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From Asiatic cholera to Covid-19: the many publics of modern public health

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The Covid-19 pandemic has served as a brutal reminder of the deadly and disruptive power of infectious diseases. The shock has been especially pronounced in advanced Western states, long used to prioritising the morbid and mortal effects of chronic lifestyle diseases and degenerative conditions.[1] Perhaps in retrospect we will come to see Covid-19 as part of a new wave of viral afflictions that began in central Africa in the mid-1990s with Ebola, followed by two that initially appeared in the Chinese manufacturing province of Guangdong: avian flu, which first jumped to humans in 1997, and SARS, which emerged in 2002. None of these, however, has had anything like the devastating impact or reach of Covid-19, which was first identified in November 2019 in the city of Wuhan in central China. At the time of writing (January 2021) the death toll is almost 2 million worldwide, among roughly 93 million cases.[2] Whatever the final toll, it is likely to pale in comparison to that of the 'Spanish flu' pandemic of 1918–20, which was upwards of 50 million.[3] But once more there is good reason for seeing Covid-19 as uniquely devastating. Thanks to the existence of a global aviation industry, Covid-19 has spread much faster; and given the relative interconnectedness and development of the global economy, its impact on trade and jobs will be far more pronounced (and perhaps already has been).

It has also served as a brutal reminder of the 'public' nature of 'public health' as a form of state intervention: as an administrative field or a set of systems that commands public funds, publicly funded personnel, and public laws and regulations. Across the world Covid-19 has prompted the activation of the kind of emergency powers normally reserved for times of war. In Britain, though the ineptitude of ministers has been staggering, the powers at their disposal have been – and remain – immense. Rushed through parliament in March 2020 and in force for two years, the Coronavirus Act, among other things, enables the government to control or suspend public transport; order businesses, schools, ports and airports to close; detain people suspected of infection; and issue regulations regarding the movement of people and their proximity to others.[4] In the same month the Treasury enacted an unprecedented 'furlough' scheme, effectively pay-rolling millions of workers: by December it had cost an estimated £46 billion.[5] This particular aspect of the publicness of public health has garnered an enormous amount of attention, prompting ongoing debates about the effectiveness of such measures (e.g. their sustainability in the short- and long-term) and their morality (e.g. whether they impinge too much on our freedoms). We should

not be surprised, for it is this aspect – which has so far culminated in three national 'lockdowns' – that has impeded some of our most cherished, if mundane, forms of society: meeting relatives and colleagues, for instance, or enjoying a pint with friends.

Yet, amid all the damage and highly charged commentary, it is not difficult to discern the crucial place of that agent whose shifting forms, capacities and problematic qualities has been traced in the preceding chapters: the public of public health; the collective of people whose health is at stake. Indeed, this has been just as much to the fore as the capacities of 'the State' or 'the Government'. Globally speaking, there are many reasons for variations in the incidence of Covid-19 and the relative success of state-led measures. One of these reasons is clearly recent experience of dealing with viral threats of this sort, which is why South Korea, Taiwan and Vietnam, all of whom were exposed to avian flu and SARS, have dealt with it so effectively. But another, so it has been suggested, has been the greater readiness on the part of their publics to act in solidarity and in conformity with state-based regulations.[6]

For now, in the absence of proper academic scrutiny, these explanations must be treated cautiously and we should certainly be wary of imputing any kind of docile collectivism to those nations that have enjoyed low death rates. Westernised, liberal New Zealand, after all, has also performed well. In any case, the centrality of the public as a key agent has been just as pronounced in those nations that have suffered comparatively badly. Britain is a case in point. For one thing, the pandemic has prompted the emergence of new risk-based taxonomies of the public, from clinical ones concerning relative vulnerability (e.g. the NHS's 'high risk' and 'moderate risk' groups) to those concerned with degrees of likely adherence to prophylactic regulations (with young men judged especially prone to disobedience). Most of all, 'public trust' and 'confidence' has been, and remains, at the heart of the story of Covid-19 in Britain. At the same time that the state has seized unprecedented powers, so too have we maintained that these powers count for naught without a diffuse public readiness to abide by draconian regulations.

This was most forcefully insisted upon following revelations that the Prime Minister's top special advisor, Dominic Cummings, had apparently broken the regulations he had helped to devise while fleeing to County Durham during the first national lockdown that began in March 2020. Besides flouting the 'stay at home' mantra of the government at the time, he also engaged in 'non-essential travel' by driving to Barnard Castle with his family on his wife's birthday. For all the laughter and despair, as well as anger, this generated – Cummings claimed he had undertaken the trip to test his eyesight – commentators were at one in suggesting that his behaviour had fatally undermined public confidence in the government's Covid-19 strategy. A hitherto powerful sense of collective solidarity and civic-spirited discipline, it was suggested, had been crushed in one brazen and bizarre act of arrogant self-exemption from the rules. 'Public trust is not merely a political commodity: in a pandemic, it is an essential public health resource. And now it has been badly depleted', wrote one commentator, echoing many others.[7] The commentators were right: subsequent surveys confirmed that the public were much less willing to heed the government's advice afterwards, though quite how much this loss of public trust hampered efforts to prevent a 'second' and then a 'third wave' remains to be seen.[8] Once more, we must

await proper academic (and official) reckoning, but this is surely one of the core lessons of the Covid-19 pandemic so far: the emergency state is not quite the all-powerful agent we think it is. In fact, it is only as strong as the public's capacity to play its part and abide by the rules. Even in times of great trial and stress, the size of the state does not always matter.

The chapters contained in this volume help to place this particular facet of the Covid-19 pandemic – the shifting, always problematic place of the public in public health – in some much needed historical perspective. As the introduction to this volume has suggested, the question of 'who' constitutes the public or publics of public health, and how and why these publics have changed over time, has not received the kind of attention it deserves. To be sure, it would be wrong to suggest that the question has been entirely neglected. Work in a social and cultural vein, which first began in the 1980s, has consistently sought to explore the way public health measures have reinforced or reworked existing understandings of 'the public', especially as these intersected with hierarchies of class, gender and race.[9] Historians of public policy have also restored the importance of commercial, philanthropic and charitable agents in the provision of health care broadly construed.[10] Both these strands of historiography have helped to overcome the tendency of an earlier generation of historians to equate the history of public health with that of the welfare state, and, moreover, to see the state as a necessarily benign agent, propelled by scientific and humanitarian impulses.[11] Yet only implicitly has this work sought to apply critical pressure to the publicness of public health as this volume understands it, and regard the public of public health as an intrinsically open and demanding category – as an actor, at once real and imagined, that assumes multiple forms, guises and roles at any particular juncture. Questioning 'the state' has meant that it is now quite orthodox to suggest that is a mutable, multi-form, porous agent.[12] We should no doubt say the same of the public of public health, but we need more studies that take this as their critical starting point.

The chapters assembled here begin this task, excavating the history of a variety of 'problem publics' across a range of sites – American and European; local, national and international – during the twentieth century. The complexities they disclose, however, are part of a much longer history, as the introduction has suggested, for the very idea of 'public health' has always carried within it some idea, however ill-defined, of a public whose health requires protecting and enhancing. We might add, too, that ever since the invention of 'public health' as a more or less discrete field of statecraft during the eighteenth and nineteenth centuries, it is clear the public has assumed a variety of problematic forms. This is not only, it should be emphasised, as the object of public health interventions, as state-centred and Foucauldian accounts are prone to emphasise: as a population which must be counted, regulated, disciplined, protected, and so on. It is also as the *subject* of public health: as an agent endowed with rights and responsibilities and various subjective capabilities, which all state-sponsored regulations or expert-endorsed norms must work with and respect. Indeed, although the place of the public might be analysed and historicised from each of these perspectives – as an object and as a subject – this very duality helps to explain its inherently problematic status. We see this today in the age of Covid, as governments

the world over grapple with what members of the public may or may not tolerate in terms of regulatory interventions. And it is amply apparent in the preceding chapters, which demonstrate that the objectification of 'problem publics' has always entailed grappling with their status as subjects in some respect, whether as civic communities (Gunn), welfare recipients (Lambert), sexually active males (Jones), people living with HIV/AIDS (Folland), food consumers (Hand), migrants (Hoffman), or as populations with violent capacities (Di Marco).

In conclusion, then, we might ask how the bigger historical picture opened up by the present volume can be pursued further. This might be done in various ways, but a core question is surely how we should explain the multiple, problematic forms assumed by the public since the inception of public health as an articulate ideal and field of government. What, in short, has determined these forms – the peculiar roles, qualities and capacities accorded to the public, or subsets of the public, at any particular juncture? The answer offered here is provisional and draws on the case of modern Britain, from the early Victorian period onward, when 'public health' began to assume a specific, institutional presence. This makes for limited geographical coverage, of course; but it also allows for some critical pressure to be applied over the long-term. And this is much needed, for as will be argued, although we should see the multiple, mutating forms of the public as the contingent product of a variety of interacting factors, this complex of factors has been at work for some time, much before the twentieth century. Each and every public of public health in modern Britain may be singular, and each and every one may be problematic in peculiar ways; but all bear the stamp of a similar set of forces.

The limits of political culture

An obvious place to start is with political culture, understood as the dominant values that form the underlying ethos of governing and public life, beyond any particular parties that might form a government (e.g. Conservative, Liberal or Labour, or a coalition of some sort). The new orthodox narrative, as evident in James Vernon's recent volume on modern Britain, presents a three-fold trajectory, which begins with a broadly liberal culture of governing during the Victorian period.[13] This is followed by a social-democratic one, which triumphed in the post-war period, before a culture of neoliberalism took hold during the 1980s, flourishing thereafter, under various party-political governments. Certainly this narrative helps us to think in very general terms about how the public has featured in public health. The one thing it captures best, perhaps, is the shifting *ideals* of public health and how they relate to particular visions of the public and the role of the state.

As scholars have shown, Victorian sanitary reform and the promotion of civic and personal cleanliness targeted a public that was conceived in highly class-bound, patriarchal and localist terms, in keeping with the broader commitment to a patrician-led central state, punitive welfare measures like the poor law, and a strictly limited, property-based, male franchise.[14] By contrast, as captured in T.H. Marshall's seminal lecture on 'Citizenship and Social Class' (1949), the interwar and post-war periods

witnessed the advent of more inclusive, egalitarian conceptions of governing and the rise of a more expansive, technocratic state.[15] In the context of public health, one thinks of those key icons of social-democratic welfare, such as national insurance, the NHS, council housing and 'family planning'. The image of the public changed accordingly, morphing into something more civic and demotic, born of the conviction that just as all (adult) members of the public were now entitled to the vote, so too were they entitled to minimum standards of health. More recently, one can point to the fraying, if not disintegration, of this culture, amid the emergence since the 1980s of more market-led, neoliberal visions of public health.[16] While the state, centrally and locally, has retreated as an agent of public health, whether through privatisation, marketisation or 'quangoisation', the public in turn has been refashioned in more consumerist and entrepreneurial terms. Members of the public are now regarded as choice-seeking 'consumers' of health care and 'clients' of various services (e.g. mental health and addiction services), and are encouraged to invest time and money in the cultivation of 'healthy lifestyles'.

These are crude evocations, but one could mine the rich historical literature on public health in modern Britain to detail at length the multiple resonances of public health with these epochal shifts in political culture, and how visions of the public changed accordingly. Two of the chapters in the present volume speak directly to this theme: Michael Lambert's on the limits of the mid-century social-democratic consensus and how it intensified anxieties about welfare dependency and so-called 'problem families'; and Jane Hand's on how, during the 1980s, an emergent neoliberal culture of governance addressed the dangers of fatty foods by constructing the public as 'consumers' while targeting those subgroups deemed most 'at risk'. Clearly these evolving cultures mattered, at the very least shaping the contours and capacities of the state and corresponding idealised – and demonised – forms of the public.

Yet we should be highly circumspect too, and not only because these evolving cultures were highly fractious, roughly hewn formations, containing multiple dissenting perspectives. It is also because the same historiography discloses uncomfortable degrees of complexity, not least the existence of multiple forms of public agency that have weaved their way in and out of each culture of governing. To give but one example, public health has long confronted the public in the form of 'consumers' demanding higher standards, better services and more accountability. In the Victorian period so-called 'consumer defence leagues' fought for purer, more consistent water supplies in London.[17] In the interwar period consumer-based forms of activism and mutualism animated the market for health insurance and demands for enhanced nutritional standards.[18] In the post-war NHS efforts to empower patients were couched in consumerist terms, as in the founding of the Patients Association in 1963, which lobbied for greater patient 'participation' and 'choice'. In 1974, newly formed Community Health Councils were championed as the 'voice of the consumer'.[19] Doubtless the figure of the consumer has become more important since the 1980s, featuring as part of a more aggressive, neoliberal assertion of market-style discipline within the public sector; but self-styled 'consumers' have been a feature of the public health landscape for a century and more.

Other examples might be explored. One thinks of the 'nimby-ish' local publics which have, ever since the Victorian period, fought against infrastructural interventions such as the building of hospitals and refuse works; or the way women, and mothers in particular, have always formed the principal public of measures designed to enhance the health of infants. Of course, these different publics have been more or less prominent and problematic at particular junctures; and this is partly explicable in political-cultural terms (e.g. the consumer, noted above). Yet it is also clear that factors which enjoy, at the very least, a relative political autonomy have an explanatory role to play here, especially those that compose what we might call the material strata of public health – the peculiar morbid processes and epidemiological profiles it deals with, as well as the technical practices, institutions and technologies it mobilises. The best example of this is the public form that we currently inhabit: the infectious public, as it might be termed, at once dangerous and vulnerable, and which is required to practice measures of isolation and notification. This particular form, even if it has always been there, has swung in and out of prominence on account of agents that, at one level, are not at all political or even human: rampantly mobile, microbiological bacteria and viruses. It hardly needs stating that there is nothing inherently liberal about the cholera that periodically devastated early to mid-Victorian Britain; or social-democratic about tuberculosis, which became an object of sustained administrative attention in the early 1900s; or neoliberal about HIV/AIDs, which first came to public attention in the 1980s – or indeed anything inherently political about any disease. And the same point might be made about the technologies and forms of expertise that public health relies on. Sewerage systems and vaccines, for example, have existed, and still exist, under regimes of radically different political qualities.

Once more, this is not to dismiss the role of political culture in forming the shifting and varied publics of public health, especially the values and idioms in which this publicness is identified; but this clearly needs to be considered in conjunction with factors that cut across different cultures of governing, and which, as such, must be considered more fundamental. In doing so we might start to think in more holistic and structural terms about the determination of the many publics of public health and, crucially, obtain a more critical view of their relative novelty or not – of the differences and repetitions that characterise the history of this most protean and problematic agent. Three of these more fundamental factors might be highlighted: *democracy*, by which is meant, loosely, considerations of citizenship and political subjectivity and inclusion; *strategy*, by which is meant considerations of organisational logistics and costs; and finally, *epidemiology*, by which is meant shifting distributions of morbidity and mortality. What follows deals with these separately, but the point is that they need to be grasped together.

Democracy

The first of these – democracy – is the one that comes closest to the political narrative sketched above, to the extent that it concerns the civic status of the public as the subject of rights, responsibilities and entitlements. At stake here, however, is not

merely conceptions of citizenship, which may or may not mutate according to the succession of different cultures of governing, liberal, social-democratic or neoliberal. Rather, it concerns a more powerful and persistent structural dynamic that public health in Britain has inhabited since the early Victorian period: namely, a dynamic of public empowerment on the one hand, and expert-official, or state, empowerment on the other. It is a neat historical coincidence in this respect that the first cholera pandemic arrived when it did, amid the agitation surrounding what would become the 1832 Great Reform Act. So-called 'Asiatic cholera' prompted the birth, albeit short-lived, of the first national administrative infrastructure composed of local and central authorities (the 'Central Board of Health'); the 1832 Act was the first time the parliamentary franchise had been self-consciously expanded and formalised.[20] The franchise would of course continue to expand thereafter, in a cumulative fashion, forming the symbolic centrepiece of a broader move toward a democratic, non-sectarian polity. Chaotic though this moment was, we should see it as marking the entrance of what was, and would remain, up to the present, an inherently problematic dynamic, whereby various, more or less expansive publics would form and coalesce, claiming their rights or defending their freedoms, alongside the formation of various kinds of official and expert sponsored public health interventions. To be clear, it is a dynamic that means we should speak of more of both over time: more expert-generated, officially sanctioned regulations and interventions, *and* more public inclusion, accountability and questioning.

It should be emphasised that this is not necessarily a confrontational dynamic, for the public could also be co-operative, supporting and not just opposing measures carried out in the name of public health. But it is a dynamic relation nonetheless and the point is that the two are bound together: just as we see the formation of new forms of public health expertise and officialdom, advocating and enacting all sorts of regulations and technologies, so too do we see the formation of new publics coalescing around them. It is significant that the 1830s and 1840s mark the moment when the idiom of 'central' and 'local' authorities first gained currency in Britain, reflecting the emergence of public health as a truly national institutional enterprise. It was at this point when local publics of landowners, ratepayers and councillors began to animate the gestation of public health. Chadwickian public health, which sought to encourage the adoption of largescale sewerage and water supply systems, marks a crucial threshold in this respect. The same legislation that created a Whitehall-based General Board of Health in 1848 – the first of many central boards and ministries – also empowered locally elected municipal boroughs (earlier reformed in 1835) and local boards of health to take charge of the measures themselves; and they were variously proactive and supportive, reactive and obstructionist.[21] A similar configuration of forces emerged in London after 1855, when an (indirectly) elected Metropolitan Board of Works and a lower tier of (directly) elected vestry and district boards presided over the building of Joseph Bazalgette's monumental sewerage scheme.[22]

We might regard these local forms of the public as institutionalised, to the extent that they also worked in alliance with the agency of elected representatives (i.e. councillors and MPs), who again might be for or against particular public health measures. By the end of the century, following the further complication of centre-local

relations under the auspices of the Local Government Board (LGB, 1871–1919), municipal ownership of water supplies, isolation hospitals and public baths had become a source of civic pride, if also of increasingly bitter partisan disputes in the council chamber and local press.[23] And the importance of local publics would be no less pronounced in the twentieth century. Although the central state assumed more powers and established forms of local agency went into decline, such as the ratepayer associations of the Victorian era, which petered out in the 1930s, new and equally active local publics emerged. The history of the NHS, for instance, which is also the history of recurrent waves of reorganisation, is dotted with local campaigns against the closure of particular facilities, campaigns which persist to this day.[24]

In general, the claims of local publics have been rooted in a sense of their rights and entitlements as property holders and taxpayers, and have normally operated beneath the radar of national publicity. This same dynamic, however, has also generated more dramatic confrontations and decidedly more problematic publics. The two most dramatic flashpoints in the Victorian period were smallpox vaccination, which was administered via the poor law infrastructure, and the Contagious Diseases Acts (CDAs), which were in force between 1864 and 1883 in selected naval and garrison towns.[25] The former was made compulsory for infants up to three months of age in 1853 and for all children under fourteen years of age in 1867; the latter enabled the forcible inspection of women suspected of prostitution. Both generated intense opposition on the part of MPs and national pressure groups, such as the Anti-Compulsory Vaccination League (1866) and the National Association for the Repeal of the Contagious Diseases Acts (1869). These were kindred, if highly eclectic, movements composed of libertarians, evangelical Christians and radicals, among others, and they advanced a variety of arguments; but both couched their opposition in terms of the rights of parents or women, or simply 'the freeborn rights of the English', against what was seen as a 'tyrannical' state acting on the basis of shaky science and dubious statistics. They were also highly militant campaigns – opposition to smallpox, for instance, resulted in the imprisonment of 'martyrs' – and, ultimately, successful. The CDAs were eventually repealed in 1886, while exemption from smallpox vaccination was permitted in 1897 on the grounds of 'conscientious objection'.

These highly organised and oppositional forms of public agency would persist into the twentieth century, not least in the context of vaccination, which continued to arouse suspicion on the part of parents, libertarians and advocates of alternative medicine, despite the end of compulsion. In the 1970s doubts about the safety of polio and whooping cough vaccinations prompted a marked decline in public uptake, and led to the formation of the Association of Parents of Vaccine Damaged Children in 1973 and the passage of 1979 Vaccine Damage Payments Act.[26] The late 1990s and early 2000s witnessed a public crisis over the safety of the MMR vaccine, amid familiar questions about the evidence base and the rights of parents.[27] Yet just the same forms of public agency might agitate in favour of public health measures, advancing the same democratic premise – that everyone has rights, needs and interests that must be subject to political recognition. To be sure, since the 1880s, when public health and welfare measures began to enter the fabric of national politics, eventually becoming the subject of precise policy commitments and manifesto pledges, political parties

have played a crucial role in mediating public demands, often in conjunction with business groups, trade unions and charities. Since the interwar period housing has been one such issue; another, the funding and capacities of the NHS. But a consistent presence since the 1830s has been high-profile public campaigns in favour of public health measures. These sometimes developed in parallel with campaigns against particular measures: the association for the repeal of the CDAs noted above, for instance, was countered by an association which *promoted* their application to civilian life. Others have emerged from within particular traditions of political activism. Most obviously the labour movement has been a longstanding source of public agitation for improved working conditions and welfare measures. This could be especially confrontational prior to the post-war welfare state. One thinks of the colourful and sometimes violent protests that accompanied the campaign for shorter working hours in factories during the 1830s and 1840s; or the 'hunger marches' of the interwar period, culminating in the Jarrow march of 1936, through which the unemployed of Northern England and South Wales showcased their resilience and dignity while condemning a punitive, mean-tested system of public assistance.[28]

Strategy

A powerful democratic imperative, then, has long animated public health, forcing experts, officials, MPs, ministers and councillors to reckon with the rights and entitlements of the public. This is not to suggest that public health has been, or is, democratic, whatever we might mean by 'democratic'. This in fact is precisely what has been at stake in so many of these struggles – that public health measures are not being sufficiently responsive to public needs or the rights and interests of the public. The point, rather, is that we can understand the production of the many publics of public health in terms of a persistent and variously expressed dynamic of public empowerment and agitation on the one hand, and administrative, regulatory innovation on the other. Nonetheless, this political dimension also has its limits and hardly helps to account for the central place assumed by the public in terms of the enactment of public health on a day-to-day basis. Although the public may agitate in favour of public health measures, as well as against, there is the more mundane, operational challenge of making these same measures work on a mass scale, often involving millions of people.

This suggests another structural factor that can help us to understand the many problematic forms and roles assumed by the public: strategy, as it might be summed up; or more precisely, the strategic limitations that have shaped the way public health has operated as an administrative field. Simply put, members of the public have long featured as key agents of public health because they are, logistically speaking, closest to where governing needs to happen if it is to succeed – which is to say, their own bodies and localities, homes and children. Once more, this strategic factor has been, and still is, mediated by evolving political cultures and concerns for privacy, the rights of property and scruples about over- and under-governing; but it is also one that has been a recurrent feature of public health since the Victorian period, when constraints

of administrative scale and complexity were first reflected on and played a part in generating public forms that were local, voluntary and, ultimately, quite individual. Regardless of political culture, public health has, for two centuries and more, had to engage with the public because of limitations of knowledge and administrative resources. Put another way, the public have been, and continue to be, central to public health for very basic operational reasons.

The best example of this is the succession of what might be called personalised or individuated publics that have inhabited public health since the 1830s, where the individual (adult) is imagined as the custodian of a significant share of his or her own health. It is often suggested that it was in the post-war period when public health became fundamentally rooted in the 'personal habits' and 'lifestyle choices' of the public, presaging the more intensive investment that has occurred in recent decades under neoliberal forms of rule.[29] Yet this is really only a matter of emphasis, and certainly not invention, for the Victorians routinely insisted on the importance of this personal dimension, which was thought of as reaching those aspects of public health which were difficult to govern through statutory regulations or the building of sanitary infrastructures.[30] It is worth quoting at length from *On Personal Care of Health*, a popular health manual published in 1876 by the military hygienist E. A. Parkes:

> … it would be a fatal error to suppose it ['State medicine', 'legislation'] can do everything. It deals with many conditions which the individual man is powerless to control, but it cannot deal with others which belong only to the individual. From within this proceed many diseases, which no public hygiene can remove. There is, so to speak, an individual or private hygiene which must also be brought into action and without which half the work must remain undone, and the burden of sickness and suffering be but half removed.[31]

Divided into chapters according to age ('Puberty', 'Manhood', 'Old Age'), each one had sections on exercise, food, drinks, clothing, plus bodily and oral hygiene. And Parkes was not alone: it was axiomatic that these elements were best left to the individual to manage for him or herself, even if central or local authorities might play a role in facilitating them (e.g. building municipal public baths to help with personal hygiene). The Victorians were explicit, too, about why. Personal exercise, diet and cleanliness were all elements that, as the LGB's chief medical officer, John Simon, put it in 1874, 'the law should not, and generally could not, take within its scope.'[32] Should not and could not: the association is crucial, for while it was considered morally and politically wrong to interfere so minutely, it was also considered entirely impractical. Not only were the details of millions of bodies impossible to know and thus regulate with any precision. Any attempt to enforce and monitor such regulations would be costly and arouse considerable opposition.

This much is obvious perhaps, but these strategic limitations are a crucial reason why public health has, for at least two centuries, reckoned with the public in a variety of problematic 'personal' forms, however much these forms might have been mediated by the values and idioms of particular political cultures (i.e. liberal, social-democratic or neoliberal). Indeed, we can also see these strategic limitations operating elsewhere in the field of public health, where they have likewise helped to elevate the public into a crucial, if unreliable, strategic ally. For one thing the public has long been

accorded a certain kind of epistemological authority when it comes to applying the *general* knowledge generated by experts and officials. It is not that members of the public have been thought of as possessing superior scientific or bureaucratic expertise; but they have been, as still are, judged better at applying and adapting this knowledge to what is closest and most familiar to them. Doubtless the self-government of the body is the prime instance of this, giving rise to various individuated forms of the public; but the same strategic premise can be seen in the formation of other publics.

A striking example is the neoliberal application of market-style discipline to various aspects of public health over recent decades, notably in the provision of primary and secondary healthcare, where the public is now thought of as a collective of consumers. The rationale for this is that consumers know best what works for them and what suits their very particular healthcare needs. The result, so it is suggested, is a more responsive, effective and efficient service.[33] Yet this is but one expression of a much deeper and enduring strategic reliance on the public. Notably, since the Victorian period, local publics composed of councillors, residents and civic associations have been prized for their intimate knowledge of local circumstances and thus their ability to apply government-sponsored regulations in a way that is sensitive to place and highly attuned to local peculiarities. As the liberal radical, J. S. Mill, argued in his *Considerations on Representative Government* (1861), in what became a much-cited discussion, central authorities should take charge of diffusing 'general principles' of practice, local authorities of applying, scrutinising and adapting them. Though Mill certainly believed in the virtues of local democracy, his argument also rested on a simple operational premise: that 'local publics' possessed a much more 'detailed knowledge of local persons and things' compared to central authorities, and were naturally more attentive to local affairs.[34] Similar convictions persisted into the twentieth century, amid the rise and fall of 'planning', and are still to the fore today. Throughout the 'first' and 'second waves' of the Covid-19 pandemic, local authorities complained that central government was not making better use of their superior knowledge of local circumstances when it came to tracking the disease and formulating localised lockdown measures.[35]

The other key manifestation of the strategic importance of the public has been the premium placed on education and encouragement, rather than compulsion. A longstanding conviction is that public health works best – more efficiently, cheaply and smoothly – when the public acts of its own voluntary accord. This is not to deny the existence of measures that have carried with them the threat of legal sanctions, fines and even imprisonment in the event of non-compliance. Examples include smallpox vaccination (up to 1948) and a range of 'nuisance' (or health and safety) regulations that apply to homes and businesses. Yet it has been a key tenet throughout that the use of legal action is a last resort, not least because it is time-consuming and expensive. As early as the Victorian period, factory and sanitary inspectors, conscious of their status as agents of 'red-tape', routinely affirmed that the best and most efficient of them worked gently, through persuasion and preliminary notices rather than formal litigation.[36] More broadly, we can point to a long history of educational initiatives that have targeted the 'personal habits' of the public, which have been posited as a crucial resource via which public health can be secured in a way that

respects individual autonomy and makes for cheaper government. The examples are many, ranging from Victorian popular hygiene manuals (like that of Parkes) and domestic visitation schemes aimed at working-class mothers through to the elaborate public information campaigns of the twentieth century, such as those that targeted syphilis and tuberculosis in the first half and heart disease and HIV/AIDS in the second.[37] All have pivoted on the same strategic premise: that it is much easier and cheaper to work with and through the manifold complexities – the peculiar habits, relations and environments – which constitute the everyday lives of the public.

Epidemiology

It will be evident from the above that the strategic considerations which have worked to make the public such a central actor in public health have combined in complex ways with the democratic ones described earlier. While the latter may complement the former, they have also complicated them: it is much harder, after all, to encourage the public to adopt a particular measure, or to develop good personal habits, when objections are raised on the grounds of rights and entitlements, or even a general aversion to what the Victorians called 'grandmotherly' intervention, or as we have it 'nanny-statism'.[38] Yet, even in combination, there are limits to the explanatory power of democratic and strategic factors, which hardly account for the way different publics have been addressed according to the shifting profile of particular diseases and forms of sickness. This is the final factor that needs adding to the explanatory mix, which we might summarise under 'epidemiology': or more precisely, the evolving nature and distribution of mortality patterns and morbid processes.

To be sure, epidemiological factors have been, and remain, subject to peculiar political mediation. The broadly liberal governing ethos of the Victorian period meant that the working conditions, housing and welfare entitlements of the poor were pushed to the margins of 'public health'. Although this was not without significant agitation to the contrary, only later, under the social-democratic settlement that followed, did they assume a more central place.[39] We might note, too, how measures and reforms in other spheres modified the priorities of public health. It is no coincidence that the health of infants and children assumed a more prominent place following the advent of compulsory elementary schooling in the 1870s, which brought to light a whole series of nutritional, ophthalmic and hygienic deficiencies, and put in place an administrative environment in which they might be addressed (e.g. via school meals and school nurses).[40]

As noted above, however, evolving patterns of mortal and morbid processes and events are hardly reducible to political factors, or indeed broader democratic or strategic ones, even if they are certainly linked to the long-term successes of public health as a disease-fighting enterprise. Looking at the broad sweep of things, it is evident that the epidemiological transition we have witnessed over the past 150 years has generated different, if always problematic, forms of public engagement, moving as it has from the relative prominence of infectious diseases and high levels of infant mortality to the relative prominence of degenerative, cardiovascular and cancerous

forms of disease among older age cohorts.[41] The sort of infrastructural projects necessary to combat the 'filth diseases' of the nineteenth century, for instance – sewerage and water supply systems, principally, to combat typhoid, typhus, dysentery and cholera – placed a premium on local and municipal forms of public mobilisation, especially those centred on property ownership and local fiscal considerations. By contrast, the salience and durability of individuated and consumer-based forms of the public since the 1940s has in part been driven by the importance of 'life-style factors' (e.g. smoking, drinking, exercise and diet) in the generation and distribution of heart disease and different forms of cancer. Recent moves to include mental health within the remit of 'public health' will only, it seems, entrench this.[42] In short, the relative importance of particular forms of the public over long stretches of time has a significant basis in the shifting and very material pathological forces that determine mortality, morbidity and longevity.

Of course, these movements, in Britain and elsewhere, have not only been driven by the long-term, cumulative efficacy of public health measures. Social and technological change has played a part. At the same time, the science of epidemiology has changed. Crucially, in terms of how the public is understood, epidemiology has participated fully in the advent of more sophisticated understandings of causality and all the statistical-methodological innovations bound up with the 'taming of chance', as Ian Hacking has memorably put it.[43] It is this that partly explains the rise, during the post-war period, of a pervasive language of 'risk' with which to describe and subdivide the public and its often challenging behaviour (e.g. 'risk groups', 'risk factors').[44] But the key point is that although the overall epidemiological landscape has changed dramatically, it has been, and remains, incredibly complex. Notably, infectious diseases have remained part of the equation, even if they have assumed nothing like the deadly significance they possessed in the nineteenth century and earlier. Since the 1950s various established infections have persisted or retreated unevenly (e.g. whooping cough, measles, tuberculosis and flu), while new ones have emerged, principally from abroad (e.g. HIV/AIDS, CJD, SARS, MERS and Covid-19); and some of these diseases have either become, or have threatened to become, epidemic within Britain.[45] Ultimately, this is a reflection of the fact that, like humans, bacteria, viruses and even prions (in the case of CJD) adapt and innovate.

The result is that, for all that the epidemiological landscape has evolved, and indeed for all the mutations of political culture, similar public forms have continued to erupt around the merits of vaccination and measure to eradicate epidemic outbreaks of infectious disease. Rights and entitlements have been invoked, as competing groups have prioritised either their liberty or their safety. Ministers and officials have encouraged, persuaded and, as a last resort, legally compelled the public. To be sure, as noted above, we see these forms elsewhere in relation to other aspects of public health; but the visceral reality of infectious diseases has also meant that the periodic re-emergence of these public forms has been distinguished by a peculiar emotional economy of fear and anxiety, one rooted in a consciousness of the movement of bodies and considerations of touch and contagion. It is here, no doubt, that we confront an aspect of the public's problematic place within public health that stretches deep into the past. One thinks, for instance, of the collective fears and conspiracies

that surrounded the plague in the medieval and early modern periods; but that these emotions, rational or otherwise, have inhabited the public forms that have erupted during modern times of epidemic distress is unquestionable.[46] This is true of cases where infections have not in fact become epidemic but have threatened to do so (e.g. CJD in the early 1990s); and they have been especially pronounced during times of a pandemic, when the disease 'invades' the country from abroad. The examples are many, notably the cholera epidemics of the Victorian period (1831–2, 1848–9, 1853–4 and 1866), various flu pandemics (1890–2, 1918–20, 1957–8 and 1968–9), and the HIV/AIDS crisis of the 1980s. All unleashed panic and dread. All were exercises in governing fear, as well as complacency, with the aim of establishing an optimal state characterised by neither – a state of public vigilance. We see this today during the still unresolved pandemic of Covid-19.

Conclusion

One of the crucial lessons we should draw from this collection is that the public has played a variety of roles within public health and assumed a variety of problematic forms, according to period, place and prophylactic initiative. Each one is singular, complex and requires careful analysis. Clearly, respecting these differences must form a touchstone of any critical historiography of the public's place within public health. Yet the historian's task is also to apply pressure to these differences: to search for analogies (if not strict identities); to compare and contrast; to situate them in a larger, more general historical context. The above account has been concerned to sketch one way in which this latter kind of critique might be advanced in the context of modern public health, arguing that, beneath the peculiarities of particular political cultures, we can discern the work of a deeper, threefold matrix of forces and factors – democracy, strategy and epidemiology. Quite whether we can see this same set of forces at work in contexts other than the British one traversed here remains to be seen; but it bears repeating that the aim has not been to repress or obscure complexity, but to illuminate it – to better understand its genesis over time and space.

Ultimately, pursuing the problematic place of the public in public health allows us to understand better how governing public health actually works, and not least the role of the state. No doubt the present volume helps to amplify what is now a longstanding strand of historiographical revisionism: the turn away from 'the state' as the key agent in public health (and welfare and much else besides) toward a more plural, diffuse and abundant field of actors. The public in its many guises and roles is clearly one of these. Yet it is not the case that the public necessarily 'crowds out' the state: that where it is big, the state is small, and vice versa. This may be true of certain areas of public health, as in those where, for strategic reasons, as discussed above, the state has withdrawn and encouraged members of the public to take charge of their own bodies and habits. But it is evidently not true of all, and indeed there are multiple areas where the relation is one of mutual amplification: that where the state has grown, so too has the place and importance of the public, owing to the need to secure public consent and co-operation. There is no better instance of this than times of

epidemic emergency, such as we are experiencing today and have experienced in the past. All this, of course, makes it hard, even impossible, to think in terms of overarching historical trends or developments in relation to 'the size' or role of the state or, by the same token, 'the size' or role of the public. Instead, we are confronted with a lumpy, uneven and multifaceted landscape, composed of multiple relations and functions, and variable levels of resistance and compliance; but much is gained in our understanding, as this volume proposes, by examining the history of public health from the perspective of the public whose health is at stake.

Notes

[1] On the complexities of changing patterns of mortality see Alex Mercer, *Infections, Chronic Disease and the Epidemiological Transition: A New Perspective* (Rochester, NY: University of Rochester Press, 2014).
[2] www.who.int/emergencies/diseases/novel-coronavirus-2019, accessed 18 January 2021.
[3] It could in fact have been as high 100 million. Laura Spinney, *Pale Rider: The Spanish Flu of 1918 and How it Changed the World* (London: Jonathan Cape, 2017), p. 1.
[4] www.legislation.gov.uk/ukpga/2020/7/contents/enacted, accessed 18 January 2021.
[5] www.statista.com/statistics/1122100/uk-cost-of-furlough-scheme, accessed 18 January 2021.
[6] Michael Penn, 'How Some Asian Countries Beat Back Covid-19', 12 August 2020 (https://globalhealth.duke.edu/news/how-some-asian-countries-beat-back-covid-19, accessed 19 January 2021).
[7] Jonathan Freedland, 'Dominic Cummings and Boris Johnson have wrecked something precious', *Guardian* (29 May 2020).
[8] Daisy Fancourt, Andrew Steptoe and Liam Wright, 'The Cummings effect: politics, trust, and behaviours during the COVID-19 pandemic', *Lancet*, 396:10249 (2020): 464–5.
[9] Early studies instances include Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge: Cambridge University Press, 1980) and Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England since 1830* (New York: Routledge, 1987).
[10] The best general narrative of this dimension remains Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain, 1830–1990* (Oxford: Oxford University Press, 1994).
[11] For a review of this historiography see Christopher Hamlin, 'Public Health', in Mark Jackson (ed.), *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2011), pp. 411–28.
[12] See especially the much-cited Peter Baldwin, 'Beyond Weak and Strong: Rethinking the State in Comparative Policy History', *Journal of Policy History*, 17:1 (2005): 12–33.
[13] James Vernon, *Modern Britain, 1750 to the Present* (Cambridge: Cambridge University Press, 2017).
[14] See especially Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (Cambridge: Cambridge University Press, 1998); Michelle Allen, *Cleansing the City: Sanitary Geographies in Victorian London* (Athens, OH: Ohio State University Press, 2008); and Pamela K. Gilbert, *Cholera and Nation: Doctoring the Social Body in Victorian England* (Albany, NY: State University of New York Press, 2008).
[15] T. H. Marshall, *Citizenship and Social Class, and Other Essays* (Cambridge: Cambridge University Press, 1950).
[16] Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in an Age of Risk* (London: Sage Publications, 1996); Colin Leys, *Market-Driven Politics: Neoliberal Democracy and the Public Interest* (London: Verso, 2003), chap 6.
[17] Vanessa Taylor and Frank Trentmann, 'Liquid politics: water and the politics of everyday life in the modern city', *Past and Present*, 211 (2011): 199–241.
[18] Martin Gorsky, John Mohan and Tim Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester: Manchester University Press, 2006); James Vernon, *Hunger: A Modern History* (Cambridge, MA: Belknap Press, 2007), chap. 7.
[19] Alex Mold, 'Patient Groups and the Construction of the Patient-Consumer in Britain: An Historical Overview', *Journal of Social Policy*, 39:4 (2010): 505–21.

[20] For further discussion on this theme see Tom Crook, *Governing Systems: Modernity and the Making of Public Health in England, 1830–1910* (Oakland, CA: University of California Press, 2016), chap 2.
[21] James G. Hanley, *Healthy Boundaries: Property, Law, and Public Health in England and Wales, 1815–1872* (Rochester, NY: Rochester University Press, 2016).
[22] David Owen, *The Government of Victorian London, 1855–1889: The Metropolitan Board of Works, the Vestries, and the City Corporation* (Cambridge, MA: Belknap Press, 1982).
[23] Christine Bellamy, *Administering Centre-Local Relations, 1871–1919: The Local Government Board in its Fiscal and Cultural Context* (Manchester: Manchester University Press, 1988); Philip Harling, 'The Centrality of the Locality: The Local State, Local Democracy and Local Consciousness in late-Victorian and Edwardian Britain', *Journal of Victorian Culture*, 9:2 (2004): 216–34.
[24] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 6th edn (Oxford: Radcliffe Publishing, 2010); Ellen Stewart, 'A sociology of public responses to hospital change and closure', *Sociology of Health and Illness*, 41:7 (2019): 1251–69; Jennifer Crane, '"Save Our NHS": Activism, Information-Based Expertise and the "New Times" of the 1980s', *Contemporary British History*, 33:1 (2019): 52–74.
[25] Nadja Durbach, *Bodily Matters: The Anti-Vaccination Movement in England, 1853–1907* (Durham, NC: Duke University Press, 2005); Deborah Brunton, *The Politics of Vaccination: Practice and Policy in England, Wales, Ireland, and Scotland, 1800–1874* (Rochester, NY: University of Rochester Press, 2008); Walkowitz*, Prostitution and Victorian Society*; and Catherine Lee, *Policing Prostitution, 1856–1886: Deviance, Surveillance and Morality* (London: Pickering and Chatto, 2012).
[26] Gareth Millward, 'A Disability Act? The Vaccine Damage Payments Act 1979 and the British Government's Response to the Pertussis Vaccine Scare', *Social History of Medicine*, 30:2 (2016): 429–47.
[27] Gareth Millward, *Vaccinating Britain: Mass vaccination and the public since the Second World War* (Manchester: Manchester University Press, 2019), chap. 5.
[28] Robert Gray, *The Factory Question and Industrial England, 1830–1860* (Cambridge: Cambridge University Press, 1996), chap. 7; Vernon, *Hunger*, chap. 8.
[29] Virginia Berridge, 'Post war smoking policy in the UK and the redefinition of public health', Twentieth Century British History, 14:1 (2003): 61–82; Peder Matthias Clark, *'Lifestyle', Heart Disease, and the British Public: c. 1950 to c. 2000* (PhD thesis, London School of Hygiene & Tropical Medicine, 2019).
[30] For further discussion on this theme see Crook, *Governing Systems*, chap. 7.
[31] E. A. Parkes, *Manuals of Health: On the Personal Care of Health* (London: Society for Promoting Christian Knowledge, 1876), pp. 4–5.
[32] *Reports of the Medical Officer of the Privy Council and Local Government Board*, PP 1874 (C. 1066), vol. XXXI, p. 7.
[33] Leys, *Market-Driven Politics*.
[34] J. S. Mill, *Considerations on Representative Government* (London: Parker, Son and Bourne, 1861), pp. 287–91.
[35] This is one reason why the much-derided national track and trace system, operated by private contractors, was eventually supplemented by localised systems run by local authorities. Adam Briggs, 'NHS Test and Trace: the journey so far', 23 September 2020 (www.health.org.uk/publications/ long-reads/nhs-test-and-trace-the-journey-so-far, accessed 20 January 2021).
[36] Crook, *Governing Systems*, chap. 4.
[37] John Welshman, '"Bringing beauty and brightness to the back streets": health education and public health in England and Wales, 1890–1940', *Health Education Journal*, 56:2 (1997): 199–209; Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: Cambridge University Press, 1999).
[38] Andrew H. Yarmie, 'British employers' resistance to "grandmotherly" government, 1850–80', *Social History*, 9:2 (1984): 141–69.
[39] An excellent account of this shift is John Eyler, *Sir Arthur Newsholme and State Medicine, 1885–1935* (Cambridge: Cambridge University Press, 1997).
[40] Bernard Harris, *The Health of the Schoolchild: A History of the School Medical Service in England and Wales* (Buckingham: Open University Press, 1995).

[41] Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856–1900* (Oxford: Clarendon Press, 1993); Matthew Smallman-Raynor and Andrew Cliff, *Atlas of Epidemic Britain: A Twentieth Century Picture* (Oxford: Oxford University Press, 2012).
[42] One aspect of this is the birth of 'public mental health' as a new area of policy development. Dinesh Bhugra et al., *Oxford Textbook of Public Mental Health* (Oxford: Oxford University Press, 2018).
[43] Ian Hacking, *The Taming of Chance* (Cambridge: Cambridge University Press, 1990).
[44] William G. Rothstein, *Public Health and the Risk Factor: A History of an Uneven Medical Revolution* (Rochester, NY: University of Rochester Press, 2003).
[45] Smallman-Raynor and Cliff, *Atlas of Epidemic Britain*, chaps 7–10.
[46] General accounts that deal with these aspects include William H. McNeill, *Plagues and People* (New York: Anchor Books, 1998); Samuel K. Cohn, 'Pandemics: Waves of Disease, Waves of Hate from the Plague of Athens to AIDS', *Historical Research*, 85:230 (2012): 535–55; and Mark Honigsbaum, *The Pandemic Century: One Hundred Years of Panic, Hysteria and Hubris* (Oxford: Oxford University Press, 2019).