public Health* 6:2 (1996).

23 *The future of the health promotion function.* Report on a consultation facilitated by the Health Education Authority, 1998.

public health can expand their boundaries, too. History in public health from another perspective, that of historians working in a public health location, opens the mind to fresh possibilities and to perspectives which might not be so apparent to a disciplinary-based historian. Here I will focus on three layers: the area of postwar history of public health in general, and within that framework the analysis of changing structures, practice and ideology, both at the central and local levels. As is perhaps obvious from the preceding section, public health has a postwar history which has so far attracted relatively little attention. Jane Lewis has written of the role of community medicine;[24] but there has also been public health as prevention, prevention not as an environmental issue, but as a matter of remedying defects in individual lifestyle. The rise of this style of thinking can be traced both internationally, as for example through the Lalonde report of 1974 and in individual country-based prevention documents, as in the U.K. The roots of this reorientation can be traced to the postwar shift in interest from epidemic to chronic disease, and to the rise of technical tools, most notably risk factor epidemiology.[25] Epitomized in the new 'scientific fact' of the link between smoking and lung cancer, this was a fundamental paradigm shift in scientific 'ways of knowing', substituting for biomedical notions of direct causation, epidemiological concepts of relative risk and statistical correlation. In statistics, biomedicine gave way to public health epidemiology. Risk factor epidemiology became the new public health/preventive discipline par excellence, associated with a host of health issues from alcohol and smoking through to diet and heart disease. This was the epitome of the surveillance society. A public health agenda emerged in the 1960s and 1970s which was based on this risk agenda, on individual avoidance of risk. It developed a strong economic dimension and a focus on education of the individual. Consequently, the role of health education assumed new significance together with the use and development of techniques of mass persuasion in the health area.

In the postwar years, it was the smoking issue which most clearly epitomised the reorientation of public health towards individual lifestyle. By the 1970s, anti-smoking interests had developed a policy agenda which focussed on economic arguments (price and tax rises, anti-industry) and on the media (advertising bans, mass media campaigns), sustained through the techniques and findings of epidemiology. In the 1980s the development of AIDS as an issue also epitomised the reorientation of public health around the concept of risk. AIDS was a syndrome initially defined solely through epidemiology and the concept of risk. It was an epidemiological syndrome par excellence; and it also exemplified the key tenets of the new public

24 Jane Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919.* (Brighton, 1986).

25 Virginia Berridge, *Health and Society in Britain since 1939.* Studies in Economic and Social History (Cambridge, 1999).

health, stressing individual behaviour modification and individual responsibility rather than any collective reaction.[26]

This history of prevention and concepts of risk in policy-making is one where, as yet, relatively little primary research has been done. If we look in this postwar period at the role of formal public health structures, then the history of public health points to other public health issues meriting historical research. The central government location of public health has its 'heroic' roots in the nineteenth century – but its contemporary history should also be considered. Historically the location of public health in central government has been important, and central/local tension is an enduring theme. The role of public health within central government in more recent times also needs to be considered. AIDS seemed to advance the position of public health centrally, with the leading role played by the CMO. The production of The Health of the Nation document continued that tradition. But what did public health gain in central policy terms? The main beneficiaries of AIDS were ultimately the clinical specialties and genitourinary medicine above all. The CMO's involvement was seen by some as a diversion, with little public health involvement in other key health issues, such as health service reorganisation. Florin's work on health promotion and the GP contract in the early 1990s shows little involvement by formal public health interests or the CMO.[27] Internal changes in the Department of Health and the merging of medical and administrative strands may also have impacted on the work of that office, with the NHS Management Executive increasingly taking on a policy role. Other key policy areas in the 'new public health', such as illicit drugs, also have little formal public health involvement on the central expert committees and coordinating units. What public health really means within central government and policy making needs examination, not least the changing role of the CMO.

Structural issues remain important at other levels as well. Walter Holland, part of postwar public health history himself, recently noted in his history of public health parallels between the purchasing role of public health and the events of the 1930s, when public health doctors ended up running hospitals.[28] There are parallels also with the 1970s, with the technician-manager role in the reformed NHS and the enhanced role of epidemiological information. The essential duality of the rationale of formal public health has been the continuing thread, on the one hand, between disease

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26 Virginia Berridge, 'Science and policy; the case of postwar smoking policy' in Stephen Lock, L. Reynolds and E. M. Tansey, eds. *Ashes to Ashes. The History of Smoking and Health* (Amsterdam, 1998). Virginia Berridge, *AIDS in the U.K. The Making of Policy, 1981–1994* (Oxford, 1996).

27 D. Florin, 'The role of public health medicine in national policy; a study of the policy for heart disease prevention by GPs in the U.K.', *Journal of Public Health Medicine*, in press.

28 Walter Holland, after dinner speech, The Liverpool conference 'Health in the City: a History of Public Health, September, 1997. See also W. Holland and S. Stewart, *The Rock Carling Fellowship, 1997. Public health: the vision and the challenge* (London, 1998).

prevention and health promotion, and on the other, between the planning and management of health services. This has been epitomised in the Janus face of the annual public health reports, uncertain of whether their rightful audience was health care purchasers or the public.[29] The leading role of public health in the new HIMPS (Health Improvement Programmes) may perhaps resolve some of these historically determined structural issues, but the historians' supposition would be that it might well continue them.

One twentieth century structural issue has not gone away. Historically the tension was between GPs and public health doctors for control of the same territory in the interwar years. In the postwar period, and especially since the 1970s, GPs have taken on many of the 'health promotion' activities – brief interventions, screening, health checks, advice on diet, alcohol and smoking, sexual health issues – which are considered to be part of the modern public health package. We now, in the 1990s, have a 'primary care led' NHS. The question may well be asked whether it is rather primary care which now carries out a considerable part of the traditional public health role. Recent moves in health service organisation have not clarified this issue. One doctor with experience in both camps commented, 'There's a lack of clarity about how functions divide between public health, the health authority and the Primary Care Groups. The interface needs to be sorted out...'.[30] It is the primary care groups rather than public health which have been given the community development role. The terrain remains unclear, with the advantage apparently to the general practitioner. This is a significant change from the early discussion of primary care in the 1960s, when, as Jane Lewis has reminded us, the term meant public health.[31]

The public health 'policy community' is both broader and more fragmented even than this issue implies. The 'players', both locally and in policy advisory terms, are a wider community than the formal public health model. The players within the various 'policy communities' which exist around the issues deemed to fall under the public health umbrella are often not public health personnel in a straightforward way – and they differ from each other. The smoking policy community, for example, is distinct from that for alcohol, or for drugs. Probation officers and psychiatrists carry out public health policies, too.

This blurring of the organisational boundaries has been accompanied by some interesting changes in the ideological and technical underpinning of what are broadly termed public health activities. Epidemiology as a technical tool has been under pressure, criticised from different directions. Its central tenets within public health, in

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29 N. Fulop and M. McKee, 'What impact do annual public health reports have?' *Public Health,* 110 (1996), 307–311.

30 Personal communication, December 1998.

31 Jane Lewis. 'Making recent community and primary care policy', lecture given at LSHTM, 4 November 1997.

particular the focus on 'risk' to the whole population, are yielding to a greater emphasis in some areas on harm and 'high risk' groups. The conflict or tensions between these two approaches is currently exemplified in debates in the alcohol field.[32] This has brought in its train a redefinition of the concept of risk. But there is also a new environmental dimension to public health which has led to further redefinition. The global environment is involved, but also a redefinition and expansion of risk at the level of the individual in society, the concept of the 'environmental citizen', a rational consumer protecting him or herself from environmental risks.[33] There is a new 'environmental individualism' demonstrated, for example, in the concept of passive smoking. This gives the epidemiological concept of risk an environmental dimension, but one still rooted in the control of individual behaviour, conceptualised with a strong moral tone.[34] Environmentalism at the level of the city or the locality has been expanded through the concept of 'community safety', which means essentially control of the individual in local smoke, drug- or alcohol-free spaces. Such spaces are also to be crime-free. The concept is applied not just to health behaviours but also to issues of public behaviour and of law and order, as in the recent UK Crime and Disorder Act. Issues of law, regulation and public health are being brought together at the local level, a development which again has its historical and especially late nineteenth century local antecedents. Issues of individual responsibility and of environmental pollution are brought together, coupled also with that 'threat of the underclass' (redefined as 'social exclusion') which was so important at the turn of the last century. We seem to be moving from a risk-based public health to one redefined around safety and harm.

## History and Historians in Public Health

These comments derive from the perspective of a historian more familiar with UK public health and its recent history. Those working in other cultures and countries would obviously have different points to make, although some of the issues are cross-national. This section of my paper is in part a call for more research on recent history, but also in part an illustration of the perspectives and possible areas of research which

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32 Griffeth Edwards et al., *Alcohol Policy and the Public Good* (Oxford, 1994). For the revisionist approach, see M. Plant, E. Single and T. Stockwell, eds., *Alcohol. Minimising the harm. What works*? (London, 1997).

33 A. Petersen and D. Lupton, *The new public health: Health and self in an age of risk* (London, 1996).

34 Virginia Berridge, 'Passive smoking: policy speaks to science?', *Social Science and Medicine,* 49:9 (1999), 1183–95.

emerge through the interaction of historical understandings with contemporary events and players. In this final section of the paper, I will turn to the role of 'historians in public health'. That arena of interaction is quite distinct from the type of 'presentism' for which many historians have such distaste. History in public health can be presentist, simply reproducing the preconceptions of the present in its analysis of historical work. But it does not have to be so. It can be a tool of analysis, bringing a historical understanding to bear, not presentist, but aware of the present.

In developing a more nuanced analysis, it is important to be a historian in public health, in the anthropological sense, to be 'living among the tribe', to be a 'stranger and a friend'. Let me give some examples from my own work and that of colleagues at LSHTM which illustrate the variety of advantages this can bring. There are practical ones. At a recent LSHTM conference, I organised a witness seminar, a group 'oral history event' on the 1980 Black Report on inequalities and health, a notable piece of recent health history, in part because of its rejection by the Conservative government. Thinking of whom to invite, apart from the members of the committee, and gaining their agreement to speak on the record in public were greatly facilitated by two things. My location in the same unit in the School as one of the members of the committee, now an Emeritus professor, meant that he readily provided information and advice to a colleague. My connections with a fellow historian, who had twenty years earlier been scientific secretary to the committee, also provided valuable briefing and contacts. The duality of the location – in public health, but also in history – was what mattered. Research work done on the role of the science/policy relationship in the revised role for health promotion in the GP contract, which took place in the early 1990s, saw medical civil servants speaking to the researcher, a public health doctor, in a forthright way which would have been less likely with a non-medical historian. But the researcher also located her work in the history of postwar general practice and public health through historical supervision. Again the duality of the location was important. Research on hepatitis B and its history gained from its location in an institution where current research was also feeding into Department of Health decision making on current hepatitis B vaccine policy. Research on the media processes round the science/policy relationships gains from a ringside seat at current debates and the process of dissemination. A recent media flurry over the safety of the pill for those who took it before having children, in which an LSHTM colleague was the focus of attention, produced interesting insights into the ways in which scientific facts can harden through dissemination through a hierarchy of media outlets. In this case the BMJ produced a press release on a paper which had appeared in another journal, and the mainstream press and TV then took up the issue. These types of processes can be related to theoretical stances on the media diffusion of science.

It helps, too, if leading medical journalists are regularly around. This practical and methodological point is an important one. At the methodological level, 'living among

the tribe' offers many opportunities. It is easier to trace the changing role of the CMO, when current and former CMOs are in the institution. It helps an understanding of nutrition policy if key scientists who play important policy roles are around. Lunching regularly with a leading smoking researcher, involved in the area for over twenty years, can be more valuable as a mode of oral history than the formal interview which a disciplinary-based historian would set up. Conversations and observation at meetings, in the corridor, in seminars may find their way into the eventual historical analysis. This type of history in public health has to be carefully managed. A range of health and disciplinary balls must be kept in the air at any one time. Historians are not current health policy 'poodles' but rather insider/outsiders, detached, yet part of the scene. The ultimate result is never cause for self-satisfaction, and its mode of analysis is often outside the conventions both of formal history and formal public health.

Here are the research advantages which this location brings. But I started with another issue – how to make public health more aware of historical concepts and research. How to bring more sophisticated historical perspectives into public health's understanding of itself is not capable of any easy solution, not least because this type of history does not offer lessons or prescriptions for the future in a directly applicable sense. When I look at the diffusion into drug policy discussions of work I did on nineteenth century opium and on drug policy in the twentieth century, it is still the analysis of 'open availability' of drugs in the nineteenth century which attracts most attention. But there is a process of gradual diffusion of the other arguments and analyses, not least because I have remained in contact with the field. This leads me to conclude that there has to be a continuing reciprocity and interchange from both sides, and the seizing of the opportunities, not least teaching, offered by the location.[35] Dissemination is important to a wide variety of audiences. The historical interest within public health is long standing and is there to be built upon. All in all, history in public health is an exciting and demanding way of doing history and one whose potentialities should be more widely realised.

## Acknowledgements

I am grateful for the support of the Wellcome Trust, which funds the history programme at LSHTM and other historical grants. My thanks are also due to Jenny Stanton whose careful editorial comments have greatly improved the paper, and to Deborah Curle for secretarial assistance.

35 This paper has focussed on research rather than on the opportunities offered by teaching as a process of diffusion. See Virginia Berridge, 'Teaching history in a medical school', Wellcome History, 1997.

# Scarlatina and Sewer Smells: Metropolitan Public Health Records 1855–1920

Andrea Tanner

The peculiarities of the history of public health in London have been the subject of several studies in the last twenty years, most notably by Anne Hardy, Bill Luckin, Lara Marks, Graham Mooney, John Davies and David Owen.[1] The purpose of this contribution is not to add to the canon, but rather to make a plea for a re-examination of some of the original sources for this field, in particular the surviving reports of the metropolitan Medical Officers of Health (MOHs), which provide a unique insight, not solely into the development of public health policy and practice in the capital, but into many aspects of London life.

London tended to be excluded from the provisions of much of the reforming legislation of the nineteenth century. It alone was left out of the 1835 Corporations Act, and the 1848 Public Health Act. This second Act decreed that, where a registration district recorded a death rate of over 23 per 1,000, the undertaking of remedial measures and the appointment of a Medical Officer of Health (MOH) became compulsory. In certain parts of London, most notably the East End, a death rate of

1 J. Davies, *The London Government Problem* (Oxford, 1988); A. Hardy, *The Epidemic Streets: infectious disease and the rise of preventive medicine 1856–1900* (Oxford, 1993); 'Public Health and the Expert: the London Medical Officers of Health, 1856–1900' in R. MacLeod, ed., *Government and Expertise: Specialists, Administrators and Professionals* (Cambridge, 1988); W. Luckin and G. Mooney, 'Did London Pass the "Sanitary Test"? Seasonal Infant Mortality in London, 1870–1914', *Journal of Historical Geography* 20 (1994); L. Marks, *Metropolitan Maternity* (Amsterdam, 1997); G. Mooney, 'Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England & Wales', *Social History of Medicine* 10 (1997); D. Owen, *The Government of Victorian London 1855–1889* (Cambridge, Massachusetts & London, 1982).

23 per 1,000 would have been seen at that time as an unattainable improvement on the *status quo*. Although the health of London had long been considered of prime national importance, it took another seven years before it was dealt with by parliamentary legislation. Under the Metropolis Management Act of 1855, the larger London parishes were formed into vestries, and the smaller ones grouped into district boards of works, 'for the purpose of the better sanitary administration of the capital'. The appointment of a Medical Officer of Health in each of these 48 sanitary districts was henceforth mandatory, although the position could be part-time, and many MOHs combined their work for the vestry or district board with either other public appointments, or with private practice. Under the Act, a new medical elite was created, which would have a great impact on the health of London.

Although they were local government employees, and not granted security of tenure until 1891, the metropolitan MOHs quickly formed themselves into an association to promote the interests of both the public health of London, and of the MOHs themselves.[2] By January 1857, they had negotiated special transfers of information from the office of the Registrar General, which enabled them to gauge the new cases of illness coming under treatment weekly in pauper practice and public institutions of the Metropolis, and publish the district meteorology of London. It was planned that a central repository would keep a general register of the present condition of the Metropolis, with regard to drainage, removal of dust etc., and of new building and sanitary works. It was thus expected that, with the cooperation of private practitioners, a public health profile of London would be produced at regular intervals, and that this information would both direct local strategies for dealing with problems, and guide the legislators to frame new laws to handle specific public health issues. Unfortunately, the Treasury refused to pay for this initiative, which is why today the historian is faced, not with a wonderfully comprehensive set of records, but with the partial survivors of the written record of a piecemeal system.

One of the most daunting, and deterrent, aspects of research is the large network of different authorities with responsibility for administering metropolitan public health. At least three government departments, six metropolitan-wide authorities and dozens of different types of purely local bodies, including Paving and Burial Boards, were entrusted with different aspects of metropolitan public health administration. The 1855 Act, and much subsequent legislation, did not replace old administrative structures, but rather added more layers of government to what was already an almost

2 *Public Health* (Journal of the Society of Medical Officers of Health), jubilee number, 1906; D. Porter, 'Stratification and its discontents: professionalization and conflict in the British public health service, 1848–1914', in E. Fee & R. M. Acheson, eds., *A History of Public Health* (Oxford, 1991); and J. L. Brand, *Doctors and the State: the British Medical Profession & Government Action in Public Health, 1870–1912* (Baltimore, 1965).

incomprehensible system. The multiplication of authorities responsible for the different geographical areas, and functions of public health legislation, and the absence of an effective metropolitan central government, even after the creation of the London County Council in 1889, means that the researcher must look in many places in order to see the whole picture. The Local Government Board, the heir to the Poor Law Commission and the Poor Law Board, had overall supervisory control over most of the public health authorities of the metropolis, until the formation of the Ministry of Health in 1919, and the abolition of the Poor Law in 1929.[3] Its main functions were in authorizing loans, inspecting the administrations under its wing, and reporting on aspects of public health administration to Parliament. It authorized the appointment of Poor Law Medical Officers, and was, after 1891, able to pay a portion of the salaries of certain local public health staff.

Neither the main Home Office papers, nor those of the Privy Council, are likely to be of great interest to the metropolitan historian, but it is important to note that these two central government departments were responsible for bodies whose records are of some importance. The Privy Council's Medical Department reported on public health matters that were deemed to be of national significance. Their first chief Medical Officer was Sir John Simon, sometime MOH to the Corporation of the City of London, whose published reports were given extensive coverage in the national press.[4] The Home Office was the department responsible for the Metropolitan Police and the London School Board, both of which had public health responsibilities. The role of vagrants in transmitting infectious diseases was a matter of prime concern to the sanitary authorities, but until 1894 it was the Metropolitan Police which had the task of overseeing and inspecting common lodging houses (what we might term dos houses today).[5] Metropolitan Police records are held at the Public Record Office (PRO) and at Scotland Yard, although it is easier to track their reports on lodging houses through the local sanitary departments' holdings, most particularly the MOH reports. This last statement may be applied to most of the larger organizations described above.

Schools were a focus for the transmission of childhood diseases, and the records of the London School Board (LSB) are excellent, not just for those wishing to track outbreaks of measles or whooping cough in a particular area, but also for details of vaccinated and non-vaccinated children. London state schools pioneered the school dinner movement, which was begun as a charitable enterprise under the London School Dinners Association in 1890 before becoming part of the educational budget of the capital, and it is possible to trace the history of this, as well as chart the

3 C. Bellamy, *Administering central-local relations 1871–1919; the LGB in its fiscal and cultural context* (Manchester, 1988).

4 R. Lambart, *Sir John Simon, 1816–1904, and English Social Administration* (London, 1963).

5 See L. Rose, *Rogues and vagabonds* (London, 1988), 56–63.

development of the schools' medical service, and its enduring emblem, 'Norah the Nit Nurse', through the records of the LSB, which was subsumed to the London County Council in 1904.

The Corporation of the City of London was, and is, a separate entity, and a law unto itself. It ran the Thames Conservancy Board, and its reports are vital to an understanding of the importance of the river as a source of drinking water and the conduit for the waste of the capital. It also ran the Port of London Health Authority, which was an essential part of the state effort to block imported disease from entering the country – in particular, rabies, cholera and plague. The Corporation had its own Sewers Commission, and its Police Force, just like the Metropolitan Police, supervised doss-houses within the Square Mile. The published annual reports of the various departments were given wide coverage in the local newspapers, most notably *The City Press* and *The Weekly Despatch*.

The middle tier of public health government is complicated. Most notably it contained the Metropolitan Asylums Board (MAB), which was created under the Metropolis Poor Act of 1867 to set up and run fever hospitals and lunatic asylums. By 1929, it ran a network of training establishments for pauper children, fever hospitals and camps, lunatic asylums, and an ambulance service for infectious cases.[6] Its surviving records are held at the London Metropolitan Archives (LMA). The Metropolitan Board of Works (MBW), created in 1855 and disbanded in 1888 after a decade of scandal, was the body which built the main drainage system of London and the Thames embankments, in addition to carving out several thoroughfares, such as Charing Cross Road and Queen Victoria Street. It also began the movement to preserve parkland and open spaces for the people of London.[7] Its records are also at the LMA, as are its published reports, although its correspondence with the various local sanitary authorities can be found among the records of the latter.

Its successor, the London County Council (LCC), was intended to become the voice of London, but, in Sydney Webb's inimitable phrase, it 'was born in chains'. It was not granted control over the vestries and their successors, and was kept under parliamentary control by its dependence on an annually-determined budget. It never attained control over London's water, or its gas or electricity services, but its role in the public health history of London is nevertheless vital, especially after the passing of the 1891 Public Health (London) Act. By the end of the Great War, the LCC was responsible for London state schools, for housing the working classes, for many of the capital's parks and gardens, for ferry services across the Thames, for co-ordinating the capital's fight against pulmonary tuberculosis and much, much more. It had its own MOHs, who reported on matters of metropolitan concern, and who conducted

6 G. M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board, 1867–1930* (London, 1971).

7 G. Clifton, *Professionalism, Patronage and Public Service in Victorian London* (London, 1992).

many investigations into the public health deficiencies of the capital.[8] Housed at the LMA, the archive of the Public Health department of the LCC is a much undervalued source, not least for the evidence of just how much was expected of it by the local MOHs.

The Metropolitan Water Board, which in 1902 took over (at vast expense) the management of London water from eight private companies, reported on the distribution and quality of the water supply. Its financial records are of immense complexity. Other bodies involved in public health included the Sick Asylum Districts, which were amalgamated Poor Law medical provision in parts of London, and the School Districts, which ran the pauper schools. Their records are at the LMA, and the correspondence with their parent body, the Poor Law Board, and its successor, the Local Government Board, is housed at the PRO.

The third layer – the bottom tranche – was not only responsible for implementing the ever-increasing level of public health legislation after 1855, but also had to pay for it. Almost the whole of the Victorian advancement in terms of sanitation and public health was paid for out of local rates, and this dependence on the individual ratepayer is a very important factor in any consideration of metropolitan public health. The published annual reports of the vestries and district boards, their successors the metropolitan borough councils, and their various departments, do not survive in one place in an unbroken run, but the majority are to be found in the library of the LMA. The local London archives also have copies of their own departmental reports, in addition to the vestry and council minutes, and the papers of the various committees and local government departments. As a general rule, the original notebooks of the sanitary officials and the original correspondence files have NOT survived.

Between 1856 and 1870, the metropolitan vestries and district boards of works spent nearly £6.5 million on paving, lighting and improvement works. Under the 1855 Act, and the 1866 Sanitary Act, they had powers to condemn and close unsanitary dwellings, purchase and demolish condemned houses, acquire land and provide accommodation for the poor, establish public libraries, baths, washhouses, mortuaries and open spaces. Note that, while they had the *power* to undertake such actions, in reality political and financial interests meant that most of these powers lay underused until the advent of the LCC in 1889. Among those who pressed the sanitary authorities to undertake their responsibilities with greater zeal were the MOHs, whose duties, as required by law, were to inspect and report from time to time on the sanitary condition of their district, to enquire into the existence of disease and into increases in the death rate, to explain the likely causes of disease in their area and to recommend measures to counteract ill-health. The Metropolitan MOH has passed into mythology as at best undervalued and at worst abused. He

8 For example, W. H. Hamer, *Report on the Sanitary Condition of Kensington*, LCC official publication no. 454, 10 November 1899.

was in effect the conscience of his employers, and, as such, was kept in his place.

Illness was a fact of life for the majority of the city's inhabitants, and premature death was the lot of the working classes. The records, published and in manuscript, contain a microscopic account of life and death in London from the mid-Victorian period onwards. It is possible, not just to see the numbers in a given district who were dying from specific diseases, but actually in which streets they were dying. One can chart infant mortality rising in the heat of summer, measles breaking out as soon as the school holidays are ended, and, as winter sets in, the great increase in deaths from chest infections among the elderly, particularly those in institutions. The public health records can reveal not only the growth of a particular district, but the nature of its housing, the state of the streets and the sewers and drains underneath them, the impact of increased population density and the development of recreational space, the weather and how it affected the inhabitants, and the water supply, not only how clean it was, but who had access to it. They can show how bad sanitary arrangements caused typhoid, no respecter of persons, in the 1860s and 1870s, and how the disease came back in the early years of the twentieth century to kill hop-pickers, watercress-eaters, and Londoners who had gone to the seaside. By 1918, the metropolitan public health records deal not only with disease and death, but with a gamut of concerns. Infant mortality and measures to educate first-time mothers, the control of tuberculosis in the community, adult male unemployment, factory and workshop conditions, smoke nuisances, food adulteration, overcrowding, disinfection of buildings, clothes and people, public baths, housing of the working classes, water supply, slaughter houses and dairies, bakehouses and rubbish. The local public health departments operated quite literally at street level, and beyond – they were among the few bodies to penetrate the living spaces of the local inhabitants and, as such, can tell us more about their lives than almost any other resource.

Changes in legislation and the demands of epidemic crises had a profound effect on the job of the MOH and on the nature and extent of the reports he produced. In the beginning most MOHs worked under the supervision of a sanitary committee. They may (or may not) have directed the work of the inspectors of nuisances, whose job it was to ensure that the vestry's statutory obligations under the 1855 Act were fulfilled. The earliest reports are, at best, sketchy, although not without interest. They contain mission statements of what the MOH expected to achieve, or follow the particular interests of the appointee. Francis Godrich, MOH for Kensington from 1856 until 1870, was interested in the occupational profile of mortality in his district, and thus provides tables of the trades of those adults who died, including women. Details of local improvements, of the objections of individual householders to the actions of the vestries, and of the work undertaken by the sanitary departments is best found in the minute books of the vestry and of its committees. Alternatively, the letters pages of the local press and the editorials give a balancing slant on how well each authority was doing, at least in the eyes of the local literate population.

The metropolitan MOH was employed primarily to investigate and control the spread of the most fatal conditions of early Victorian London – infectious diseases. He was an intrepid seeker after dirt, disease – and smells. The olfactory element of his work cannot be underestimated, for the miasmic theory of infectious disease, whereby it was believed that bad smells could infect the individual, took many years to be overtaken by the arguments of the bacteriologists. The MOH was a servant of the vestry, which was the servant of the ratepayers, who objected loud and long to any unpleasant whiff emanating from the street drains or from the sanitary arrangements within their own homes. The minutes of the vestries and the sanitary committees hold vast detail of the nuisances occurring within each district and at that time perceived as dangers to human life. It is possible to chart the building of the main sewerage system, not just through the records and reports of the MBW, but through the vestries. Street by street, one sees houses being connected to the main drains and the results of shoddy workmanship and house building on unsuitable sites. There you can find the record of the numerous attempts to banish the smell of sewerage from the city streets – by putting charcoal and disinfectant down the drains or trapping and covering the offending sewer. There also can be found the history of local residents taking matters into their own hands and blocking the drains themselves, which, in the words of one MOH was

> ...a course to be regretted, as it is better to have stench here and there in the roadway than the escape of sewer gases into houses...sewers must be ventilated, and if this is not provided for artificially the resistance of almost any drain will be overcome by the pressure of the contained gases and foul effluvia, with all their injurious consequences, find their way into our houses.

The smell of the sick themselves is vividly evoked by the MOH for St George in the East, in his description of fever patients:

> the odour of such persons, so peculiar, depressing, and nauseating, is really very much due to the decomposition of their own dried up perspiration, and unctuous secretions of the skin, which saturates their rarely washed or changed clothing. These effete matters from their bodies yield an effluvium, as your Sanitary Officer expressed it, very like a pig pound, and when their places are visited, the windows and doors are usually found closed, often, I believe, that the condition of the place may not be seen by others. This shows that filthiness is not unrecognized by such inmates, but nevertheless they manifest a powerful disinclination to remedy it.

Smells did not just emanate from sewers and the sick. One can find out what servants did with the rubbish produced by their employers, chart how they, and indeed the rubbish collectors, during the building boom could make money by selling the contents of the grate or the sweepings from the floor, and the difficulties of disposing refuse after the 1880s. The correspondence registers of the sanitary committees and the letters pages of the local newspapers are filled with the howls of complaint from householders whose refuse had been left lying for weeks at a time. Trades were pursued in London which those familiar with Mayhew will know about only too well. Every part of the metropolis boasted its slaughterhouses, its cowsheds, and its fat-rendering factories. One particular business was the inoffensively-named marine stores, the lowest form of rag and bone merchant, with the emphasis on the bone. Anything that was not wanted, in whatever state of putrefaction, ended up in the marine stores.

Rubbish is a fertile area of study for the archaeologist and also for the historian. For example, here is the MOH for St George in the East describing the attractions and dangers of refuse in his district in 1879:

> The tenants in spite of our parochial receptacle much prefer to throw their dust on the ground. 1 person told me she thought her little girl's fever was contracted by her fondness for playing in the dustbin before breakfast. The courts in this scheduled area are the close playgrounds of these children inhabiting them, and it is no wonder that infectious diseases rapidly spread. A doctor visiting a house, even, is a source of some attraction to the playmates of a child ill, and its funeral is most alluring.

In the early days the metropolitan MOH had to deal not only with the human population, but with the pigs and other animals which had to be rooted out and removed from dwellings, and the MOH for St George in the East discovered a donkey living in a tenement on his patch. This exercise was not without its difficulties – Thomas Orme Dudfield, MOH for Kensington from 1870 to his death in 1908, had to have a police escort while making his pig inspections, as the customary greeting of the inhabitants of Notting Dale to all officials involved liberal gifts of bricks and mud, the latter almost certainly made out of the by-product of the porcine population.

All these factors have a bearing on public health, of course, but the prime concern of the local MOH was to reduce the mortality levels of his district, to as near 17 per 1000 inhabitants, which was the figure considered as perfection by the Registrar General. Before 1900, this meant that the work of the MOH was directed towards the control of infectious diseases. In 1870, vaccination against smallpox was made compulsory for children, but the job of keeping the registers was not given to the MOH, but to the local public vaccinator, who was invariably a Poor Law Medical

Officer and directly answerable to the Vaccination Department of the Local Government Board. From 1872 local registrars of births, marriage and deaths in London sent details of local birth registration up to three times a week to the vaccinators, so that they could visit the homes of the parents and arrange for the child to be vaccinated when it was three months old. The registers are to be found among the Poor Law union collections at the LMA, and are very detailed.

In the same year the first of the MAB fever hospitals was opened, to which were sent paupers suffering from smallpox. These hospitals were built in what were then outlying parts of London–Hampstead, Fulham, Stockwell and Homerton – and treated thousands of patients during the smallpox epidemic of 1871–1872. Theoretically, treatment at an MAB hospital pauperised the patient, which was a powerful disincentive for Londoners suffering from the disease to be open about it. In theory, smallpox patients could only be sent to an MAB hospital by order of the Poor Law Relieving Officer. In practice, MOHs and general practitioners sent patients to the hospitals directly, by-passing the Relieving Officer, in the interests of controlling the spread of the dread disease. When smallpox was not rife, scarlet fever, typhoid, typhus, diphtheria and whooping cough patients, many of them children, were sent to the MAB hospitals. While it is relatively simple to examine the surviving hospital registers, it is also possible to chart outbreaks of infectious disease, via the MOH reports. Smallpox outbreaks spread by laundresses or milkmen are meticulously recorded with all the contacts of the carriers, across London and beyond, listed. Cases of hidden infectious disease are similarly followed, and, after the Elementary Education Act of 1870, so are outbreaks of disease, most notably measles, in schools throughout the Metropolis.

Several MOHs made monthly and quarterly reports, or looked at specific local problems in special reports. Water was of prime concern; the first MOHs were uniform in condemning the quality of London water, both from the wells, which the Lambeth MOH described as representing '...the drainage of a great manure bed', and from the water companies. The latter hid behind their statutes to justify supplying water from a single standpoint in some areas for less than an hour a day, and often not at all on a Sunday, the one day when it was most needed. The Metropolis Water Act of 1852, which decreed that all companies had to give a constant water supply by 1857, was largely ineffective. There was also the problem of cutting off–if the landlord failed to pay the water company charges, they were entitled to cut off all supply to the house without notice. After the 1854 cholera outbreak, most companies had moved their intakes of water further up the Thames, but this did nothing to remedy the fact that large towns further up the river still discharged their sewage, untreated, into the river. It could have been no consolation to the Londoner that his lightly filtered drinking water contained the waste products of Reading and Oxford, but not of Hampton and Wandsworth.

As the century progressed, housing conditions became increasingly highlighted as a major contributory factor to high mortality rates in London. Clearance of slums for commercial buildings or railways put great pressure on the diminishing housing stock, resulting in high rents and poor conditions. The 1866 Sanitary Act, for the first time, classed overcrowding as a nuisance, and, as such, it came into the realm of the local sanitary authorities. One particular problem in London was 'houses let as lodgings', which were large dwellings built for one family which had been sub-divided to accommodate several families in furnished rooms. Although the vestries could register and control the numbers and the condition of such houses from 1866, the majority of them did not bother. Capital was sacrosanct, and the vestrymen were not prepared to interfere with the profits of the rentiers. It was not until after the shocking evidence and report of the Royal Commission on the Housing of the Working Classes in 1884–85 that action was taken. For the researcher, the lists of these houses, proceedings taken against the owners and the disease profiles of the tenants can all be gauged from the monthly and annual reports of the sanitary departments.

The working conditions of Londoners in factories and workshops became the concern of the vestries in 1867, but, none of them at this time was prepared to employ more staff to carry out inspections, and the researcher must wait until after the advent of the LCC for any systematic record of metropolitan working conditions. From 1893 onwards, several local authorities employed female sanitary inspectors, initially to enforce legislation with regard to the industrial working environment of women and young adults.[9] The reports of these women make fascinating reading, as they play a cat and mouse game with employers unwilling to bear the expense of extra ventilation or toilet facilities.[10] Within a decade, national concerns regarding the degeneration of the race, and a sustained high level of infant mortality in the metropolis, meant that these women inspectors were specifically charged with investigating the working conditions of mothers in London, and were joined, after 1907, by a small army of female health visitors, whose job it was to support and report on the living conditions of families whose babies were at risk of premature death.

As the nineteenth century progressed, progressive legislation changed the functions of the local public health department. The professionals saw the importance of infectious disease in their work diminish. After 1891, MOHs and their staff were

9 This was pioneered by Kensington, under pressure from its long-standing MOH, Thomas Orme Dudfield. T.O. Dudfield, *Women's Place in Sanitary Administration* (London, 1904); A. Tanner, 'Thomas Orme Dudfield: the model medical officer of health', *Journal of Medical Biography* 6 (1998).

10 One of the first women sanitary inspector's experiences is given in R. Squire, *Thirty Years in Public Service, an Industrial Retrospect* (London, 1927).

more concerned with factories and workshops, the inspection of houses, the adulteration of food, and the regulation of refuse collection and disposal in the metropolis. These were all important, but did little to affect the death rate from those conditions that had become most fatal, namely, tuberculosis and respiratory diseases, cancer, and diseases of infancy. In London, consideration of the 'new' killer conditions leads inevitably to the role of the voluntary sector in public health. It was a significant one, but one that is difficult to quantify. Numerous religious organizations had developed domestic visiting systems over long years, and these became transformed into crèches, infant welfare centres, mothers' dinner clubs. While these were primarily philanthropic and religious in character, they enjoyed a close relationship with the local authority services, and this alliance was confirmed throughout London during the First World War, when the mother and baby welfare services of the capital were officially recognized as being delivered by the voluntary sector. The numerous bodies attracted local authority grants from 1916, and joint committees of the voluntary and public sector were set up throughout the capital. Some of the new metropolitan borough councils had set up their own municipal provision for maternal and infant welfare – Battersea ran a municipal milk depot for a few years after 1902, and St Pancras established an internationally-renowned School for Mothers in 1908, the archives of which are to be found in the Camden local studies collection. The vital role played by the voluntary organizations, however, means that any student of metropolitan public health must look at their records as carefully as those of the local public health departments or the LCC. Locating these records is much simpler, thanks to the Wellcome Institute Library, and a search through their catalogues, or on the National Register of Archives website, will be of immense value to the researcher.

The end of the period under review is marked by several important developments in public health, most notably the formation of the Ministry of Health in 1919. This department would increasingly remove responsibility for the range of public health provision from the local authorities, and impose a national standard of services. Central government files, housed at the PRO, become vital adjuncts to the records of the local public health departments, but that is another story… .