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Comment

A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848

Nancy Krieger, PhD, and Anne-Emanuelle Birn, ScD

Social justice is the foundation of public health. This powerful proposition—still contested—first emerged around 150 years ago during the formative years of public health as both a modern movement and a profession. It is an assertion that reminds us that public health is indeed a public matter, that societal patterns of disease and death, of health and well-being, of bodily integrity and disintegration, intimately reflect the workings of the body politic for good and for ill. It is a statement that asks us, pointedly, to remember that worldwide dramatic declines—and continued inequalities—in mortality and morbidity signal as much the victories and defeats of social movements to create a just, fair, caring, and inclusive world as they do the achievements and unresolved challenges of scientific research and technology. To declare that social justice is the foundation of public health is to call upon and nurture that invincible human spirit that led so many of us to enter the field of public health in the first place: a spirit that has a compelling desire to make the world a better place, free of misery, inequity, and preventable suffering, a world in which we all can live, love, work, play, ail, and die with our dignity intact and our humanity cherished.

Why commemorate the 150th anniversary of 1848? Because knowing the paths our field has traversed and identifying which dreams of the early public health visionaries have been fulfilled and which have not can help us understand our current situation, put contemporary conflicts in perspective, build a collective identity, and substantively inform options for future endeavors. Historical imagination is midwife to transformation: learning from those who have gone before and appreciating what we can now see that they could not encourages us to think critically in our own era. In so doing, we may resist the hubristic belief that, as public health professionals, we have all the answers

or can by ourselves improve the public's health without efforts to ensure social and economic justice.

Why 1848? Because in 1848 popular uprisings and movements around the world were championing social justice and political and economic democracy, including the socialist and trade union movements in Europe, the anti-slavery and women's rights movements in the United States, and movements resisting imperialism in India and Mexico, as well as nationalist and suffragist movements (Table 1). 1848 was the year in which the *Communist Manifesto*¹ was published and became a landmark text coalescing the era's visions for social change. This period also marks a burgeoning of public health activity, from studies of workers' health in France to public health legislation in Britain to recognition of the political basis for health inequities in Prussia. Some of these efforts were highly influential, some delivered mixed results, and still others failed, but all derived from a spirit of social, political, and public health activism that are foundational to public health and from which we can—and must—learn.

Consider, for instance, the case of the 1848 Public Health Act in Great Britain. This act authorized a newly created General Board of Health to establish local boards to deal with water supply, sewerage, and control of offensive trades, as well as to institute

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surveys and investigations of sanitary conditions in particular districts.²⁻⁵ The impetus for this act lay not simply in the growing filth of rapidly industrializing and ever more densely populated cities but in the responses of an emerging capitalist state to a labor movement that was demanding improved working conditions, better pay, and decent housing; a Chartist movement calling for political democracy; and socialist movements calling for an end to economic exploitation and for an economy based on cooperation and economic democracy rather than competition and greed.²⁻⁸

Edwin Chadwick, architect of the 1848 Public Health Act, was also author of Britain's draconian poor law of 1834. He held fiercely to the view that filth and the immorality of the poor—not economic policies—were principal causes of disease.⁹ But William Farr and other new public health professionals and advocates vigorously disputed Chadwick's view, arguing that poverty was not only a direct cause of disease, for example, via starvation, but also a critical determinant of family discord and alcohol abuse.^{3,7,10-12} Improved sanitation certainly improved health^{2,4,13}; neglecting other pathways by which poverty and poor working conditions harmed health, however, had a cost. These disputes of 1848 reflect a set of debates, still ongoing, about what and who is responsible for inequality, disease, and suffering and what steps should be taken, by whom, to improve the public's health.^{4,5,14}

Alternatively, recall how the abolitionist movement in the United States spurred reinterpretations of racial disparities in health, which were no longer seen as a sign of innate inferiority, but rather as a consequence of social inequality. In the 1840s and 1850s the first generation of credentialed African American physicians—exemplified by Dr James McCune Smith and Dr John S. Rock¹⁵⁻¹⁸—empirically challenged the long-standing credo embraced, even promulgated, by prominent physicians and other scientific authorities that poorer health among Black Americans than among White Americans was but one more sign of White racial superiority.¹⁸⁻²² To make their case, abolitionist physicians marshaled data to show that just as poverty produced ill health among White Americans, so too did slavery, conjoined with poverty, produce racial inequalities in health.¹⁵⁻¹⁸ Sadly, these insights were muted in the aftermath of the Civil War and the subsequent rise of social Darwinism.²³⁻²⁶ In the 1930s and again since the 1960s, public health researchers have challenged naive, fallacious, and dangerous race doctrines and are now reviving the idea, based on contemporary understanding of population genetics

TABLE 1—Selected Notable Events In and Around 1848

1840–1847
1840–1847
Louis René Villermé publishes the first major study of workers' health in France, <i>A Description of the Physical and Moral State of Workers Employed in Cotton, Linen, and Silk Mills</i> (1840). In England, Edwin Chadwick publishes <i>Report on the Sanitary Condition of the Labouring Population in Great Britain</i> (1842). First child labor laws in Britain and the United States (1842). End of the Second Seminole War (1842). Prison reform movement in the United States initiated by Dorothea Dix (1843). Frederick Engels publishes <i>The Condition of the Working Class in England</i> (1844). John Griscom publishes <i>The Sanitary Condition of the Laboring Population of New York With Suggestions for Its Improvement</i> (1845). Irish Famine occurs despite high agricultural output and protests against British agricultural and trade policies (1845–1848). Start of US–Mexican war (1846). Frederick Douglass founds <i>The North Star</i> , an anti-slavery newspaper (1847). Southwood Smith publishes <i>An Address to the Working Classes of the United Kingdom on Their Duty in the Present State of the Sanitary Question</i> (1847).
1848
Worldwide cholera epidemic. Uprisings in Berlin, Paris, Vienna, Palermo, Milan, Naples, Parma, Rome, Warsaw, Prague, and Budapest. Start of the Second Sikh war against the British in India. In the midst of the 1848 revolution in Germany, Rudolf Virchow founds the medical journal <i>Medical Reform (Medicinisches Reform)</i> and writes his classic "Report on the Typhus Epidemic in Upper Silesia," in which he concludes that preserving health and preventing disease requires "full and unlimited democracy" and radical measures rather than "mere palliatives." Revolution in France, abdication of Louis Philippe, worker uprising in Paris, and founding of the Second Republic, which creates a public health advisory committee attached to the Ministry of Agriculture and Commerce and establishes a network of local public health councils. First Public Health Act in Britain, which creates a General Board of Health, empowered to establish local boards of health to deal with the water supply, sewerage, and control of "offensive trades," as well as to conduct surveys of sanitary conditions. The newly formed American Medical Association sets up a Public Hygiene Committee to address public health issues. First Women's Rights Convention in the United States, Seneca Falls, NY. Henry Thoreau publishes <i>Civil Disobedience</i> to protest paying taxes to support the United States' war against Mexico. Karl Marx and Frederick Engels publish <i>The Communist Manifesto</i> .
1849–1854
Elizabeth Blackwell sets up the New York Dispensary for Poor Women and Children (1849). Lemuel Shattuck publishes <i>Report of the Sanitary Commission of Massachusetts</i> (1850). Founding of the London Epidemiological Society (1850). Indian Wars in the Southwest and Far West of the United States (1849–1892). Compromise of 1850 retains slavery in the United States and the Fugitive Slave Act is passed (1850). Harriet Beecher Stowe publishes <i>Uncle Tom's Cabin</i> (1852). Sojourner Truth delivers her "Ain't I a Woman" speech at the fourth Seneca Falls convention (1853). John Snow removes the handle of the Broad Street pump to stop the cholera epidemic in London (1854).

and social determinants of health, that racial/ethnic inequalities in health reflect the embodiment of lifelong histories of economic and social deprivation, including experiences of racial discrimination.²⁷⁻³⁴

A gaze in the direction of international health and tropical medicine reveals further complexities entwined with colonialism and imperialism. The decimation of indigenous populations in the New World wrought by military conquest and the consequent spread of smallpox and other diseases in the 16th century was succeeded in subsequent centuries by ever more death, disruption, and disease.³⁵⁻³⁸ Driving this misery were powerful economic interests, intent on extracting raw materials, increasing agricultural productivity, and displacing populations to replenish the labor supply.^{39,40} Ecological alterations—

such as the construction of canals, cesspools, and irrigation ditches—exacerbated malaria and cholera by causing floods, creating breeding sites for mosquitoes, and sullyng water supplies.⁴¹⁻⁴⁴ In the face of these myriad problems, colonial public health measures served more as colonialism's handmaiden than as its corrective. Not only were public health measures parceled out selectively but they were robbed ideologically, geared more toward protecting imperial armies and settlers than indigenous populations.^{36,39,40,45} Mid-19th century public health measures in British India, for example, were much more concerned with ensuring that the British military were prepared against the possibility of another 1857 Indian mutiny than with extending the reach of sanitary infrastructure.⁴⁶ Likewise, early 20th-century

control of yellow fever, hookworm, and other diseases in Latin America proved a success more for free commerce and US scientific models than for local public health.^{47,48}

These brief examples caution us to remember that the field of public health in fact has many strands, repressive as well as progressive. Recognition of these conflicting legacies can illuminate contemporary debates about public health research and action and also help uncover ideologies and policies that contribute to or even expand social inequalities in health. At a time when virtually every nation is questioning the role of the state in fostering human welfare and when the very notion of public health as social good is being challenged by profit-driven agendas,^{5,14,49-51} it is useful to recall that the phrase “public health” was coined in the early 19th century to distinguish actions governments and societies—as opposed to private individuals—should take to preserve and protect the people’s health.^{2,52} We may do well in our own time to embrace the concept of “collective health,” coined by Latin American public health professionals to emphasize the notion of shared health outcomes determined in the polis, if manifested in individual bodies.⁵³⁻⁵⁵

To acknowledge, then, the importance of 1848 for the field of public health, the new Spirit of 1848 Caucus has organized an evening extravaganza on November 17, 1998, at the 126th Annual Meeting of the American Public Health Association (session 2302.1). The evening will combine music, poetry, dramatizations, and photography, along with 3 academic presentations, to stimulate reflection on and commitment to public health activism. Participants will represent more than 20 American Public Health Association caucuses, sections, committees, and affiliated organizations. We invite you to attend, to learn, to reflect, and above all to celebrate our field’s dedication, past and present, to the belief that social justice should be the foundation of public health. □

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Comment: The Past and Future of National Comprehensive Tobacco Control Legislation

In June 1998, the US Congress came as close as it ever has to passing comprehensive national tobacco control legislation. What were the provisions of the proposed bills? Why did they fail? And most important, where does the public health community go from here?

Tobacco Industry and States Reach Initial Agreement

This account begins in April 1997, when the tobacco industry began serious negotiations with the state attorneys general who had collectively sued the tobacco industry to recoup Medicaid funds spent on treating tobacco-related diseases. The result was a comprehensive national settlement. The tobacco companies agreed to make significant public health concessions, including advertising and marketing restrictions, comprehensive restrictions on youth access to

tobacco products, tougher health warnings, a \$500-million-per-year public education campaign, funding for state and local tobacco control programs, smoking cessation assistance, regulations against environmental tobacco smoke, recognition of the authority of the Food and Drug Administration (FDA) over tobacco products, and substantial penalties if tobacco use among children did not decrease to specified levels.

In addition, the tobacco industry agreed to drop court challenges to FDA regulation over tobacco products and to cease trying to subvert the Environmental Protection Agency's risk assessment of secondhand smoke. Finally, \$365 billion was earmarked for state and federal public health programs and related activities. Much of this funding was to come from a per-pack increase in the price of cigarettes.

In return, the state attorneys general agreed to settle their individual state lawsuits and all pending private class action suits.

They further agreed to limits on future lawsuits, protection for the tobacco industry against prospective class action suits and punitive damages, and an annual cap on the amount the industry was forced to pay in punitive damages.

Congress Responds to Call for Stronger Measures

The agreement was announced on June 20, 1997. The outcry from certain tobacco control advocates was immediate and intense. Their major points of contention were the limits placed on FDA jurisdiction, the inadequacy of the expected payments by the industry, and the terms related to future litigation against the tobacco companies.

After 3 months of review, President Clinton allowed that while the agreement was an important step forward, stronger provisions were needed. He outlined a set of