

"AGAINST ALL ODDS": LONDON'S HEALTH RECORD IN THE  
NINETEENTH CENTURY

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Despite recent illuminating research into the demographic and socio-medical history of London during the eighteenth century, surprisingly little has yet been published on similar themes for the nineteenth. The main reason for this omission is almost certainly that the capital, with a population of nearly one million by 1800, has proven itself too large and too demanding an object of study for the individual historian. As to *why* London achieved so rapid a rate of demographic growth for so long, this is a process which has yet to be fully explored, although E.A. Wrigley's seminal work has shown that it was already well underway by the mid-seventeenth century. Given the overriding problem of size, a plausible alternative for the period since the beginning of civil registration is to focus on the individual district. This certainly presents difficulties - - notably the unreliability of causes of death adopted by the Registrar-General and frequent boundary changes - - but they are not insurmountable.

That there was a generalized improvement in the 'health of the people' in London during the nineteenth century is undeniable, but it was an amelioration which followed an unpredictable and highly regionalized pattern. This tension helps to explain the title, 'Against All Odds'. The phrase was chosen because the number of interrelated factors - - continuingly high levels of overcrowding, intermittent reactivations of the type of large-scale in-migration experienced during the first four decades of the century, and brute poverty: all these seemed to make it feasible - - if not likely - - that the population of the capital would continue to be stricken by deadlier epidemics and by a larger volume of debilitating endemic illness than in fact it was.

It was necessary, as well as logical, to start with infant mortality. It was well known by contemporaries - - and later substantiated by historians

- - that this key indicator declined much less rapidly than the adult death-rate: London's poorer districts were still experiencing exceptionally high levels in 1900. This phenomenon can be placed in broader perspective by recalling that the infant mortality rate for London as a whole has been estimated at 370 per thousand live births in the 1730s, rising to about 380 in the 1740s, and declining thereafter to about 205 by 1810. Such a reduction, which was consolidated between the 1780s and the end of the first decade of the nineteenth century, was crucial to a quite novel demographic process: a continuing and self-reinforcing upward movement in population, no longer necessarily or wholly dependent on massive flows of in-migration or pulled back by the age-old 'internal deficit'.

Socio-medical historians of nineteenth century London know more about cause-specific mortality among infants and young children than those working on the eighteenth century. An exceptionally important component here was infant diarrhoea, which might account for up to 15 per cent of all deaths below the age of one during hot summers. In terms of causation, there was a strong correlation between the consumption of tainted milk, food and water, especially during weaning, and susceptibility to the deadly 'summer infection'. These preconditions were reinforced - - emphatically so in poorer districts - - by the non-removal of human and other waste from areas close to living quarters and to rooms where food was prepared or stored.

A rather different view of infant and early childhood mortality can be gained from an examination of data on measles. The crucial distinction here is between the massive numbers contracting yet surviving this very nearly universal infection and the minority - - invariably of exceptionally poor nutritional status - - dying from it. In London mortality from measles was especially marked during the 1860s and the 1890s. In the former decade the nature of the educational and social infrastructures ensured that the bulk of fatal infection was probably generated and passed on within the domestic environment. By the 1890s, when the illness entered another highly virulent phase, schools were closed and children sent home. This procedure may have been counter-

productive since it brought infected school children into even more intimate contact with their baby brothers and sisters. In very poor districts - - St George-in-the-East or Southwark, for example - - two-year-olds, suddenly deprived of the immunological protection bestowed upon them by their mothers, were intensely vulnerable. The surviving clinical evidence confirms that this fatal measles, then in the East End, as now in the developing world, has characterized by large, blotchy, peeling spots and a deadly hacking cough. In methodological terms, the distinction between surviving and dying from the infection might well be deployed by social historians as a proxy for regional differentials in levels of health, standards of living and nutrition.

Among adults the key 'disease' - - in social, epidemiological and symbolic terms - - was 'fever'. (Tuberculosis occupied centre-stage as a large-scale killing injection but quantitative and regional research into this condition continues to be dogged by severe data problems. As for cholera, its all-round importance has probably been exaggerated). It was only in the early 1870s that the Registrar-General made a formal distinction between typhus, carried by the human body louse, and typhoid, predominantly transmitted *via* infected water, milk and food. But other types of source material - - medical officer of health reports and hospital admissions registers - - make it possible to disaggregate and rework the pre-1870 registration material. The conclusion which emerges from an exercise of this type is that London was afflicted by both diseases at historically low levels of intensity during the 1850s but that typhus predominated - - during a final onslaught - - in the 1860s. (The data for the 1840s is ambiguous: but it seems likely that the louse-borne infection flared upwards, at exceptionally high levels of aggregate mortality).

What are the implications of these findings? Since typhus is an indicator - - though not a completely reliable one - - of levels of employment, housing and social stability and instability, they confirm that the 1850s were distinctly less traumatic, in health terms, than the 1840s had been. This is hardly surprising but the ramifications for the 1860s are more complex: the social impact of typhus during that decade suggests that the

types of evidence that have been traditionally deployed by contributors to the standard of living debate need to be augmented by rigorously selected epidemiological material. As for typhoid, the narrowing of differentials between affluent and poor districts during the 1870s reveals that the private water companies were now belatedly delivering safer supplies to every part of the capital. The decline in mortality from this infection also indicates that real wages had improved so as to enable a larger proportion of working-class families to obtain fresh supplies of milk and essential foodstuffs.

Once typhus and typhoid had ceased to kill in such large numbers, the public statements of leading metropolitan health activists became increasingly optimistic and, at times, euphoric. Three retrospective qualifications need to be made to the official consensus. First, as we have already seen the poorest sections of the capital - - in the East End, immediately to the south of the river, and in the increasingly commercially-dominated inner-city - - were still experiencing traumatic levels of infant mortality. In parts of Shoreditch, Whitechapel, St George-in-the-East and Southwark, the infant death rate may have been only slightly lower than the 'all-London' average of 1810. During that same decade - - the 1890s - - a baby born in Stepney was twice as likely to die from infant diarrhoea than one born in Hampstead: twice as likely to die from respiratory infection: nearly three times more likely to die from measles: and two and half times more likely to die from whooping cough. Secondly, the improvements that had been achieved in many areas of London had simultaneously revealed the inadequacy of the traditional indicators used to evaluate the healthiness or otherwise of the capital, and the country at large. Thus it was that, thirdly, public health agencies - - notably the Metropolitan Asylums Board, funded in the late 1860s - - started to refine methods of measuring and evaluating cause-specific morbidity.

The unending 'slaughter of infant life' among the poor, and the identification, and social and economic causation of non-fatal infection, continued to dominate medical and environmental thinking in London from the 1890s until the outbreak of the First World War.

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