

## INTRODUCTION

Some years ago the school my daughters attended was found to be infested by cockroaches. This was reported to the appropriate authority and the problem took its place at the bottom of a long list, to be dealt with some months hence. One parent, however, had connections with the city public health department. A quiet word; an inspector arrived, looked, ordered immediate cleansing, and closed the school. That was Friday; Monday morning the roach-free school was open.

But what is this mysterious “public health”? Can the “public” even have a “health”? Surely “health” applies to individuals; aren’t matters of the individual “private” not “public”? The term seems almost an oxymoron. Nonetheless, in many societies this “public health” has an authority to act on lives and property greater than that of any public agency save a fire department. But what are its boundaries, goals, justifications? Is it mainly an instrument with which a state guards those human goods that are its chief property? Or is it the institution through which we collectively secure our well-being?

What masquerades as an obscure offshoot of medicine or a marginal division of civil engineering is really a vast but unexamined part of our culture. Hidden beneath expertise and technology are our notions of what health is, of what problems have priority, of the conditions under which public authorities can or must act, even our notions of “decent” and “disgusting.”<sup>1</sup> At its best public health is built of sound science and shared moral reflection. When we talk of it we are dealing in social philosophy, with ideas of liberty and responsibility, and even with the grand metaphysical questions of cosmology and causation.

Modern “public health” took shape in the nineteenth century. While it drew from many countries (and still differs from country to country in subtle and fascinating ways), it is usually seen to have come together in industrial revolution Britain in the 1830s and 1840s, at least so say the textbooks. There

<sup>1</sup> For some of the conceptual problems see Roy Acheson and Elizabeth Fee, “Introduction,” *A History of Education in Public Health: Health That Mocks the Doctors’ Rules*, eds. Roy Acheson and Elizabeth Fee (Oxford: Oxford University Press, 1991), 1–14; Dorothy Porter, “Introduction,” *The History of Public Health and the Modern State*, ed. Dorothy Porter (Amsterdam: Rudolphi, 1994), 1–44.

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French traditions of statistics and medical topography and German traditions of medical police were blended by a group of statist philosopher-civil servants into an institution to respond to diseases, initially through the public structures of water supply and sewerage. Exported to the Continent, the colonies, and the rest of the world as they became urbanized and industrialized, British sanitary systems became the universal mark of adequate public provision for health.

When historians talk of public health they may mean one of three things – the actual state of the public’s health, measured in mortality rates, filth in the streets, and so forth; or the institutions of Public Health; or finally some ideal PUBLIC HEALTH in whose name they condemn or congratulate the past. It is that ideal that is troublesome, for it implies that we can talk unproblematically about how far we are along the road to the ideal. Yet “public health” is not some eternal form; what “public” and “health” are to be, and how they are to be related, are political questions. Someone, somewhere, must say what aspects of whose health are the public’s business, and equally what public businesses will be held accountable for their effects on health. What rights to what sorts of health will I, as one of a certain race, class, gender, nationality, and age, possess? For which of my illnesses is the polity, or other individuals or institutions, responsible; which will be judged acts of God or unavoidable products of natural systems (like markets)? The focus of nineteenth-century public health was epidemics of infectious disease, but other factors too affect health (depending of course on what one takes health to be). What of arcane toxins or violence or nutrition or forms of work, or even systems of political economy? On occasion, the missions of “public health” have been terrifyingly malleable: to its perpetrators, the Holocaust was a public health campaign, a matter of necessity and expediency.

Admit the unavoidability of determinations of which people have what rights to health and it becomes impossible to sustain the illusion of an ideal toward which all progressive public health is ever tending. The history of public health at that point ceases to be a subdivision of state growth or medical science and becomes part of the history of the acquisition of political rights or, if you will, the history of class struggle.

## I

The focus of this study is the public health movement that arose in industrializing Britain in the 1830s and 1840s. Thanks to Charles Dickens, the scene is a common part of our historical imagination. It is a time of rapid change. People are on the move, from rural Ireland, the Scottish highlands, the newly enclosed English countryside, attracted to boom wages in new industry or expelled from the land by “improving” agriculturalists. Despite several years of abysmal harvests and epidemics, there are many more people – nine million

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in England and Wales in 1801, twice that fifty years later. Town populations double within two or three decades, infilling into cellars, spreading into new and cheap housing. Many now work in factories run by steam; and they work as extensions of automatic machines, power looms or self-acting mules. An age of benevolence, rooted in the elevation of sentiment and the presumption of a “moral economy” regulating social relations, gives way to an age of austere political economy, thriving on conflict and rooted in what are conceived the natural laws of human society, like those espoused by Ebenezer Scrooge. Exacerbating those changes are the twenty years of war with France between 1793 and 1815, which disrupt the economy and strengthen the forces of isolation and repression. Management of social relations by parish, parson, or justice of the peace gives way to policy-formulating royal commissions of statistician Benthamites. New breeds of religious seriousness set in: Unitarians and Anglican and dissenter evangelicals mix enthusiasm with intellect and challenge sensibilities and policies alike. It is also a time of some of the most profound social and political and scientific thinking: Paine, Coleridge, Bentham, Carlyle, Malthus, Burke, Darwin.

The political ranks too include truly able figures – concerned, diligent, well educated, honest: one thinks of Peel, Russell, and Palmerston. For the first third of the century governments (mostly Tory) fear to fiddle with the social and political “crises.” Either the old makework English “constitution” is as good as it can be or there are just no clear solutions and interference will make matters worse. Getting their chance in the constitutional crisis of 1831, the Whigs broaden the franchise and redistribute the seats, but do not satisfy a literate and often militant working “class.” For, above all, it is an age of incipient revolution. Nothing like France in 1789 or the Continent in 1848 ever quite happens – but it almost does on numerous occasions and in many places, in Ireland, London, Lancashire, South Wales, the West Riding.<sup>2</sup>

In the midst of this change is the lawyer Edwin Chadwick, “the bureaucratic radical,” disciple of the archutilitarian Jeremy Bentham, author of the

2 Such a portrait might be drawn from many sources. Among those I have found most useful are Benjamin Disraeli, *Sybil, or the Two Nations*, with an introduction by Walter Sichel (London: Oxford University Press, 1926); Maxine Berg, *The Machinery Question and the Making of Political Economy, 1815–1848* (Cambridge: Cambridge University Press, 1980); Boyd Hilton, *The Age of Atonement: The Influence of Evangelicalism on Social and Economic Thought, 1785–1865* (Oxford: Clarendon Press, 1988); Gertrude Himmelfarb, *The Idea of Poverty: England in the Early Industrial Age* (New York: Random House, 1985); Paul Mantoux, *The Industrial Revolution in the Eighteenth Century: An Outline of the Beginnings of the Modern Factory System in England* (Chicago: University of Chicago Press, 1983); E. P. Thompson, *The Making of the English Working Class* (Harmondsworth, U.K.: Penguin, 1968); Llewellyn Woodward, *The Age of Reform, 1815–1870*, 2d ed. (Oxford: Clarendon Press, 1962); Anand Chitnis, *The Scottish Enlightenment and Early Victorian English Society* (London: Croom Helm, 1986); William Ashworth, *The Genesis of Modern British Town Planning: A Study in Economic and Social History of the Nineteenth and Twentieth Centuries* (London: Routledge and Kegan Paul, 1954); Graeme Davison, “The City as a Natural System: Theories of Urban Society in Early-Nineteenth-Century Britain,” *The Pursuit of Urban History*, eds. D. Fraser and A. Sutcliffe, 349–70 (London: Edward Arnold, 1983).

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famous *Report on the Sanitary Condition of the Labouring Population* (1842), written while he was secretary to the commission administering the new poor law. On the basis of his report the first modern public health agency, the General Board of Health, was founded in 1848, with the mission of promoting the magnificent *systems* of urban infrastructure that Chadwick dreamed of. Chadwick was a hydraulic thinker, imagining a constant flow of water sweeping rapidly and continuously through towns, cleaning everything, carrying all wastes to be used for beneficent purposes in the countryside. Chadwick led the board until 1854, when he was deposed: Culture, institutions, even nature resisted the systems his tutelary state would impose.

Nonetheless there followed a great age of sanitary improvement, lasting until the First World War. Sanitation became a social movement, focused on liquidating readily identifiable targets (like “all manner of filth,” that awful entity at which Victorians loved to shudder) or intangible yet easily imagined targets, like the wisps of malignity that backed up through sewers or later those monad armies, the germs, which being “beings,” were surely no less willfully hostile than the host of a rival nation or of a colony in the making.<sup>3</sup> It was a time of impressive investment in environmental quality: in water supply, waste disposal, smooth clean streets, ventilated and roomier dwellings, public green space. Remarkably these were democratic or leveling technologies, bringing to all what had been available only to the wealthy. Indeed, sanitary reform has been seen as the most profoundly humanitarian of reforms, the proof of society’s recognition that human health matters. Its central tenet, the filth theory of disease, is seen as a courageous advance over the “comfortable belief” that deadly disease was but the appropriate end for “the unfit and superfluous, the paupers and the weaklings.”<sup>4</sup>

## II

There are many problems – of who, why, and how – in understanding why modern public health should emerge in Britain in the 1830s and 1840s. One might argue that public health appears where one would least expect it.

First, ideology: Those who effected state growth were against it. They embarked on a great campaign of public investment in disease-preventing public works in a cultural climate that minimized the range of problems considered public.<sup>5</sup> The mix of liberal political economy with more or less Malthusianism championed the truly free person who, acting in the marketplace

3 See the character Mr. Firedamp in Thomas Love Peacock, *Crotchet Castle* (1831), Peacock, *Nightmare Abbey/Crotchet Castle*, ed. Raymond Wright (Harmondsworth, U.K.: Penguin, 1969), 139.

4 R. A. Lewis, *Edwin Chadwick and the Public Health Movement, 1832–1854* (London: Longmans, Green, 1952), 42.

5 David Roberts, *Victorian Origins of the British Welfare State* (1960; reprint, Hamden, Conn.: Archon Books, 1969), 100–101.

(less so in the polity), made the world. Free people took care of their own health. True, many political economists recognized a sphere of appropriate state regulation. They did not agree what belonged in it, nor did a duty to *regulate* some markets (in water, roads, sewers, railways, gas, perhaps houses and food) imply a responsibility to *provide* those services. For most this sphere was small. Such a perspective had little in common with the Continental tradition of medical police, the most prominent version of a public health. A medical police conceived human bodies as state resources to be managed for state ends.<sup>6</sup> Medical police concerns were the product of worries about depopulation; from the perspective of early-nineteenth-century British Malthusianism there were already too many people. If humans are not assets, the status of fatal disease as a public problem is ambiguous at best.

Considerations of what a state is to do assume the existence of a viable state. Compared to Prussia, Austria, or France, early-nineteenth-century Britain was hardly a state. Quite different institutions and perspectives prevailed in Scotland and Ireland from those of England and Wales; with regard to many matters relevant to public health, England was more an agglomeration of counties, parishes, and common law courts than a state. Much is said of the nineteenth-century “revolution in government”; of paper-shuffling clerks at Whitehall and roving bands of expert inspectors promulgating new standards of health, welfare, and accountability; enforcing rules; offering the necessary legal, financial, medical, or technical expertise.<sup>7</sup> The century did produce a modern state, but it did so through dealing with public health and similar matters, not as a precondition for dealing with them. Bureaucracy-driven France or science-driven Germany would seem a likelier place for a great public health movement.

Third, public health was the product of odd coalitions. Joining the Benthamite policy analysts were the strangest of bedfellows, the evangelical Christians. Beyond wondering how someone like the seventh earl of Shaftesbury, transfixed with the imminence of the last days and the world’s sinfulness, could have worked with the ruthlessly secular and obsessively bureaucratic utilitarian Edwin Chadwick lies the question of how the evangelicals came to put faith in sewers and water.<sup>8</sup> Evangelicals, like political economists, varied greatly in

6 George Rosen, “Cameralism and the Concept of Medical Police,” “The Fate of the Concept of Medical Police, 1780–1890,” “Economic and Social Policy in the Development of Public Health,” in his *From Medical Police to Social Medicine: Essays on the History of Health Care*, 120–41, 142–58, 176–200 (New York: Science History, 1974).

7 Oliver MacDonagh, “The Nineteenth Century Revolution in Government: A Reappraisal,” *Historical Journal* 1 (1958): 52–67. For a review of recent literature see Roy M. MacLeod, *Government and Expertise: Specialists, Administrators, and Professionals, 1860–1919*, ed. Roy M. MacLeod (Cambridge: Cambridge University Press, 1988), 1–24. See also S. E. Finer, “The Transmission of Benthamite Ideas, 1820–1850,” *Studies in the Growth of Nineteenth-Century Government*, ed. Gillian Sutherland (Totowa, N.J.: Rowman & Littlefield, 1972), 11–32.

8 J. L. Hammond and Barbara Hammond, *Lord Shaftesbury*, 3d ed. (London: Constable and Co., 1925); Lewis, *Chadwick*, 183.

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outlook. In general their worry was for the souls of the industrial proletariat. Public solutions, like a right to public aid or “improvement” via water-and-drainage projects, treated symptoms and were distractions, postponing the time when each individual had to reckon with divine will. The very harshness of making a living was providential; it reinforced the call to virtue. Some stressed the charitable bonds between people at different social stations. They insisted that these be personal; to substitute bricks, pipes, and bureaucrats for Christian love seemed not only inappropriate but retrogressive, inasmuch as it endorsed false notions of autonomy and unrealistic and inappropriate political and social expectations.<sup>9</sup> It is true that on many questions of social policy – education, prison and poor law reform, opposition to slavery – coalitions of philosophical radicals and evangelicals had been politically effective. The two groups had common social origins in middle-class dissent, their spiritual journeys were often parallel, they held in common a belief in the possibility of thoroughgoing human reformation (though they appealed to very different sources to warrant those beliefs). But to find them involved in big government and sanitation is at first glance surprising.<sup>10</sup>

Fourth, medicine, the profession one might expect to lead in public health, did not, and was in no condition to do so. A united, if still not unified medical profession was only achieved in 1858. By then there were plenty of job-hungry practitioners to form the rank and file of public health, many of them medical officers to poor law unions.<sup>11</sup> They did take command, but by then public health was already mainly an institution of local government and infrastructure, which they could only minimally reshape.<sup>12</sup>

Had there been agreement about the causes of disease, medical leadership might have been less crucial. Yet with regard to what disease meant, what caused it, how to prevent it, there was only the vaguest consensus. Yes, environment affected health, but which elements of environment were responsible for which diseases in which degrees? Attributions of disease (or damage to the “constitution”) to environmental factors were often so general as to be unfalsifiable; specific allegations (e.g., Chadwick’s claim that “all smell is disease”) were falsified repeatedly yet not abandoned. Hence those who would appeal to medical theory got nothing solid from it. The very possibility of

9 David Roberts, *Paternalism in Early Victorian England* (New Brunswick, N.J.: Rutgers University Press, 1979), 7–8.

10 M. C. Buer, *Health, Wealth, and Population in the Early Days of the Industrial Revolution* (London: Routledge, 1926), 45; Raymond Cowherd, *Political Economists and the English Poor Laws: A Historical Study of the Influence of Classical Economics on the Formation of Social Welfare Policy* (Athens: Ohio University Press, 1977), 89.

11 Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978); Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994), 50.

12 Dorothy Watkin, “The English Revolution in Social Medicine, 1889–1911” (Ph.D. diss., University of London, 1984); Steven J. Novak, “Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration,” *Journal of Social History* 6 (1973): 440–62.

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epidemiological research was hampered by insufficient data. Causes of death registration was established in England only in 1837 and was hardly straightforward even then; what morbidity data were available reflected all the accidents of a system of medical care based in dispensaries and charity hospitals.<sup>13</sup>

Finally, consider the kind of public health that arose in Britain, one preoccupied with water and wastes. It is difficult to acknowledge a need to explain this for it remains a central and uncontroversial part of public health. The water and sewage technologies the sanitarians developed quickly became one of the most widely diffused technological complexes in human history. They so exemplify development and decency (not to mention health) that many of us judge places mainly on “sanitary” grounds: be the inhabitants dull, rude, even brutal, so long as they have proper restrooms they are civilized (nor, conversely, will genuine humanity or conversational brilliance compensate for bad toilets).

That we no longer see this achievement as revolutionary shows only how well the revolutionaries “black boxed” it. A world in which modern sanitation would have been rejected is unthinkable – the overflowing privy transcends ideology, calling only for a minimally competent engineer.<sup>14</sup> Not so in 1840, however. This course of urban evolution would be questioned on grounds of principle (that it was no business of government to discipline defecation) and on grounds of practicality. Water and sewerage systems are prodigiously expensive, and in the 1840s had no “track record” of successful performance – and who would pay for the retrofit of urban Britain?<sup>15</sup> In the best of circumstances, public actions are hard to explain, the more so when they require long effort and large expenditure, involve layers of complex choices (on everything from soil mechanics to property law), are taken to secure a future barely imaginable, and are done more or less voluntarily through quasi-democratic local institutions, rather than as mandates of an authoritarian state.

Moreover, the sanitarian’s gaze belies our stereotypical Victorian’s refinement: It is on excrement. One can perhaps understand how that fastidiousness might have led them to see muck as a public problem, but not one to talk about in public. Yet talk they did, and endlessly – in euphemisms, but with great earnestness. On it they leveled their exacting empiricism. Consider Jo-

13 Christopher Hamlin, “Could You Starve to Death in England in 1839? The Chadwick-Farr Controversy and the Loss of the ‘Social’ in Public Health,” *American Journal of Public Health* 85, no. 6 (1995): 856–66.

14 Bruno Latour, *Science in Action: How to Follow Scientists and Engineers Through Society* (Cambridge, Mass.: Harvard University Press, 1987).

15 In the summer of 1838 at the very beginning of the sanitary movement, one of Chadwick’s friends, James Mitchell, advised him that the idea of a public health based on new sewerage was ludicrously impracticable: “To remedy this [lack of drainage] is far beyond the powers of anybody to effect. The expense would be enormous. Who is to bear this expense?” (“On the Districts in Which Fever at Present Prevails,” *Poor Law Commission [PLC]-Bethnal Green Correspondence*, June 1838. Public Record Office [PRO] MH 12/684).

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seph Pritchard of the Wigan Working Classes Public Health Association (founded May 1848), who classified “certain districts . . . according to the degree of privy accommodation afforded. . . . Out of a large number of privies observed there were

Rather filthy 2  
 Filthy 10  
 Very filthy 45  
 Exceedingly filthy 7  
 Disgustingly filthy 26<sup>16</sup>

What can be the need for so careful a discrimination; how, we wonder, does he decide? Far from being indecent, dung and dirt were polite conversation – not so food and wages, as we shall see.

## III

How we are to explain these anomalies? The dominant paradigm of British public health history appeals to the logic of rational state growth. It took shape in the 1950s. The welfare state had triumphed. The new National Health, no less than the Allied victory, seemed both the climax of a great struggle and the proof of progress. Chadwick is properly central in it: In 1952 appeared the two great biographies of him – Samuel Finer’s *Life* and R. A. Lewis’s treatment of his years in public health. These were followed by Royston Lambert’s study of Chadwick’s successor John Simon and by many detailed studies of state growth. As usually told, this story is one of the triumph of empirical science, accountable government, and even compassion over ignorance, apathy, and corruption. The perspective is plain in David Roberts’s title, *Victorian Origins of the Welfare State*, or Ruth Hodgkinson’s *The Origins of the National Health Service*, whose true subject is its subtitle: *The Medical Services of the New Poor Law*. Such titles were not publishers’ anachronisms; they reflected the larger story of which public health was a part.<sup>17</sup>

16 Quoted in G. T. Clark, *Preliminary Inquiry into the Sewerage, Drainage, and Supply of Water, and Sanitary Condition of the Inhabitants of the Town of Wigan*, 1849, 3, 8–9.

17 S. E. Finer, *The Life and Times of Sir Edwin Chadwick* (London: Methuen, 1952); Lewis, *Chadwick*; Royston Lambert, *Sir John Simon and English Social Administration* (London: McGibbon and Kee, 1965); Ruth G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834–1871* (London: Wellcome Historical Medical Library, 1967); Roberts, *Victorian Origins*; Oliver MacDonagh, *Early Victorian Government, 1830–1870* (London: Weidenfeld and Nicolson, 1977), 130–152. For the persistence of this tradition see Anthony S. Wohl, *Endangered Lives: Public Health in Victorian Britain* (Cambridge, Mass.: Harvard University Press, 1983); Virginia Berridge, “Health and Medicine,” *The Cambridge Social History of Britain, 1750–1950*, Vol. 3, *Social Agencies and Institutions*, ed. F. M. L. Thompson (Cambridge: Cambridge University Press, 1990), 171–242. This perspective similarly characterizes much American writing on the history of public health (e.g., John Duffy, *The Sanitarians: A History of American Public Health* [Urbana: University of Illinois Press, 1990]). George Rosen, crusading for the new social medicine, identified a larger



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At the risk of sacrilege let me caricature that paradigm with a tale I will title "The Sanitarian's Progress." First was St. Jeremy the Bentham, who told of the government that must come. After Jeremy had prophesied he gained as a disciple the young lawyer Edwin, a journalist's son, from Rochdale, in Lancashire. After saintly Jeremy's death, Edwin roamed far to expose the evils of the land, to heal them with the balm of right bureaucracy, and to speak of the sanitary kingdom to come. But though he brought good to the people, he was hated by the rich.<sup>18</sup> When he entered the capital he was set upon by the water seller, Mr. "Filthy-Stein" (for thus he drank his beer), Mr. "Fair-a-See" (who saw no filth; all was fair), and all the lawyers of the (Inner) Temple, who scattered confusion across the land and then preyed upon the confused. And when he went to baptize the poor with pure soft water, to flush their sins away through pipe sewers, and to fertilize the new garden with sewer manure, they turned on him. In 1854 he was betrayed by the politicians and left office forever. Yet his followers, especially Simon, who was his Paul, spread the word of Edwin about the health that could be, and the sewers and waterworks were built, and disease and squalor were banished from the land.

If public health is understood in this way, its history is pretty well done. Here Chadwick the discoverer is but the vehicle of truth. Carried on the current of empirical social science, he can do no other in leading the way to sanitary salvation. Our only job will be to chart that salvation in town after town. Everywhere the plot will be similar, with the same "parish pump" irrelevance, a contest between right-wrong, good-bad, clean-dirty, honest-corrupt, moral-immoral, progressive-reactionary, harmony-discord, change-stagnation.

But what we need from history has changed. Given the fragility of contemporary civil and urban life, we are in no position to celebrate an achievement; our problem is to solve the puzzle of how to live together in healthy, diverse communities. The old paradigm admits no real puzzles or possibilities. It is a winner's story; the very success of the winner's choices makes them unproblematic. Health did improve during that great age of public health. Yet to make that progress its own explanation, to say that the public health reformers did what they did because it was "progressive" to do so, is at best perilously close to making an event the cause of its own happening. That paradigm also omits real alternatives. The Chadwick biographers, like the

domain for public health than did most of the writers on Britain but was no more willing to see that scope as contingent and negotiated (Rosen, "What Is Social Medicine? A Genetic Analysis of the Concept," *Bulletin of the History of Medicine* 21 [1947]: 674-733). For a critique of this perspective see Paul Richards, "State Formation and Class Struggle," *Capitalism, State Formation, and Marxist Theory*, ed. Philip Corrigan (London: Quartet, 1980), 49-78; Adrian Wilson, "The Politics of Medical Improvement in Early Hanoverian London," *The Medical Enlightenment of the Eighteenth Century*, eds. Andrew Cunningham and Roger French, 4-39 (Cambridge: Cambridge University Press, 1990).

<sup>18</sup> Hammond and Hammond, *Lord Shaftesbury*, 155.

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gospel writers, speak only for the protagonist. Few others receive even the gift of voice, much less an opportunity to defend or explain themselves. We don't even learn much about the protagonist, for ultimately such accounts offer no explanation beyond invocations of grace (true observation) and destiny (necessary solutions). Politics and power appear as obstacles to truth, rather than as forums for reconciling differences or expressing public will. This leaves us without a clue as to *how* the winners finally won (for the game is clearly political), yet ironically it strengthens the simple appeal to truth, which remains as the only possible explanation.

The vision of the inexorable progress of science and health is usually founded in an appeal to "conditions," the idea that public health activity is driven by public health need. Filling our narratives are overflowing privies and windowless cellars, descriptions drawn from any of the many social investigations of the period. Accompanying them are death tolls of epidemic diseases ascribed to these conditions. Often historians move from descriptions of such conditions to the conclusion that those conditions demanded remedies and that they were therefore provided, more or less expeditiously. Given enough disease, as with cholera in 1832, the responsible authorities will correlate it with various factors, say urban squalor. Through trial and error, they home in on its true causes and take ever more effective action. Thus one historian writes that "drainage and water were needed by everybody (why not food and work, one might ask), and their regulation if not their provision entailed local responsibility for public services." Another writes: "The growth of an industrial and urban society brought serious social abuses which . . . forced the English to establish effective central departments. Child labor and unhealthy slums, in conjunction with negligent JP's and town councils, led inevitably to factory inspectors and a central Board of Health."<sup>19</sup>

Yet the historian's imperative has no teeth. Of course conditions were deplorable, but their deplorability tells us nothing about who responded to them and how. The need was not always met; the responsibility had to be recognized to be acted upon. Not everybody, not in Britain, not in Europe, not in the rest of the world, not then, not now, had or has drains and water, whether one calls these luxuries or necessities. Communities and states tolerate different degrees of environmental unpleasantness, different levels of preventable mortality.

The recognition that conditions do not determine responses is necessary if we are to avoid falling under the rhetorical spell cast by sanitarians a century and a half ago.<sup>20</sup> When we write that water or drains were "needed" or

19 Ursula R. Q. Henriques, *Before the Welfare State: Social Administration in Early Industrial Britain* (London: Longman, 1979), 117; Roberts, *Victorian Origins*, 316–17; cf. *ibid.*, 215; MacDonagh, *Early Victorian Government*, 133–34.

20 As I write this a storm has just swept down leaves and branches to clog the drains, leaving a great pool of stagnant water that the surveyors of highways (or the modern equivalent) will not soon