Successful Societies

How Institutions and Culture Affect Health

Edited by

PETER A. HALL
Harvard University

MICHÈLE LAMONT
Harvard University

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Contributors

Gérard Bouchard, member of the Royal Society of Canada and the Académie des lettres du Québec, is professor at the Université du Québec à Chicoutimi. Trained in sociology and history, he has spent more than twenty-five years conducting multidisciplinary research in various fields of population and social history. In 2007–8, he co-chaired with Charles Taylor a public consultation commission on inter-ethnic tensions in Québec.

Peter Evans is Professor of Sociology and Marjorie Meyer Eliaser Professor of International Studies at the University of California, Berkeley. His work on the comparative political economy of national development is exemplified by his 1995 book *Embedded Autonomy: States and Industrial Transformation.* He is now working on "counter-hegemonic globalization."

Peter A. Hall is Krupp Foundation Professor of European Studies at Harvard University and Co-Director of the Successful Societies Program for the Canadian Institute for Advanced Research. His books include *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage* (2001).

Clyde Hertzman is a physician-epidemiologist, Director of the Human Early Learning Partnership (HELP), and Professor in the School of Population and Public Health at the University of British Columbia. He is a Fellow of the Canadian Institute for Advanced Research (CIFAR), a Canada Research Chair in Population Health and Human Development, and a Fellow of the Royal Society of Canada.

Jane Jenson holds the Canada Research Chair in Citizenship and Governance at the Université de Montréal, where she is professor of Political Science. Her research focuses on comparative social policy.

Daniel P. Keating is a developmental scientist working at the University of Michigan, as Professor of Psychology, Psychiatry, and Pediatrics; Research Professor at the Center for Human Growth and Development; and Faculty

Associate, Survey Research Center, Institute for Social Research. Most recently his work has focused on understanding the developmental mechanisms that are the causal underpinnings of social disparities in child health and development, including current planning and implementation of the U.S. National Children's Study.

Will Kymlicka is the Canada Research Chair in Political Philosophy at Queen's University and a visiting professor in the Nationalism Studies program at the Central European University in Budapest. His most recent book is *Multicultural Odysseys* (2008).

Michèle Lamont is Robert I. Goldman Professor of European Studies and Professor of Sociology and African and African American Studies at Harvard University and Co-Director of the Successful Societies Program. Her most recent book is *How Professors Think: Inside the Curious World of Academic Judgement* (2009).

William H. Sewell, Jr., is the Frank P. Hixon Distinguished Service Professor Emeritus of Political Science and History at the University of Chicago. His most recent book is *Logics of History: Social Theory and Social Transformation* (2005). He is currently working on the cultural consequences of early capitalist development in eighteenth-century France.

Arjumand Siddiqi is a social epidemiologist. She is Assistant Professor in the Gillings School of Global Public Health at the University of North Carolina, Chapel Hill; a Faculty Fellow at the Carolina Population Center; and a Junior Fellow of the Canadian Institute for Advanced Research. She is interested in societal determinants of inequities in health and human development.

Ann Swidler is Professor of Sociology at the University of California, Berkeley. Her most recent book is *Talk of Love: How Culture Matters* (2001). She is currently studying cultural and institutional responses to the AIDS epidemic in sub-Saharan Africa.

Rosemary CR Taylor is Associate Professor of Sociology and Community Health at Tufts University. Her current research explores the response of societies and their governments to health threats perceived to accompany people and products across increasingly open national borders.

Preface

This book is the result of an encounter between a heterogeneous group of social scientists and the Canadian Institute for Advanced Research (CIFAR). This innovative research organization has a well-established practice of supporting the work of researchers over several years so that they can engage in interdisciplinary exploration of new and important topics. Unlike other funding organizations, CIFAR gives its researchers carte blanche. It does not require a predefined plan with clear deliverables. It recognizes the open-ended nature of the research process and aims to facilitate and empower it. This highly original approach often leads to unexpected results.

In 2002, some of us were contacted by CIFAR and asked to come together to think about what defines successful societies and the social conditions that sustain them. After supporting research teams in the fields of population health and human development for a decade, CIFAR was turning its efforts in a new direction to consider a wider range of social factors affecting population health. It called upon us to bring to the table the analytical tools we had deployed in our respective research on a range of topics, including the impact of institutions and cultural frameworks on social relations. Thus an interdisciplinary team that included sociologists, political scientists, a historian, an epidemiologist, and a psychologist came together. We met several times a year in various locations to exchange papers, to learn from each others' work, and to interact with other scholars. From this experience emerged a common definition of the problems we wished to consider together.

Our joint effort began in January 2003 with a first meeting at the Center for Advanced Studies in the Behavioral Sciences in Palo Alto, California. We debated at length the meaning of "successful societies" and whether one could use the term while avoiding ethnocentrism. We agreed that health outcomes (low infant mortality, high life expectancy) are useful universal indicators of successful societies. We also agreed that our efforts should be concerned with "health plus," that is, with the wider correlates of positive health outcomes, such as greater equality, social inclusion, and democratic participation. We

spent the following years analyzing how various aspects of social life might contribute to such outcomes. We developed empirical projects that build directly on a joint cognitive platform. This book is the product of the first four years of our collaboration, which is still ongoing.

At the outset, none of us claimed ownership of the term "successful societies." Yet, slowly, we made it ours and attached to it the questions that became our common agenda. Exchange was possible because we interacted pragmatically around the concept of a successful society, while maintaining purposefully a certain ambiguity about the terms of the collaboration, including the full meaning of "successful societies." We developed a complementary understanding of the contexts that sustain such societies. A complex picture emerges when the topics we study are considered in juxtaposition to one another.

Now the time has come to offer the product of our joint endeavors to the informed public and the critical eyes of our colleagues. We hope that the book will be read by a wide range of readers. Our goal is to generate new dialogues and to create new bridges between fields. *Alea jacta est* ...

We are most grateful to the Canadian Institute for Advanced Research for the generous support that made our collaboration possible. We express our great appreciation to Chaviva Hosek, president of CIFAR, for her intellectual vision and her continuing engagement with our work. We also thank Penny Codding for her wise guidance, Sue Schenk for her constant help as the project developed, and Susan Leclaire for the many ways in which she facilitated our work. The production of the book would not have been possible without the technical assistance of Heather Latham and Joe Cook, whom we gratefully acknowledge.

Within the Successful Societies Program, we have benefited enormously from continuous input from the members of our advisory committee, many of whom faithfully attended most of our meetings: Suzanne Berger, Natalie Zemon Davis, Danielle Juteau, Richard Simeon, and Wolfgang Streek, and in particular, Jonathan Arac, the chair of this committee. Our final formulations were improved by the comments of several new members joining the program: James Dunn, Ron Levi, and Leanne Son-Hing.

Finally, we thank the colleagues who took time to offer insightful comments on the book manuscript: Blair Wheaton, John Hagan, and the dedicated members of the program's review committee, Marcel Fournier, Peter Gourevitch, Kathy Newman, Claus Offe, Stephen Toope, and Leonard Syme, its chair. During the years when we were working with these ideas, dozens of scholars took the time and trouble to present their work at meetings of this program. Our conversations with them were deeply stimulating and are reflected in many ways in the pages of this book. We dedicate the book to these scholars and to the power of intensive interdisciplinary exchange.

Making Sense of Contagion

Citizenship Regimes and Public Health in Victorian England

Jane Jenson

Successful societies protect and foster the health of their populations. This volume is premised, moreover, on the knowledge that health status depends on much more than the availability of health care for the treatment of individuals. Instead, much of health depends upon avoiding the dangers of social interaction, whether these take the form of contagion, environmental pollution, or unequal social status. International panics in recent years about that the next flu pandemic is only the latest in a long line of efforts to anticipate and prevent the spread of infection. The "epidemic of obesity" among children as well as adults is only one example of attention to social as well as physical conditions that lower the chances of individual good health and therefore societal success. The Public Health Agency of Canada, created in response to the 2003 scare about Severe Acute Respiratory Syndrome (SARS), is only one example of an institutional and structural reform based on the recognition that personal strategies for health cannot address threats affecting entire groups and populations.

Such long-standing concerns about intersections between individual and societal well-being is the domain of public health. International organizations seek to promote it, national governments institutionalize it, medical science debates it, and social science as well as epidemiology tracks its variable patterns over time and space.[1] Studies of public health practices reveal them to be widely diverse. There have consistently been major variations among societies in the diagnosis experts draw from aetiological knowledge as well as the prophylactic strategies they adopt.

How might we understand such variation in interpretations and practice? One account might be framed in terms of knowledge, and what is available

[1] In Chapter 1 in this volume, Hertzman and Siddiqi provide several examples of the epidemiological variations in patterns of public health across countries and across socioeconomic status (SES) groups as well as their correlation with politically generated efforts to alter the distributional gradient of well-being.

in medical science for fostering health and well-being. The availability of vaccines against a wide variety of childhood and other diseases has clearly had effects on not only child mortality but also life expectancy rates. Another might focus on individual-level social relations and their cultural content, via which greater value is ascribed to some persons and ways of being than to others, thereby generating the wear and tear of everyday life for those ranked as less worthy. Useful as both these accounts are, it is necessary to supplement them. The claim of this chapter is that politics matters for explaining cross-time and cross-space variation in public health practice. In particular, the chapter argues that shared political narratives about collective solidarity, belonging and merit – expressed among other places in ideas about citizenship – have consequences for governments' actions and policies, including for the ways that they understand threats to public health, sources of disease and protective mechanisms deployed to limit ill-health.

The goal of this chapter is to contribute to understanding why "we don't act on what we know." In other words, the question is: why is social knowledge, about which there is little scientific debate, not quickly translated into effective public policy? The chapter argues that specific public health choices follow from the particular narratives and practices of citizenship deployed in modern states. For one historical case, that of nineteenth-century England, it tracks the partial implementation of public health measures despite near consensus about what interventions were needed and demonstrates that such processes are profoundly shaped by broader societal debates about the role of the state and its responsibilities vis à vis citizens. The options considered to be available and the choices made are constrained by the political discourse as well as institutions and interests of the time.[2]

ANALYTIC TOOLS FOR THINKING ABOUT POLICY VARIATION

Better medical science has generated greater capacity to explain disease and propose helpful strategies for improving public health. Vaccinations against most common diseases were invented by the early decades of the twentieth century, and public health efforts have been organized around mass campaigns at both the national and international level since then. Nonetheless, references to the science alone cannot provide full accounts of public health initiatives. For example, in the early nineteenth century epidemiologists such as Louis René Villermé had statistically documented the relationship between income inequality and health outcomes, but these studies did not much influence policy in nineteenth-century France or Britain, where environmental causes (such as miasma) were preferred over explanations derived from the social determinants of disease and in particular poverty.[3]

[2] Jenson (1986; 1989); Hall (1989: 383–6).

[3] Villermé's analyses provided classic epidemiological findings about health gradients: "In 1826, he demonstrated across Parisian districts a gradient in mortality in close accord with the percentage of rents too low to tax; in 1840, in a six-year study of the textile town of Mulhouse, he found striking gradients by occupation" (Susser 2000: 882). As the chapters by Keating (Chapter 2) as well as Hertzman and Siddiqi (Chapter 1) in this volume indicate, the interpretation of gradients still provokes scientific controversy.

Nor do all examples of stubborn inattention to scientific findings come from the days when modern medical science was in its infancy. Contemporary epidemiologists and the population health perspective have documented the stubborn persistence of income and class gradients in health outcomes, which they term "modernity's paradox."[4] Such findings provide "strong arguments for a focus on social and economic determinants and for investments in the sectors that 'produce health' such as education, income, and housing."[5] In other words, this science leads to proposals to intervene to change the unequal *distribution* of access to a range of goods and services. Much public health policy remains focused, however, on what produces ill-health.

This chapter examines a historical moment when social knowledge exhibited a relative consensus about actions needed to promote health, but that knowledge was not translated into effective public policy for many years. Examination of this example, now well behind us in time, reveals the extent to which seemingly simple interventions to promote health by ensuring access to clean water and sanitation can be chronically limited by ideas about the responsibility of states and markets, about rights, about governance and about solidarity across social classes. It teaches a lesson for understanding societal success. Just as health care is inadequate to produce health, knowledge about health is insufficient to prompt appropriate action by political authorities. In the intellectual battles over the meanings of epidemiological results and about the long-term consequences of social marginality, in which we are now engaged, it is helpful to remember this example. It is one, and hardly an exceptional one, in which the norms of citizenship carried as much if not more weight in the structuring of public policy than did either medical or social scientific knowledge.

IN PUBLIC HEALTH, "POLITICS MATTERS"

Historians of science and of society have pointed out that politics matter in the history of public health.[6] As Peter Baldwin recounts in detail, at least since the 1940s and the work of historians following Erwin Ackernecht, a popular contention has been that authoritarian and liberal states favored different aetiology and prophylaxis for the spread of disease and its prevention.[7] Because

[4] Keating and Hertzman (1999).

[5] Kickbusch (2003: 385). See also Evans (Chapter 4, this volume) who argues too that much more than health policy has long-term effects on population health.

[6] Dorothy Porter (1999: 1–2) describes the classic public health literature as one that deploys a narrative of linear progress. Her book disputes this position by adopting a more sociological account, anchored in historical thinking about state formation. See also Peter Baldwin's (1999) massive history of varying strategies to fight epidemics.

[7] Baldwin (1999: 12ff. and passim).

public health interventions involve a tension between individual liberty and the collective good, nineteenth-century liberals supposedly tended toward sanitarian interventions that interfered least with individual behavior (such as building sewers and providing clean water) and, therefore, also tended to explain that disease resulted from lack of public hygiene. In authoritarian states, there was less concern for interference in the lives of individuals. Therefore quarantines were supposedly more acceptable and theories of interpersonal contagion most popular. Summarizing the Ackernechtian explanation, Baldwin writes: "it was not the nature of the disease which specified how it would be prevented and limited, but the kind of political regime under epidemic attack."[8]

In his cross-national comparison of public health policies in France, Britain, Germany, and Sweden from 1830 to 1930, Baldwin rejects the Ackernechtian stance as too simplistic. His account of the three major public health threats in nineteenth-century Western Europe – cholera, smallpox, and syphilis – led him to propose a set of three general factors that combined in variable ways in each society to generate public health strategies:

> Though politics was certainly part of the story, a simple Ackernechtian reading of prophylactic strategies cannot explain the polymorphous divergence of the precautions imposed across nations. As supplement and replacement, other factors have been adduced here: geoepidemiological location, both in terms of positioning vis-à-vis the epidemic currents of contagious disease and in those of the topography required to make certain preventive strategies work; and commercial interest and administrative capacity, both of which had implications for various tactics.... Such factors were the general conditions within whose ambit prophylactic decisions were taken, but only a historical accounting of the precise steps behind every such choice can explain any specific outcome.[9]

In other words, after identifying a number of large structural and institutional conditions, Baldwin sends us back to a classic method of detailed historical recounting.

While not disputing the validity of his method or his detailed analysis, and indeed engaging with his challenge to "amend or supplement a political interpretation of ... public health and statutory intervention,"[10] I argue here that attention to the regime level of analysis – rather than the distinction between authoritarian and liberal political systems that preoccupied the Ackernechtians – helps to put some general order into the variable and even contradictory practices Baldwin found. In particular, by focusing on the "citizenship regime" it provides an account of the difficulties English sanitarians faced in advancing toward full implementation of their position through the mid-Victorian years as well as some of the opposition it provoked. Norms

[8] Baldwin (1999): 13).
[9] Baldwin (1999: 550).
[10] Baldwin (1999: 35).

about citizenship rather than topography, state capacity or commercial interests are proposed as explanatory factors for both the process of implementation of the sanitary idea and the mobilization in opposition to some forms of compulsory behavior imposed by sanitarians on noncitizens.

POLITICS AND CITIZENSHIP REGIMES

Public health interventions involve fundamental matters touching on individual rights, the role of the state, and its respect for the liberty of individuals while ensuring the foundations of social solidarity – what the French revolutionaries termed *fraternité*. Public health policy is, in other words, a matter of citizenship.

This chapter uses an historical-institutionalist approach to substantiate its claim that the particular content of the citizenship regime at any point in time operates as a set of institutionalised ideas working "to constrain the normative range of legitimate solutions available to policy makers."[11] This claim follows from a standard premise of that approach: in order for policies to be adopted, "they must fit with the underlying norms and values of the society."[12] More specifically, the chapter describes the ways in which ideas and practices of the citizenship regime constrained the translation of medical knowledge into policy action, despite the existence of a broad-based consensus on what should be done.

The discourse of citizenship provides a narrative about inclusion and exclusion and the practices that stem from it.[13] These have varied widely over both the long term – when, for example, only men who could take up arms for the nation could be citizens and women were thereby excluded – and the short term, in which, for example, ideas about the rights and duties of citizenship altered significantly with the widespread ideological shift toward neoliberalism in the 1980s and 1990s.[14] The notion of citizenship regime is helpful for tracking

[11] Campbell (1998): 385); Hall (1993); Thelen and Steimo (1992).
[12] Campbell (1998: 380), describing Peter A. Hall's position.
[13] This analysis can be seen as a specific case in which practice is shaped by collective imaginaries and vice versa. An historical-institutionalist approach requires linking discourse to institutions as well as to interests. But even more philosophical approaches argue that ideas – or imaginaries – are anchored in practice. As Charles Taylor (2002: 107) says of social imaginaries, "the relation between practices and the background understanding behind them is therefore not one-sided. If the understanding makes the practice possible, it is also true that the practice largely carries the understanding. At any given time, we can speak of the 'repertory' of collective actions at the disposal of a given sector of society." Bouchard (Chapter 7, in this volume) also raises questions about the effects of institutions on collective imaginaries and cultural repertoires.
[14] Sewell (Chapter 10, in this volume) provides a consideration of neoliberalism. On the consequences of neoliberalism for citizenship regimes, see for example, Jenson and Saint-Martin (2006).

changes in understandings of citizenship across time.[15] It focuses attention on the institutional arrangements, rules and understandings that guide and shape concurrent policy decisions and expenditures of states, problem definitions by states and citizens, and claims making by citizens.[16]

To map both the institutional arrangements and ideas it is helpful to see a citizenship regime as composed of four elements:

- *A responsibility mix:* Citizenship involves the expression of basic values about the responsibility mix, defining the boundaries of state responsibilities and differentiating them from those of markets, of families and of communities. The result is definition of "how we wish to produce well-being," whether via purchased welfare, the reciprocity of kin, collective support in communities (both virtual and spatial), or collective and public solidarity, that is state provision. The state's portion is the citizenship portion, and its size can vary significantly across time and in different places.
- *A definition of rights and duties:* Through formal recognition by the state of particular rights and duties (civic, political, social, and cultural; individual and collective), a citizenship regime establishes the borders and boundaries of inclusion and exclusion of a polity. When certain needs are met via an extension of rights, the role of the market as well as family and community sectors have less responsibility for them. If, however, the state refuses any responsibility, then the other sectors will be pressed to fill the gap and take up their duties.
- *A prescription of governance practices:* Among these are democratic rules, including the institutional mechanisms giving access to the state, the modes of participation in civic life and public debates and the legitimacy of specific types of claims making. It sketches routes to representation, the ways in which legitimate voices are recognized and actors provided entry into the policy process.
- *A definition of who belongs:* This involves identity and membership, in both the narrow passport-holding sense of nationality and the more complicated notions of multiple feelings of belonging to several public communities. These feelings of belonging will set the boundaries of inclusion and exclusion into full citizenship.

The specific content of each dimension of any citizenship regime is established through political action, which arises from competing ideas as well as the interests of actors and institutions within which they act.[17] Therefore, even

[15] For the concept of citizenship regime and its application see, inter alia, Jenson and Phillips (1996; 2002); Yashar (1999); Papillon and Turgeon (2003).

[16] While this definition is directly adapted from Esping-Andersen's (1990) depiction of a welfare regime, it is hardly different from some definitions of culture deployed in organizational institutionalism. For example, "by 'culture' [Frank] Dobbin meant the shared conceptions of reality, institutionalized meaning systems, and collective understandings that guide policy" (Campbell 1998: 381).

[17] The notion of ideas and norms about citizenship used here is different from, although by no means contrary to, what Bouchard (Chapter 7, in this volume) calls the collective imaginary ("representations through which a society provides its members with a definition of selfhood and otherness, a vision of their past and their futures, as well as territorial appropriation"). Indeed, the dimension of "belonging" in the citizenship regime covers similar ground.

though a regime is a temporarily stabilized set of discourses and practices that represent the contemporary play of power relations, there is almost always competition from other actors seeking inclusion, recognition, and opportunities to realise their own aspirations. Dissonance is to be expected. Ideas about science as well as social justice will clash as scientists and other experts and as social movements and political formations press the state to adopt one kind of social knowledge rather than another. State institutions themselves are likely to be traversed by conflict even as they move to recognize and act on some ideas and actors, consigning others to the margins of influence.

This chapter demonstrates that public health interventions were constrained by ideas about citizenship (who is responsible for what, what rights, who has access, who belongs), such that the consensus around the "sanitary idea" was not fully implemented for more than four decades. This is, then, an analysis that agrees that politics matter in order to understand public health practices. It illustrates these patterns of constraints by tracking the history of public health with respect to contagion in England in the nineteenth century.[18] It will document that a sanitarian approach to public health had garnered wide support in England by the third decade of the nineteenth century, and that it certainly fit the *reformed* citizenship regime better than the alternative, which was based on limiting contagion by quarantine. Nonetheless, it was only partially, and according to its promoters, inadequately implemented in the various pieces of legislation dealing with public health of the mid-Victorian period. Full implementation of the sanitary idea only could occur when the predominantly liberal citizenship regime, and particularly the institutions of governance and ideas about the responsibility mix, had undergone significant adjustment. This did not happen until after 1870. In that same decade as well, social mobilization arose against the most illiberal elements of the sanitary idea. As citizenship became more inclusive in the last three decades of the century, it became more difficult to treat noncitizens, particularly women and the working class, in the draconian ways that sanitarians had themselves promoted when citizenship was a status reserved for middle-class property owners by the Great Reform of the first decades of the nineteenth century.

MID-NINETEENTH-CENTURY ENGLAND: ONLY PARTIAL IMPLEMENTATION OF THE SANITARY IDEA

In Britain, life expectancy had increased significantly in the eighteenth century, but in the second and third decades of the nineteenth-century urban life brought ill health and early death. Longevity continued to increase in the

[18] Scotland and Ireland followed different public health policies at this time (Hamlin and Sheard 1998).

countryside, while life expectancy "in such cities as Manchester, Glasgow, and Liverpool [was] falling to levels not seen since the mediaeval Black Death."[19] Moreover, the rates stuck at those low levels until the 1870s. In 1871 average life expectancy was still hovering at 41 years, the level it had achieved in 1821. In the largest cities (over 100,000), the rate had not recovered from its plummet between 1821 and 1851, and had stabilized at a rate lower than where it was in 1821. It was only after 1870 that substantial new gains were made.

Smallpox was still a scourge, despite Edward Jenner's discovery of how to vaccinate against it in the previous century. Venereal diseases threatened reproductive health as well as longevity in general. But cholera was "the classic epidemic disease of the nineteenth century." Four pandemics swept out from Asia to Europe during the nineteenth century.[20] The disease was carried from British India to Britain itself on water and rail. Landing in the "mushrooming towns and cities of a society in the throes of rapid urbanization, it took advantage of overcrowded housing conditions, poor hygiene and insanitary water supplies."[21] In the first pandemic of the early 1830s, most European governments acted in the same way, using traditional policing methods to enforce *cordons sanitaires* that had served to combat earlier plagues.[22] Ships were quarantined, ports shut down, and travel restricted. In the next pandemics, however, English practices would diverge from those of the rest of Europe.

SANITARIANS AND PUBLIC HEALTH

At the time experts in the international public health networks did not have a shared diagnosis of the mechanisms spreading cholera and other epidemics such as yellow fever.[23] There were three main aetiological positions. One described contagion by contact between infected individuals, and therefore the prophylactic strategies were quarantine or vaccination.[24] Another argued that bad air – in the form of miasma – arising from filth and rot was the mechanism of infection and prescribed vastly improved public sanitation infrastructure to eliminate the sources of disease. A third position with respect to cholera was that transmission occurred by contaminated water, and therefore providing

[19] Szreter (1999: 147).
[20] Evans (1988: 124–5).
[21] Evans (1988: 124).
[22] Ibid.: 139.
[23] Porter (1999: 81–2); Eyler (2001). The cholera bacillus was identified only in the 1880s by Robert Koch (Baldwin 1999: 139). The bacillus thrives in warm water and is passed on the excreta of the sick and other carriers, entering the body through the mouth (Evans 1988: 127). Until the 1880s (and even after) the precise role of water in transmitting the disease was hotly debated (Eyler 2001).
[24] Edward Jenner's vaccine against smallpox had been available since 1798. Quarantine had been standard practice for centuries.

sanitary water supplies and waste disposal was the way to limit the spread.[25] Even though the second and third aetiology of contagion were quite different, one pointing to air and the other to water as the carrier of infection, they both agreed on what to do. This convergence meant that by the middle of the nineteenth century English policy makers had moved clearly away from any general reliance on quarantine and were firmly on the side of the sanitarian paradigm.[26] Many historians term this position the "sanitary idea."

The 1848 Public Health Act was a landmark piece of legislation. It followed more than a decade of public inquiry, expert reports, and public discussion about what to do about public health. It was promoted by Edwin Chadwick, at the time a high-level civil servant and who continued to be a well-known public intellectual through the whole of the middle of the century. But what Chadwick promoted was no more than the consensual position.[27] There was little dispute that cleanliness of water, streets, housing, and persons was important. Indeed, "it was a commonplace of educated opinion by the beginning of the 19th century."[28] The various inquiries, royal commissions, statistical reports, and scientific research piled up evidence confirming the strong correlation between lack of sanitation and disease. There was consensus about the need to build sewers and provide clean water; "public health was not a party matter, nor was the need for comprehensive sanitary legislation controversial."[29]

But there was no consensus about how to do it. Ideas about the proper arrangements of government and governance to ensure clean water and functioning sewers were controversial and partisan. At issue were fundamental questions about the citizenship regime's responsibility mix and governance: the role of public versus private provision and central versus local control. When the pioneering legislation actually passed in 1848, it was an adulterated version of the full sanitary idea.

The act constituted an effort to implement the sanitary idea in a citizenship regime dominated by liberal notions of the responsibility of states

[25] In 1854 Dr. John Snow famously removed the handle of the Broad Street pump, and infection rates declined (McLeod 2000).
[26] Scotland focused instead on the improvement of poor relief, and Ireland sought to coordinate and expand provision of infirmaries (Hamlin and Sheard 1998: 591).
[27] The 1848 Act was inspired by the miasmic approach of its main author, Edwin Chadwick, who had the support of recognized experts of the time. For example, William Farr, statistical superintendent of the General Registrar Office, in the 1840s and 1850s carefully mapped patterns of cholera and found that they varied by height of land. This finding allowed him to postulate that a specific, nonliving zymotic material caused each of the class of diseases that included cholera (he labeled the zymotic material cholerine). These epidemic, endemic, and contagious diseases were most prevalent in urban slums, prisons, and port towns because "in such places the air was ladened [sic] with organic matter from respiration, perspiration, decomposition and putrification." The concentration of miasmata – the airborne particles – would decrease as one climbed out of the river basin (quoted in Eyler 2001: 228).
[28] Szreter (1997: 705).
[29] Hamlin and Sheard (1998: 589).

and markets and the role of the central state. The 1848 Public Health Act contained numerous sanitary clauses about the cleansing of sewers, sanitation of houses, supervision of lodging houses and slaughterhouses, and maintenance of pavements. It created a new central department, the General Board of Health under a nominated president, and permitted the establishment of local boards of health. Each board of health was empowered to appoint a surveyor, an inspector of nuisances, a treasurer, a clerk and an "officer of health" who had to be a legally qualified medical practitioner. The General Board had no powers to enforce local action where the clauses of the act were not first adopted locally, however.[30]

Indeed, as enacted, the 1848 act provided mechanisms for governance that virtually ensured it would not achieve its intended effects. "Smoke prevention and insanitary burial grounds, both seen as important health problems, were jettisoned. Metropolitan London was left out ... Scotland and Ireland were left out ... To retain some independence from parliamentary interference, Morpeth[31] bargained away most of the provisions to guarantee health."[32] Such compromises were necessary because of party differences about good governance. "[T]he Tories saw the Home Office or some other cabinet office as planning the needed works and enforcing standards. Influenced by Chadwick, Morpeth and the Whigs were wary of too much parliamentary accountability in technical matters. As models they looked to the Privy Council ... or the Poor Law Commissions – administrations independent of parliamentary interference," and under local control.[33] The act therefore left to local rate payers the decision whether to establish a health board as well as the power to elect its members.[34] It also maintained the existing relationship between the public and private sectors. Responsibility for carrying out the improvements in the water supply – the key to success – remained in the hands of the private companies that already owned the rights to water distribution and sewage collection. As historian Dorothy Porter put it: "the creation of a public health system in Britain was founded upon a political economic philosophy which intended to use statutory regulation to enhance the free operation of market relations."[35] There were, unfortunately, few market incentives to provide clean water or sewers to the poor who did not have the wherewithal to pay for them.[36]

[30] Baldwin (1999: 138–9).
[31] Lord Morpeth who carried out the political negotiations around the act, was in charge of the Office of Woods and Forests, where much urban refuse was dumped.
[32] Hamlin and Sheard (1998: 589–90).
[33] Hamlin and Sheard (1998: 589).
[34] The act did include an option for the central government to impose a board of health on a municipality where mortality exceeded 23/1,000 (Hamlin and Sheard 1998: 590). London was excluded from this law, in part because any objective reducing the rate to 23/1,000 seemed vastly too ambitious (Tanner 1999: 37–8).
[35] Porter (1999: 121). As a liberal influenced by the utilitarians, Chadwick supported leaving sanitation in private hands (Hamlin and Sheard 1998: 589).
[36] Szreter (1997: 707).

The result of such compromises was a very partial implementation of the sanitary idea with respect to access to clean water and sewers:

> Chadwick had envisaged every urban house connected to a clean water supply and to a water-borne mains sewerage system. ... Plenty of new mains water supply pipes were laid under dug-up streets from the 1840s onward, but the Royal Sanitary Commission found as late as 1871 that most provincial cities were only just then beginning to build the integrated sewerage system necessary to avoid contamination from wastes.... Furthermore, except where the wealthier residents paid for it in their suburban villas, little effort before the last quarter of the nineteenth century was devoted to connecting-up, en masse, individual homes to the enhanced water supplies.[37]

Public health interventions to prevent ill-health and the spread of disease involved more than these public health acts, of course. Two other areas of action are illustrative of the mid-nineteenth-century view of citizens, their rights and responsibilities, and of the ways in which the citizenship regime structured public health interventions in their lives. These are the treatment of international travellers, the vast majority of whom were of middle-class or even aristocratic background. The other was the treatment of noncitizens. The sanitary idea applied quite differently to the two groups.

International travel was booming in the nineteenth century, with movement back and forth between the colonies and around the world as international trade ballooned. An unintended but important consequence of heightened rates of population mobility was the geographic spread of disease. Cholera, for example, spread from Asia to Europe as waves of pandemics, approximately every five years from the 1820s until 1890s. Faced with this and other contagious diseases, governments had to decide how to respond, and particularly whether to impose quarantines on travelers from ports known to have cases of these deadly contagious diseases. If the British government concurred with the choice of most of the other European countries in the cholera pandemic of 1826–37, in later ones it diverged sharply.

Throughout the rest of the nineteenth century, the British steadfastly refused to align with strict quarantine practices favored by Continental governments, making instead the same commitment to liberal sanitarian practices that had underpinned the Public Health Act. "Throughout the 1880s and nineties, during the interminable disputes that pitted the British against most other nations over precautions to be imposed in the Middle East, the contrast was between the fundamentally sanitationist approach taken by the British and their Indian allies and the quarantinism of the major continental powers."[38]

They invented what Peter Baldwin terms the English system of neoquarantinism, passengers arriving at a port of entry who exhibited signs of disease could be detained (quarantined), but passengers appearing healthy were free to continue their travel, as long as they provided details of their destination

[37] Szreter (1997: 708–9).
[38] Baldwin (1999: 194).

and notified authorities of any subsequent illness.[39] This preference for medical surveillance and notification contrasted with the observation quarantines advocated by many other European governments. These latter involved detaining for a fixed period of time all passengers arriving from infected ports, whether they exhibited signs of illness or not.[40] Travelers to England, many of whom would be British citizens, were assumed to be sufficiently responsible that they could be relied upon to notify authorities. The same practices applied within the country; the English system in general relied on citizens reporting illness to authorities, disinfecting their homes and linens, refraining from taking public transportation, and so on. Public authorities intervened only when they judged individuals did not, or would not, fulfill their duty to avoid affecting others. In many cases, the poor and working class were judged to lack this sense of duty.

The second example provides a sharp contrast, therefore. In these same years, individuals lacking full citizenship were treated as legitimate targets for state interference, and compulsion was the norm. Even in liberal Britain, noncitizens could be subject to the type of surveillance and compulsion as were subjects in authoritarian systems. One example that contradicts the expression an "Englishman's home is his castle," comes from the program of a pioneer public health professional. London's activist medical officer of health in the 1850s, John Simon, displayed no compunction about overseeing the lives of the poor: he had "inspectors examining hundreds of houses at regular intervals, thus transforming what had been envisaged as temporary visitations during epidemics into a system of permanent and periodic sanitary superintendence of the dwellings of the poor."[41]

Children, and particularly children of the poor, were also targets of state intervention. The 1853 Vaccination Act closely followed on the pioneering Public Health Act of 1848. The law required parents to have their children vaccinated against smallpox, and the children of the poor were particularly sorely treated.[42] That they were the main targets of enforced mass public vaccinations is evidenced by the fact that responsibility for overseeing the program was assigned to the local Poor Law guardians, tasked with ensuring

[39] Baldwin (1999: 152–3).

[40] Baldwin (1999: 196).

[41] Baldwin (1999: 240).

[42] "Vaccination was hardly a matter of 'clean needles': at that time it did not involve needles at all. Instead, the infant's skin was scored with a lancet in several places and viral material rubbed into the wound. Eight days later, the parent was required to bring the child back: those who had developed vesicles [blisters] had the lymph harvested for direct application to another child. This 'arm to arm' method was cheaper than vaccination with calf lymph but was, unsurprisingly, much resented by the poor, who could neither prevent their children from being used as a sort of petri dish for the cultivation of vaccine material nor choose the source of the material smeared into their own child's wounds. (The better-off had their children vaccinated privately, with calf lymph or lymph taken from a child whose pedigree they knew.)" (Pedersen, 2005: no page).

that all infants born within their district were vaccinated against smallpox. Vaccination provoked mobilization by working-class (and likely disenfranchised) parents as well as by middle-class liberals. They generated an antivaccination movement that railed against an authoritarian state:

> For compulsory vaccination hit the poor in particular: it was the poor who had to be vaccinated at the despised Poor Law hospitals, the poor whose children were smeared seriatim with lymph of unknown provenance, the poor who would find it hard to pay the fines levied on resisters, and the poor who went to prison if unable to find the cash. Small wonder, then, that working-class opponents saw the Acts as 'class legislation' – a form of tyranny suffered by respectable and vigilant parents for no better reason than that they were poor.[43]

Although raising standard Victorian tropes about bodily purity, this mobilization also opposed vaccination in the name of citizenship: "the rhetoric of political rights were [sic] employed by the anti-vaccinators, who raised questions about the rights of parents and of citizens and called attention to the 1853 Act's differential application to middle- and working-class children."[44]

FITTING THE "SANITARY IDEA" INTO THE AGE OF REFORM'S CITIZENSHIP REGIME

At each point of policy choice from the 1830s through the 1870s, public health policy makers selected the action that (1) involved the least challenge to a responsibility mix in which the private predominated over the public sector and the local over the center, (2) assigned responsibility to individuals as well as the state for maintaining public health, (3) focused draconian intervention and compulsion on those excluded from full citizenship. These choices meant that private interests installed water and sewers for those able to pay the price, that local ratepayers were able to choose low taxes over healthy environments, that individuals became monitors of their own health, unless they were not citizens, in which case their houses and their bodies were subject to the kind to intrusion commonplace in the authoritarian systems of Continental Europe.

These patterns were not chance events. They followed from the new narrative of citizenship, profoundly different from the eighteenth-century version, that was institutionalized in the 1830s and 1840s in a wave of legislation and other public actions covering much more than public health. The policy instruments for public health described in the previous section made good sense within the narrative of citizenship deployed in Britain after the 1830s, years sometimes termed the Age of Reform. Examining these norms of citizenship helps explain why the 1848 Act was only a pale imitation of the sanitary idea, why an English system of neoquarantinism was developed and why house inspections and compulsory vaccination overseen by the Poor Law

[43] Pedersen (2005).

[44] Robinson (2006: 471).

guardians were considered a modern and scientific public policy for dealing with the health of the poor.

By the end of the eighteenth century a collective narrative describing a nation of merchants and manufacturers developed in opposition to the "Old Corruption." This idiom was understood at the time both in its narrow sense of the widespread use of pensions, sinecures, and gratuitous emoluments deployed by the government for purposes of bribery and reward and in a wider sense by radicals to designate systematic reliance on sinecures, nepotism, and closed corporations, such as the East India Company and those handling municipal affairs. The old and reviled system depended on ties to the Crown, the aristocracy, and the Tory Party, encapsulating a profoundly premodern and non-Weberian view of the state.[45] Radicals opposed to the Old Corruption constructed

> different sets of values and frames of references. In this regard the radical, revolutionary nature of Victorian liberalism and reform becomes more apparent, as do the real bases of 'Victorianism': not sexual prudery or an apology for capitalist exploitation but the imposition of rationality and "modernity" upon the irrational and pre-modern – a gain for the ordinary man, not a loss – as well as individuality, the coincidence of merit and reward, and the extension of responsibility and privacy.[46]

The Age of Reform consecrated a new position for the middle class and its rights to representation.[47] Reform rested on recognition of the modern social structure of Britain, with its reliance on agricultural improvements, international trade, and industrial production, much of which occurred in rapidly expanding cities. The middle classes of small property owners, shopkeepers, and professionals gained political power.

Citizens' political rights changed profoundly. The design of the Reform of Act of 1832 reshaped the governance dimensions of the citizenship regime. The parliamentary franchise was enlarged by lowering property restrictions, thereby enfranchising the middle classes, and providing representation to large industrial cities, such as Birmingham and Manchester.[48] The parallel Municipal Corporations Act of 1835 laid the foundations for municipal government, inventing democratically based corporate bodies (rather than ad hoc private corporations) that could undertake local public projects financed by rate payers. A key idea of reform was to allow the middle-class English to escape from the burdens of the Old Corruption's expenditures and to keep taxes at a reasonable level. This was the patriotic position. A quantitative analysis of two centuries of the iconography of John Bull, the symbol of patriotic

[45] See Rubenstein (1983: 55; 57–8; 86). S. H. Beer classifies the defence of the Crown as an "Old Tory" position and of the unreformed House of Commons as "Old Whig." Both contrast with Liberal and Radical positions (1957: 614ff.).

[46] Rubenstein (1983: 86).

[47] Beer (1957: 630).

[48] Lizzeri and Persico (2004: 737).

Britishness, maps the changing representations in the popular press of the claims of ordinary citizens. From 1784 until 1832 by far the most important issues raised by John Bull were the tax burden and the civil list. The latter disappeared after 1832, but the tax burden remained the priority.[49]

Social rights were also fundamentally redesigned, via the debate about and then passage of the New Poor Law in 1834. Still excluded from political citizenship by reason of their lack of property, the poor who were not able to provide for themselves lost their previous rights to some measure of relief and were consigned to the "modern" workhouses, populated almost exclusively by the old, lone parents and their children, and the most feckless of men. The governance structure of the citizenship regime ensured that workhouse conditions would remain harsh; administration at the local level provided every inducement for the Boards of Guardians to act as guardians of the rates rather than the poor.[50] The new law, including the institutionalization of local management, "dramatically cut the nation's expenditure on welfare payments to the sick, old and poor from 2% of the national product ... to only 1%."[51]

Sanitarians saw their policy proposals as directly linked to social welfare and the citizenship rights of the "deserving poor." Indeed, "the maximum sanitationist program implied change on a revolutionary scale, granting to the poor living conditions largely achieved by the well-off."[52] Others reasoned in terms of the responsibility mix of citizenship. For example, Edwin Chadwick advocated his policies for improving health and preventing disease as the best way to halt the major cause of poverty, which he saw as being acute infectious diseases fatal to male breadwinners. Loss of a breadwinner could result in an increase in the population of the workhouses. The sanitarian position was one, then, that could offer to keep families intact and capable of maintaining themselves. Dorothy Porter summarizes the relationship between the citizenship regime's vision of family, market and public responsibilities this way:

> Reducing the cost of destitution and poverty by preventing the premature mortality of breadwinners was one feature of a new theory of government which asserted that efficiency and justice could only be obtained through the scientific and rational organization of the affairs of state. Policy-making should become a managerial practice. Edwin Chadwick was the central figure in bringing this approach to the management of public health with his "sanitary idea."[53]

[49] Taylor (1992: 96–9).

[50] The structure of interests was built into the franchise for welfare spending which was reformed in 1818–19 as well as 1834. Only property owners (including absentee ones) could vote on tax levels, whereas previously entire vestries (including, therefore, the potential receipts of poor relief) had sometimes voted on relief levels. As Lizzeri and Persico (2004: 739) put it: "by 1834 property owners had taken a dominant role in voting on issues related to poor-law spending."

[51] Szreter (1999: 147).

[52] See Baldwin (1999: 142). See also the quotes from parliamentary debates in Hamlin and Sheard (1998).

[53] Porter (1999: 121).

Such changes in citizenship norms and public actions that put an end to the Old Corruption were followed by significant changes in policy that reflected the interests of the newly enfranchised urban middle classes and the ideas upon which they relied. Total government spending as a percentage of GDP (after accounting for spending on war) remained stable from 1790 to 1890, while total taxation as a portion of GDP decreased after 1800 and did not rise again until after 1870. There was, however, a major shift in the composition of spending. Although poor relief fell, local spending as a proportion of government spending began to climb, albeit slowly.[54]

Such patterns track the shift in political power from the Crown and aristocracy to the urban middle classes. The latter had a clear interest in some public goods being provided. If the poorest of the poor (those excluded from citizenship rights) were sequestered in workhouses, vast numbers of the working poor shared urban space, water and air with the enfranchised middle classes.[55] In this situation, then, theories of miasmatic transfer of disease made sense of a situation in which property owners in industrial cities might succumb to contagious disease alongside the poor. As the 1844 report of the Parliamentary Committee of Inquiry into the State of Large Towns and Populous Districts put it, miasma did not stay put: "The presence of such emanations, whether they be derived from stagnant ditches, open cesspools, or from accumulation of decaying refuse, is a great cause of disease and death, not confined to the immediate district in which they occur, but extending their influence to neighbourhoods, and even to distant places."[56]

Nonetheless, as we have pointed out, the sanitary idea was not fully implemented. Nor were policy communities unaware that their hopes had been derailed. Indeed the 1857 foundation of the Social Science Association, in which Chadwick and many other liberal reformers were active, was explicitly framed as a response to the perception that the "stream of reform" had been "chilled if not frozen."[57] Rather than forward movement and progress in sanitation and public health, there was a "prolonged period of municipal inactivism from the 1830s until the 1870s."[58]

The limits on the sanitary idea's prescriptions for water, sewers, and urban cleanliness in general followed from two dimensions of the citizenship regime itself – those of governance and the role of the state. Building the full infrastructure would have required going against the mid-Victorian citizenship regime's norms for the responsibility mix, with its commitment to private

[54] Lizzeri and Persico (2004: 710–12).

[55] William Farr wrote in 1838, "the epidemics which arise in the east end of the town [London] do not stay there; they travel to the west and prove fatal" (quoted in Lizzeri and Persico 2004: 714). Moreover, while the wealthy could move to suburban villas, the newly enfranchised middle-income rate payers often still lived within the central city (Szreter 1997: 705).

[56] Quoted in Lizzeri and Persico (2004): 742.

[57] Goldman (1986: 116 and passim).

[58] Millward and Sheard (1995); Szreter (1997: 706).

over public action, and preference for local choice rather than central institutions of governance. "In the name of local self-government, a virtual rebellion among this class [the 'shopocracy'] of ratepayers took place against those clauses of the 1848 Public Health Act that threatened to force towns to spend on improving their water supply."[59] The result was that the clauses were rarely used and indeed were rescinded in 1858. This occurred despite the availability via the popular local press of statistical and other evidence of contagion patterns documented and reported in the General Registrar Office reports prepared under the supervision of William Farr.[60]

Despite having plentiful social knowledge, in the form of increasingly popular statistical analyses, resistance to full implementation of the sanitarian program for water and sewers predominated. It came from municipal voters who were caught between two sets of interests: for a healthy environment and for low taxes. The latter interest generally won out; opposition to implementing the sanitary idea came from market-favoring citizens and political forces and they managed to hold back the achievement of its goals for decades. The Municipal Reform Act of 1835 had given political power to a "diverse and growing amalgam of petty capitalist rate-payers, with their numerous doctrinal and congregational differences [who] could all agree on only one thing: not to spend each other's money if at all possible."[61] It was local elites and rate payers eligible to vote in local elections who revolted against the dictates of the "clean party."[62]

Moreover, improvements that were made often privileged commercial and industrial expansion over general public health. Water mains were installed, and the volume of constant-pressure water supply (necessary as an industrial raw material) vastly improved. But the sanitarians' key idea of connecting every dwelling to a supply of clean water and a sanitary sewer was not realized, and therefore the 1872 Public Health Act had still to promise to guarantee "the right of each Briton to pure air, water and soil."[63]

THE RECONFIGURED CITIZENSHIP REGIME AFTER 1870: PROGRESS FOR THE SANITARY IDEA; OPPOSITION TO SANITARIANS

By the time the 1875 Public Health Act was passed, the citizenship regime was already substantially changed. Although not as all-encompassing as the move from the Old Corruption to the Age of Reform, there were a number of significant internal adjustments to its liberalism that made it more inclusive and legitimated a more active state, albeit still a local one.

[59] Szreter (1997: 708).

[60] Szreter (1997: 705); Eyler (2001: 229–30).

[61] Szreter (1999: 148).

[62] Porter (1999: 120).

[63] Baldwin (1999: 149).

The Politics of Water and Sewers in the 1870s

When the consolidating Public Health Act was passed in 1875, "much that had been permissive became imperative."[64] Municipal governments, for example, were obliged to create a local health board and hire a local health officer as well as provide adequate local water and related health services. Rate payers could no longer use cost control as an excuse to avoid setting up a board. The Vaccination Act of 1871 also required action, mandating the employment of vaccination officers by the local authorities.[65] In the last three decades of the nineteenth century there was a significantly reduced reliance on the private sector to provide access to clean water, sewers, and other improvements, at the same time that the momentum of public spending on water, public health, gas and electricity, roads and trams, and education increased, both as capital expenditures and current costs.[66]

This new politics of public health cannot be explained by any new scientific consensus; the principles of the sanitary idea remained the same and still rested on an agreement about prophylactic strategies masking differences about aetiology. Parts of the public health movement still relied on the miasmatic version of sanitarianism, as they had in the 1840s. Some sanitarians resisted germ theory formulations and as late as "the early nineties, reputable British public health experts were still rejecting Koch's bacillus as the cause of cholera, appealing instead to atmospheric conditions or simple filth."[67] On the other hand, as early as the 1860s William Farr, who had started by being convinced by theories of miasma, had been converted to transmission by water (John Snow's argument) and even gave his zymads "additional properties of life, until they became nearly indistinguishable from living organisms," such as Koch's bacillus.[68]

Fuller implementation came not from new scientific knowledge but rather with major changes on several dimensions of the citizenship regime. Most obviously, political rights were expanded. Formal political rights were extended to whole new population groups in the parliamentary franchise reforms of 1867 (an 88 percent increase in the size of the electorate) and 1884 (bringing household suffrage). Parallel municipal franchise reforms in 1869 and 1888 reduced residency and rate-paying requirements, in effect giving the vote to laborers who rented housing.[69] But beyond that, as the next paragraphs describe, governance practices were redesigned, both by the inclusion of many more voters from the ranks of the working poor and by restrictions placed on local authorities' capacity to resist. Second, the norms about the responsibility mix were altered, and they brought much greater legitimacy for the state to assume

[64] Hamlin and Sheard (1998: 590).
[65] Durbach (2005: 8).
[66] Millward and Sheard (1995: 503ff.).
[67] Baldwin (1999: 184).
[68] Eyler (2001: 230).
[69] Lizzeri and Persico (2004: 737–9).

responsibility for delivering a healthy environment to citizens. The changes involved were, in other words, institutional and normative; they shifted patterns of interests as well as ideas.

Still reluctant to take greater responsibilities for governance on itself, the central government in the 1870s was nonetheless newly willing to *oblige* municipal authorities to ensure services were available as well as find the revenue sources to pay for them, something it had refused to do in the compromise legislation of 1848 and 1858.[70] Parliament was actively legislating in a wide range of areas that changed governance patterns in the citizenship regime by assigning new responsibilities to local authorities. These included the 1870 education act establishing school boards, an 1875 housing act (Artisan Dwelling Act), and an 1856 police act.

New local governance practices took shape and the new activism had several origins. One was the obligations imposed on local authorities, just described. Another source was the redistribution of rights that widened access to political participation. Newly enfranchised tenants had a real interest in their rented housing being linked to the sewer and water mains and to the cleanliness of that water and functioning of the sewers. This institutional reform shifted the balance of local political power in a major way, breaking "the hold of rate-payer 'economy' over municipal politics" that had shaped local politics in most cities for more than three decades.[71] Elected municipal politicians could see a clear political interest in responding to these constituents, and they did not tarry in adjusting their program.

Yet the addition of new voters alone can not account for the enthusiasm with which municipal leaders threw themselves into building infrastructure. These decades in British politics are sometimes labeled those of "municipal socialism" and "gas and water socialism." Terms chosen to represent the wide scope and large ambition of municipal action, the local authorities' policies and programs owed more to liberal principles of human improvement and classical visions of successful societies than they did to left-wing thought.[72] What happened in these decades was that the investment in the infrastructure that the sanitarians had long been advocating could finally be married to a normative position on citizenship that not only permitted but also virtually required increased spending. John Bull significantly reduced his focus on and opposition to the tax burden in the years 1876–85.[73]

[70] See Millward and Sheard (1995).
[71] Szreter (1999: 149).
[72] The great liberal politician and mayor of Birmingham from 1873 to 1876, Joseph Chamberlain, became a leader in this movement, innovating not only in his political programme appealing to the newly enfranchised but also in the forms of local governance. He pioneered in the use of large, long-term, low-interest loans to finance improvements as well as in setting up municipal monopolies for services, whose profits would finance infrastructural costs (Szreter 1998: 709ff.).
[73] Taylor (1992: 99).

Ideas of the "civic gospel" providing new norms of behaviour and citizen engagement for prosperous citizens provided goals and standards other than those of saving taxes. "The 'civic gospel' spread with something of a rivalry now developing between the town halls of many of Britain's great 'city states' during the last quarter of the century, as they competed with each other for salubrity, sanitary provision, healthy amenities and the lowest death rates." Good citizenship no longer enjoined a common effort to save money. "[E]xplicit parallels began to be drawn by the confident city fathers with the cultural achievements of the city-states of classical Greece and Renaissance Italy, as models for the corporate conversion of mere industrial prosperity into positive human progress, civilisation, art and learning."[74]

Social gospelers were not the only ones to turn back to Greece for ideas. British social thinking became centred on a form of Platonic idealism, that flowered into an "emphasis on corporate identity, individual altruism, ethical imperatives, and active citizen-participation."[75] The result was a consensus reaching from the social collectivism advocated by Helen Bosanquet and leading members of the Charity Organization Society (who invoked "the companionship and assistance" of friendly societies, cooperatives, and trade unions) to the Fabianism promoted by Beatrice and Sidney Webb.[76]

These normative positions could easily sustain claims for spending to realize the sanitary idea and policy action was immediate: local authorities received subsidized loans for sanitary activities from the central exchequer at a rate that increased eightfold, from eleven million for the years 1848–70 to eighty-four million for the period 1871–97. "Whereas Britain may ... have underinvested in its cities in the classic industrial revolution period, such could not be said of the late nineteenth century. The public sector played a central role in its expansion; its share was half in the early 1870s but it was accounting for nearly three-quarters by the early years of this [twentieth] century.... investment in roads, public health, and water supply all showed a rise."[77]

Citizenship and Bodily Integrity – Opposition to Sanitarians

If the sanitary idea finally made good headway in municipal politics with respect to sewers and water after 1870, the same cannot be said for its scientific knowledge imposed on noncitizens in the mid-Victorian years. Middle-class, mostly male reformers had proudly developed their institutions for social knowledge

[74] Szreter (1999: 149).

[75] Harris (1992: 118) obviously takes issue with A. V. Dicey's characterization of the years after 1870 as a transition from individualism to collectivism. See also Harris (1992: 137; 123ff.).

[76] "The Webbs, for example, wholly shared the Bosanquets' belief that private and public virtue were not independent, that 'state-conscious idealism' was the goal of citizenship, and that social-welfare policies should be ethically as well as materially constructive.... But they claimed that the deviant or needy individual could far more easily be provoked into self-improvement from within the context of state social services than if left to his own unaided efforts" (Harris, 1992: 133; also 131–3).

[77] Millward and Sheard (1995: 504–5).

where medical experts, statisticians, and other social observers met to discuss and promote reform. By the late 1860s, their actions and even their bastions were under assault from social movements acting in the name of the excluded and those seeking full citizenship. Two movements for more inclusive citizenship, in the form of both political rights and the basic civil right of bodily integrity for those excluded from citizenship, challenged some sanitarian practices. They explicitly rejected a number of fundamentally ill liberal norms of the citizenship regime with regard to noncitizens, developed at a time when the status was conferred almost exclusively on middle-class male property owners. In other words, as the citizenship regime was altered, providing new rights and reshaping governance, some of the practices of sanitarians were contested by appealing to the norms of the new regime.

Two examples illustrate this process. The Compulsory Vaccination Act of 1853, covering all infants born in England and Wales, had resulted from the research work and lobbying by some of the most prominent sanitarians of the time, organized in the London Epidemiological Society.[78] The 1853 legislation was reformed in 1867 and then in 1871. The third reform's policy design demonstrated the same governance practices that had finally prompted massive infrastructural investments: central authorities placed obligations on local authorities by mandating them to hire and pay for vaccination officers.[79] All three laws, but especially the third, provoked civil disobedience on the part of working-class parents as well as much public outcry in the streets and the press. The vaccination officers were feared and reviled as representatives of authoritarianism and the poor law.

Opposition did not focus, therefore, on its costs to taxpayers, as it might have in earlier decades. Rather, "resistance to compulsory vaccination was mobilized not only by Liberal reformers, but by members of a large and politically active working class who lobbied for their rights as English citizens."[80] Resisters made explicit links to the broadest issues of citizenship, that is the representation of the very nation, when they asked rhetorically as one pamphleteer did, whether "'Englishmen, Scotchmen and Irishmen' were 'fit to enjoy Home Rule over their own bodies, and over the bodies of their offspring.'"[81] Antivaccinationists explicitly targeted the sanitary idea and the citizenship regime of the mid-Victorian years. They accused legislators, for example, of treating working-class babies as a "nuisance" and the working class in general as "conduits of disease."[82] But they reserved perhaps their greatest opprobrium

[78] Among other members were the by now familiar William Farr and John Snow (Evans 2001: 226).

[79] Local authorities resisted the 1853 law, and such nonenforcement caused the central government to impose higher fines and other mechanisms of coercion in the second and third pieces of legislation (Durbach 2005: 2–10).

[80] Durbach (2000): 46.

[81] Ibid. In this sense they were contesting in the name of what Bouchard (Chapter 7, in this volume) calls the collective imaginary.

[82] Durbach (2000: 50, 49).

for the way the law was enforced. Relying on the Poor Law guardians put vaccination, in the eyes of its working-class opponents, in the same basket as the menace of the workhouse and the cutbacks in poor relief that were, as we have seen, a major element of the citizenship regime from the 1830s on.

One part of their repertoire confronted the sanitarians directly, by disputing the very statistics used to justify small pox vaccination and arguing it harmed more than it helped.[83] But perhaps the argument that carried the most weight was the one calling for sanitarians to live up to their aetiological position, and this in an ironic twist. The emergence of germ theory in the 1870s and 1880s provided anti-vaccinators with "a new, authoritative medical language to articulate what they continued to identify as smallpox's material and social cause: dirty environments and compromised constitutions."[84] Thus they could make claims to the very sanitary idea that had promoted the hated system in the first place, doing so by distinguishing themselves from the "undeserving" poor.[85] They could argue that as citizens who were responsible – and therefore almost by definition "clean" – working-class parents ought to be able to make their own decisions about their children's bodies. They could make claims in the name of the more inclusive citizenship regime for the respect of their bodily integrity and against the surveillance and intervention of well-meaning but ultimately interfering middle-class sanitarians. Faced with unrelenting dissent and noncompliance, the law was changed following the report of the royal commission appointed in 1889. Beginning in "1898 any parent who could satisfy two justices or a police magistrate that he or she 'conscientiously believed' that vaccination would be harmful to their child was granted exemption from the Act."[86]

The second example of opposition to sanitarians' limited view of citizenship rights comes from the opposition to the draconian forms of surveillance and attacks on bodily integrity in the Contagious Diseases Acts. These were frequently seen as similar to the Vaccination Acts in respect to their interference with the bodily integrity of those whose rights were unrecognized.[87] The mobilization for repeal pitted the proponents of the sanitarian paradigm, whose liberal principles of minimal interference to ensure the removal of sources of infection and nuisances had been set aside in this case, against a mobilization for recognition of the women's right to bodily integrity and autonomy.

Britain's three Contagious Diseases Acts passed in the 1860s targeted prostitutes in garrison towns who supposedly spread disease to the army, thereby

[83] Durbach (2005: 2; 47).

[84] Durbach (2005: 150).

[85] Durbach (2000) develops in detail the ways in which the antivaccination campaigns embedded this distinction between the "respectable" and "undeserving" within the working class itself.

[86] Pedersen (2005).

[87] Durbach (2000: 45, 49) documents the quite explicit connection that antivaccinationists made to the Contagious Diseases Act, as well as the similar sense of horror at the treatment of women as not respectable (for example, p. 59).

weakening it at the very time that Britain's identity as a nation required a large imperial presence. The acts resulted from an alliance between military leaders whose interest was in a healthy fighting force and medical men who propounded regular examination as the key to controlling venereal diseases. After trying first to institute compulsory examinations of soldiers, and failing when opponents argued it "contravened men's self-respect" – understood as a citizenship right – attention turned to prostitutes. Targeting prostitutes serving enlisted men, the 1864 Contagious Diseases Act required any allegedly diseased prostitute to undergo an inspection. If infected, she could be held in a lock hospital for up to three months. The 1866 Contagious Diseases Act empowered a special police force to order bimonthly inspections for up to a year. Changes in 1869 required registration of prostitutes, increased inspection locales and the number of towns targeted, and upped incarceration in a lock hospital from three to nine months. The methods deployed were much closer to Continental Europe's quarantinism than to England's emphasis on noninterference.[88]

This state strategy of policing and quarantine was vehemently opposed by civil society groups.[89] Josephine Butler, one of the leading activists for repeal, exposed the link between women's lack of the basic civil right of bodily integrity and the sanitarian position on filth and nuisance:

> This legalisation of vice, which is the endorsement of the "necessity" of impurity for men, and the institution of the slavery of women, is the most open denial which modern times have seen of the principle of the sacredness of the individual human being. ... An English high-class journal confessed this, when it dared to demand that women who are unchaste shall henceforth be dealt with "not as human beings, but as foul sewers" or some such "material nuisance," without souls, without rights, and without responsibility.[90]

The campaign to repeal the Contagious Diseases Acts erupted in the bastion of positivism and liberalism frequented by sanitarians, the meeting of the Social Science Association in Bristol. This conflict that began in 1869 was "to the evident amazement of the doctors and civil servants of its Public Health Department – the very men whose scientific rationalism had led to the

[88] For detailed analyses see Walkowitz (1980) and Baldwin (1999: 372–4), in which Britain's position on venereal disease is described as being closer to the Continental model than it was, for example, with respect to cholera.

[89] In 1869 repealers founded the National Association for the Repeal of the Contagious Diseases Act, followed immediately by the creation of the Ladies' National Association for the Repeal of the Contagious Diseases Act. This second association was a linchpin in the long campaign for repeal and its initiatives were supported at various points by all leading activists for women's rights, including Josephine Butler, Harriet Martineau and Florence Nightingale. The repealers argued points of principle rather than simply focusing on medical effectiveness, as the public health experts had. As Josephine Butler put it, the issue was "the autonomy of the individual" (quoted in Jeffreys 1987: 185).

[90] Quoted in Jeffreys (1987: 185).

introduction of the Acts in the first place."[91] The Social Science Association represented a middle class whose popular sentiments and social knowledge were composed of a "widely flourishing culture of popular 'social science', operating through the medium of national and local sociological and statistical associations."[92] It provided "a social vision ... dominated by the belief that middle-class progress could be universalized."[93]

This positivist world view shaped the collective narrative and practices of citizenship. It was, therefore, a logical institution in which to debate the issues raised by the Contagious Diseases Acts; compulsory medical examinations and incarceration for resistance to them infringed a basic civil right of citizenship. For several years, disputes over citizenship, and particularly women's civil right to bodily integrity, was intense. Eventually, the powerful movement for repeal transmogrified into the movement for women's political rights of citizenship, representing the liberal and moral feminism that opposed flagrant manifestations of a double standard and claimed for all women, no matter their class or calling, the right to be treated as fully human.

The long campaign and eventual repeal of the legislation in 1886 signaled, in other words, one of the ways in which the citizenship regime was becoming more inclusive and the practice of differential treatment of citizen and noncitizen favored by sanitarians could not be sustained.

SUMMARY AND CONCLUSIONS

In the cross-time comparison presented here, it has been possible to observe several patterns that help make sense of some of the different prophylaxis choices that were made during the mid and late Victorian period, the reasons for their partial and then full application, and the mobilisations against sanitarians' preferences for heavy-handed restrictions on noncitizens.

First, England's commitment to the sanitarian paradigm from the 1830s through the 1870s was stronger than that found among its Continental neighbors. This commitment matched well to British norms of citizenship, which in the Age of Reform had become not only more liberal but was also more inclusive of urban middle-class ideas and interests and involved a commitment to a modern, technocratic and evidence-based policy process. Other norms of this same citizenship regime, however, worked to limit the full translation of the sanitarian medical paradigm into policy. Norms for the responsibility mix and governance stressed private provision, deemphasized Parliamentary imposition and sustained beliefs in local authority. They allowed middle-class rate payers to trade off their interest in low taxes against spending on public goods such as clean water and sewers, in which they also had an interest both for themselves and for their environments more generally. This trade-off became less

[91] Goldman (1986: 129–30).
[92] Goldman (1986); Harris (1992: 120).
[93] Harris (1992: 120).

sustainable in the 1870s, as decision makers developed new ideas about "great cities" and responsible citizenship. Politicians and municipal institutions had every interest to respond to the demands of the newly enfranchised voters, whose economic circumstances never allowed them to entertain the hope of a personal escape from the overcrowded and filthy cities. But in addition the blockages to the sanitary idea coming from the dimensions of governance and responsibility mix were lifted and the paradigm could be more fully implemented.

Second, some of the mixed patterns in prophylaxis – the "polymorphous divergence of precautions" – that Peter Baldwin[94] emphasises take on a clearer meaning when the citizenship status of the targets of intervention is factored into the analysis. In Britain through the mid-Victorian years even sanitarians were quite willing to act as the Continent's authoritarian quarantinists did when the target was a poor person without political rights or a woman lacking recognized civil and political rights. Draconian measures such as confinement in a lock hospital and compulsory unsanitary vaccination were overturned via mobilization in around claims for citizenship and eventually gave greater responsibility over their own bodies and those of their children to those who had been subject to the sanitarians' ministrations.

Third, this example demonstrates that no medical paradigm is fully hegemonic. Even as the sanitarians were promoting public health interventions to fight miasma, alternative scientific theories were competing for recognition. Eventually, "the good" science drove out "the bad" and the bacteriological basis for cholera and other contagious diseases was accepted. The result was not consensus, but rather a set of new disputes about the role of dirt and the importance of cleanliness, several of which maintained the familiar distinction between prophylactic strategies for citizens and for noncitizens. In other words, over the nineteenth century there was little reduction in the widespread middle-class fear that the lives of the popular classes were defined by dissolution and dirt. Male workers were now citizens, but working-class wives and poor women were still fair game for inspection and regulation of their daily life, particularly with respect to that key female activity of childbirth and child rearing.[95] Both the germ theory paradigm and lingering miasmatic thinking provided a "scientific" basis for middle-class social workers and doctors working for the state or private philanthropic agencies to regulate working-class and poor women's housekeeping, child rearing, and hygiene. But that is another story.[96]

[94] Baldwin (1999: 550).
[95] As Dr Harold Kerr, assistant medical officer, Newcastle upon Tyne, said in 1910 (quoted in McIntyre, 1997: 724): "The terribly heavy death rate among young children in our town is of course due to a certain extent to the relative unhealthiness of our surroundings, but that is by no means the chief cause. The factor that is of primary importance is maternal mismanagement ..., every visitor in the homes of the working class knows only too well the hopeless ignorance of the majority of the mothers in regard to everything connected with the rearing of healthy offspring."
[96] For some of that story see Jenson (1986).

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