Public Health Classics

This section looks back to some ground-breaking contributions to public health, reproducing them in their original form and adding a commentary on their significance from a modern-day perspective. Elizabeth Fee & Theodore Brown review measures to improve public health in England and Wales in the 19th century, with special reference to the Public Health Act of 1848, of which extracts are reproduced below.

The Public Health Act of 1848

Elizabeth Fee[1] & Theodore M. Brown[2]

The Public Health Act of 1848, legislating on the sanitary conditions of England and Wales, is one of the great milestones in public health history, "the beginning of a commitment to proactive, rather than a reactive, public health" (1). For the first time, the state became the guarantor of standards of health and environmental quality and provided resources to local units of government to make the necessary changes to achieve those standards. The Public Health Act established a General Board of Health empowered to create local boards of health, either when petitioned to do so by at least one tenth of the taxpayers in the district, or compulsorily when the average mortality rate in the area exceeded the national crude death rate of 23 per 1000 over a period of seven years. The local boards had authority to deal with water supplies, sewerage, control of offensive trades, quality of foods, paving of streets, removal of garbage, and other sanitary matters. A local board could appoint a medical officer of health, an inspector of nuisances, a surveyor, a treasurer and a clerk. National and local boards of health were accountable to and underwritten by the national Treasury, and they reported to the Privy Council. Loans for capital expenses were supplied by the central government and subsequently financed by local rates (2).

The circumstances in which this ground-breaking public health legislation was conceived and enacted have long been studied and discussed by historians (3). The Act is generally viewed as a response to the social and health problems generated by the industrial revolution. Starting in the late 18th century with the expansion of the market economy, the introduction of steam power, the growth of transportation, and the increasing dominance of the factory system of production over home labour, the industrial revolution demanded a constant source of labourers to feed the growth of machine production. Workers thus had to be brought into the factories, located in industrial towns and cities.

Mobilizing this industrial labour force required abolition of the older system of poor relief. Landowners, rationalizing agricultural production, had enlarged and enclosed their holdings and thus began to drive rural labourers off the land. At first, provision was made for the landless and the unemployed in the parishes of their birth, following the Elizabethan Poor Law system. But as the ranks of the unemployed swelled and poor rates rose, the old Poor Law came to be viewed — at least by landowners, industrialists, and rate-payers — as a constraint on the mobility of labour and an impediment to progress (4).

The organization and financing of poor relief was a central social policy problem of the early 19th century. A Royal Commission was appointed in 1832 to examine the operation and administration of the Poor Laws, and its report, largely written by Edwin Chadwick, appeared in 1834. The Poor Law Amendment Act of 1834, incorporating the principles of the report, decreed that no able-bodied pauper could be given assistance except in a workhouse. The conditions of labour in the workhouses were to be made "less eligible", i.e. more miserable than those of the worst situated labourer outside the workhouse. The immediate intent and result of the Act was to reduce the burden of the poor rates, but it also served to drive the poor out of the rural areas and into the new industrial towns. Within 20 years, the proportion of the population living in industrial cities doubled and the mushrooming of towns and cities, speculative building practices, ramshackle housing and congestion led to an explosion of disease rates. Builders rarely troubled themselves to supply sewers, water closets or privies and little was done to supply fresh water, clean the streets or remove the garbage.

The cholera epidemic of 1831 and 1832 had drawn attention to the deplorable lack of sanitation in the industrial cities. It was obvious that cholera was concentrated in the poorest districts, where sanitation was most neglected and the slum housing most befouled by excremental filth and other dirt. The relationship between disease, dirt and destitution clarified the need for sanitary reform as, in the crowded and congested cities, disease could fairly readily spread from the homes of the poor to those of the wealthy.

Chadwick became convinced that the health of the labouring population was largely determined by the state of its physical environment. In 1838, the Poor Law Commission reported that it had employed three medical inspectors to look into the prevalence and cause of preventable disease in London

[1] History of Medicine Division, National Library of Medicine, Building 38 1E21, 8600 Rockville Pike, Bethesda, MD 20894, USA. Correspondence should be sent to this author (email: elizabeth_fee@nlm.nih.gov).

[2] Department of History, University of Rochester, Rochester, NY 14642, USA.

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and that these physicians, James Philips Kay, Neil Arnott and Southwood Smith, had reported that the expenditure needed to prevent disease would "ultimately amount" to less than the cost of the disease being created — the latter measured in lost productivity as well as the costs of hospital and burial care and the Poor Law support of widows and orphans. Sanitary measures were needed on grounds of economy as well as of humanity. In 1840, the Select Committee on the Health of Towns declared that preventive measures were required for reasons of humanity and justice to the poor, but equally for the safety of property and the security of the rich (5).

In 1839, the government had instructed the Poor Law Commission to examine the health of the working population in England and Wales; its survey was later extended to Scotland. Over three years, its members collected a vast amount of information which provided the basis for Chadwick's magisterial *Report… from the Poor Law Commissioners on an enquiry into the sanitary condition of the labouring population of Great Britain* (6). The report provided a compelling argument that diseases among the working class were related to filthy environmental conditions caused by the lack of water supplies, drainage and sewers, and any effective means of removing dirt and refuse from houses and streets. The problem of public health was declared to be largely an environmental rather than a medical problem. "The great preventives," wrote Chadwick, "drainage, street and house cleansing by means of supplies of water and improved sewerage, and especially the introduction of cheaper and more efficient modes of removing all noxious refuse from the towns, are operations for which aid must be sought from the science of the civil engineer, not from the physician, who has done his work when he has pointed out the disease that results from the neglect of proper administrative measures, and has alleviated the sufferings of the victims" (6: 396).

One result of Chadwick's report was the appointment in 1843 of a Royal Commission for Inquiry into the State of Large Towns and Populous Districts. Again, Chadwick played the leading role in drafting the reports of 1844 and 1845 and in arguing that poverty, crime, ill-health and high mortality were all closely associated with the appalling environmental conditions of the industrial cities (7). He proposed that central government assume basic responsibility for the public health with the creation of a new government department and that, in each locality, a single administrative body be responsible for all water supplies, draining, paving, street cleaning and other necessary sanitary measures. By the 1840s, many voluntary groups were actively compiling data, issuing reports, and advocating for the health and well-being of the working population, among them the Metropolitan Association for Improving the Dwellings of the Industrious Classes, the Society for the Improvement of the Condition of the Labouring Classes, the Health of Towns Association, and the Association for the Promotion of Cleanliness Among the Poor.

In 1848, a new wave of cholera was sweeping westwards across Europe. By June an epidemic was raging in Moscow and by September it had reached Hamburg and Paris. Watching its spread with anxiety, the British Government, after several failed attempts, passed the Public Health Act on the last day of August 1848, establishing a General Board of Health for a provisional five-year period. George Rosen notes that the activities of the Board of Health were, from the beginning, resisted by "vested interests" who opposed the new regulations in the name of property rights and human freedom (3). As the criticism became more vociferous and the Board of Health increasingly unpopular, Parliament refused to renew the Act after the first five years and the National Board of Health, at least in that form, came to an end. Chadwick was forced into retirement, albeit with a generous government benefit. The General Board of Health was then reestablished, but on an annual basis until 1858, when its functions were transferred first to the Privy Council and then to the Local Government Board. Later, the Public Health Act of 1875 consolidated public health legislation and brought some uniformity to its administration by dividing the entire country into urban and rural sanitary districts, each with a local health authority and a medical officer of health.

Recent studies have added several layers of complexity to this standard account of the Public Health Act of 1848 and its aftermath. Christopher Hamlin & Sally Sheard suggest that what George Rosen interpreted as brute resistance to the Act and the Board it created was equally attributable to political confusion, because there were no clear answers in mid-19th-century England to the problem of what legislative and administrative means would best achieve sanitary ends. Rather than discounting all opposition as coming from "vested interests," they stress the necessary complications of determining jurisdictions and fiscal responsibilities (1). Who should initiate projects for sanitary improvement, plan, carry out and evaluate them, and — above all — pay for them? What was the proper role for the medical officer of health? What was the proper unit of administration? If a polluted river ran through a city, was the city or the factory upstream responsible for dealing with the problem? All of these matters were confusing, difficult and often contentious, and the resulting legislative and administrative decisions were the result of battles won and lost, compromises accepted, and the gradual evolution of local forms of democracy. Indeed, the Public Health Act of 1848 can be viewed as a powerful catalyst for the development of local government and for local government responsibility for public health. From this perspective the Public Health Act is less a key step in the growth of central state authority and more a marker in an ongoing struggle to sort out jurisdictional levels of government and to solve, at all levels of government, questions of ethics, rights and responsibilities in relation to the public's health (8). ■

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