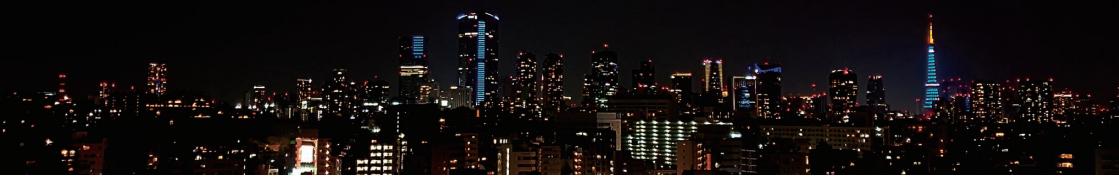
UTokyo-Cambridge Voices Series

COVID-19

in Historical Perspectives: Politics, Industries and Relief



UTokyo Cambridge
Strategic Partnership

Contents

Foreword

The University of Tokyo and University of Cambridge have long enjoyed partnerships valued by both universities. In March 2015, a Strategic Partnership Agreement was signed to promote and further academic links between the two institutions, which has since been extended every five years. Among the various events under the partnership agreement have been regular joint symposia and research workshops on a variety of topics. UTokyo-Cambridge Voices was created in 2020 as a new academic event where participants could exchange views on an ad hoc basis.

The year of 2020 saw the world hit by the Covid-19, and we held a session of the UTokyo-Cambridge Voices under the title of 'COVID-19 in Historical Perspectives: Politics, Industries and Relief' as a joint event with the University of Tokyo Humanities Centre in April 2022. This was an online workshop with more than fifty participants from various backgrounds. It is a pleasure to publish the results of the workshop in this booklet. I am grateful to those who participated in the session and to those who contributed to the booklet. My special thanks go to Professor Mika Suzuki, who chaired the session, and Dr. Mariko Kasahara for her help in organising the event.

March 2025
Shunsuke Katsuta

After the Virus: Lessons from the Past for a Better Future

Simon Szreter

Note: as this text predominantly presents a brief summary of the book, ***After the Virus****, references to support statements are not included, as they can all be found by consulting the index and full bibliography in* ***After the Virus****. Only additional sources, not appearing in the book, are referenced here in Footnotes.*

Introduction:

In 2021 Hilary Cooper and I published a book combining the expertise of a public policy economist and a historian of modern Britain. The book's text was finalized in late April 2021 and it was published on 21st September 2021. It aimed to provide an historically-informed account of the impacts of the pandemic on society and how this was influenced by UK government policy both before and during the crisis.

Since the analysis offered was extremely critical, the book also concluded by drawing on British history to propose that British society and its economy will benefit from a complete change of direction in government policy. The virus was a stress test which exposed the bankruptcy of a brand of liberal economics which has never served the people of the UK well, either when it was first tried in the nineteenth-century or since its revival in neo-liberal form during the last four decades.

British history throughout the last 400 years instead demonstrates that after the virus the UK needs to rediscover the benefits of the collectivist individualism which the UK government first pioneered, to the nation's great economic and social benefit, for over two centuries from 1601 until 1834. This model was again revised in a new social democratic form in 1945; but it has been increasingly abandoned since 1979, causing tangible increases in inequality and consequent poor health for large sections of the population as the authoritative January 2024 report from the Institute of Health Equity has graphically confirmed.[1] The apologists for neoliberal policies claim that its primary virtues are superior economic efficiency and greater growth in the economy, which 'trickles down' from the incentivized rich to the rest. After four decades of running this experiment there is no evidence to support this. In addition to much increased income and

[1] *Health Inequalities, Lives Cut Short:* https://www.instituteofhealthequity.org/resources-reports/health-inequalities-lives-cut-short.

regional inequality, the overall productivity performance of the UK economy, 1979-2025, has been poor. Consequently the UK has fallen ever further down the league tables comparing its population's health and its economic performance with comparator OECD peer countries.

The global environmental crisis is now upon us. This makes it all the more crucial that the UK and all democracies move decisively away from the inequality-expanding neoliberal consensus of the last four decades in order to be able to co-ordinate the domestic and global policies needed to collectively protect the planet, its species and all of its human individuals with equity.

Why 'After the Virus'?

Covid-19 has not been consigned to history – it arguably never will be entirely. But we are in a world that has been shaken by the pandemic. In that sense we are all living in a world after the virus, needing to look forward, not back to where we were immediately before. Shocks of this order of magnitude – revolutions, wars, natural disasters or pandemics – can significantly alter the relationship between states and citizens. This can be enduring, as happened in 1945, when a new social contract followed the ravages of two devastating world wars within the space of a generation. This ushered in the modern welfare state, not only in Britain, alongside equivalent mass social security systems across much of Europe, but also across the world as re-formed and entirely new democratic nation states aspired to provide legitimating public services for all their citizens.

Covid-19, alone, might not be seen as a challenge on such an earth-shaking scale now that effective vaccines have ridden to the rescue. But it is only one manifestation of the multiple dimensions of the dramatically changed relationship between humanity and its natural environment that is the *Inconvenient Truth* which Al Gore brought to public attention in 2006 and which we now see increasingly inconveniencing us all as the world's temperature climbs. Although the alarm began to be publicly sounded in various ways as long ago as the 1960s (Rachel Carson's *Silent Spring* and Paul Ehrlich's *The Population Bomb*), a political commitment to ever-rising consumerism and profits was only cemented further, as the implicit contract between governments and their democratic electorates throughout the following decades. All governments and their electorates have come to see GDP growth as the marker of success without reference to sustainability. Indeed, in the course of the 1980s and 1990s, the commitment to growth through free trade was expanded both to the global South and to the ex-Comecon zone of Eastern Europe, in the era of the so-called 'Washington consensus'. This was a hubristic libertarian and consumerist ideology, glorying in

corporate profits and personal accumulation of wealth and status (breeding the cult of 'celebrity'). It was relatively unconcerned with the consequences that such unbridled, competitive commercial expansion might have for the planet or for relations between citizens within nations. The development by the UN Development Programme (UNDP) of the HDI index from 1990 onwards represented early recognition among a global technocracy that GDP was not everything. But HDI has so far failed to displace GDP from the centre of public and political attention in most democracies. Authoritative, publicised international measures for assessing and reducing environmental costs have begun to be developed but remain on the policy margins at present, despite the 29 annual COP meetings we have seen since 1995.

In *After the Virus* we are arguing that the UK has a similar challenge to that faced 80 years ago in the 1940s. There is an urgent need to bring about a 2020s shift akin to the reformed social contract that led to the establishment of the modern welfare state after the second world war, to once again redefine what we value and how we behave, both in the UK, which is the focus of this book's analysis, and much more widely.

Why history is central to our argument

A) Recent History since c.1979

In the first half of the book a review of recent history is presented to reveal why it was that the UK, a country which had created in the 1940s the modern welfare state with its NHS and which had a long-functioning history of public health surveillance dating back to the continuous annual publication of causes of death since 1839, was so caught-out and lacking in resilience when Covid-19 hit in February and March 2020.

It was shown how the vulnerability of a large section of the population was the direct result of the neoliberal political economy project c.1979-2020. Under this ideology planning of any kind was derided as a poor substitute for letting an unregulated free market economy lead the way. Similarly, publicly-funded services were devalued, seen as a distortion impeding the purity of the market pricing mechanism. Their funding was reduced and their services privatised as much as possible, including, for instance, much of the social care sector - residential homes for the elderly. Accordingly, trade-unions' bargaining power was an early target for this ideology and was legally restricted from the early 1980s in order to 'free' competitive private enterprise, while allowing finance capitalism ('shareholder value') to expand unimpeded. With private accumulation of wealth seen as the only valid incentive, reduction of the 'burden' of taxation on the wealthy and on corporations continues to be seen as a moral imperative by the proponents of this secular theology, whose primary political agency is the plutocratically-funded Conservative Party.

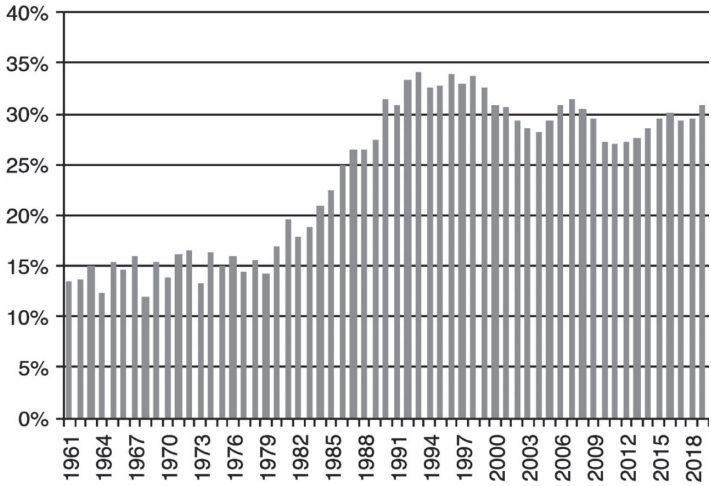


Figure 1. Percentage of children living in relative poverty (after housing costs), 1961 to 2019–20.

Note: Children living in households with less than 60 per cent of median household income after housing costs. Financial years after 1993. Great Britain only before 2002–3, UK thereafter.

Source: Institute for Fiscal Studies https://ifs.org.uk/living-standards-poverty-and-inequality-uk

The most poignant indicator of the long-term net effects of the neoliberal project on the fortunes and health of the poorest one-third of the population is demonstrated by the graph of childhoods spent in relative poverty.

The proportion of the nation's children suffering from this disadvantage during their growing years more than doubled to peak at 33% in prevalence during Mrs Thatcher's 11 years in office, 1979-90. Though it fell back to 27% by 2010 after 13 years of New labour government, it was once again, on the eve of the pandemic, raised to the high levels of the Thatcher era by a new generation of her admiring Conservative leaders from 2010 onwards so that it stood at 31% in 2019.[2]

These policies and the general disposition to imagine that 'the market' could solve all significant problems through the price mechanism of supply and demand meant that the UK was particularly unprepared and lacking in resilience because of infrastructure degradation dating from the 1980s but also intensified since 2010, when the incoming administration sought to cut spending and reduce the size of the state. The 2012 Health

[2] For UK data on relative child poverty (children living in households below 60% of the median income after housing costs) in the period since 1961 up to the pandemic see the data link on this page https://ifs.org.uk/living-standards-poverty-and-inequality-uk.

and Social Care Act downgraded the funding of local public health surveillance and response capacity and replaced it in 2013 in each part of the UK with a cheaper single centralized body, the largest being Public Health England. However, an elected government whose ideology blinded them to the positive importance of collective action and preventive planning dropped the regular practice of war-gaming pandemic preparedness after Exercise Cygnus in 2016, even though Cygnus had identified serious deficiencies in preparedness and the UK government's National Risk Register considered a pandemic (of influenza) to be its highest risk.[3] Despite this, Public Health England had no detailed plan for pandemic response in this principal strategy document which happened to be published in September 2019 on the eve of the Covid outbreak.

On taking office in 2010 the Conservative Chancellor George Osborne proclaimed an 'austerity' strategy to shrink the size of the national Debt by reducing the deficit (the gap between government annual revenue and expenditure). This was justified on the basis of academic research that was already shown in 2013 to have been both flawed and mistaken.[4] Conservative governments continued, however, after 2013 to prioritise this, through the one-sided and inequality-exacerbating policy of constraining the costs to the Exchequer of the public services which provide crucial support for poorer households, while at the same time providing tax cuts for the better-off. The gap could – very obviously – have been closed by the opposite set of policies (keeping public expenditure constant while raising the government's income through increasing taxation on the more prosperous half of the nation). As a result - and of direct relevance to the lethal course of pandemic mortality in 2020 - NHS hospital bed capacity was cut by 30,000 (17% of the total beds) between 2010 and 2019 and by the outbreak of the pandemic critical care bed capacity was among the lowest in the EU.

One of the most heavily criticized mistakes committed by the Health Minister, Hancock, was to attempt to remedy the lost bed capacity by discharging at short notice 25,000 elderly patients from hospitals into the privatized care homes all round the country without first giving them all COVID tests, while stockpiles of protective PPE had been run down prior to the pandemic on cost grounds and against expert advice and the risk assessments from the Cygnus Exercise.

With high numbers of agency staff on low wages working with inadequate PPE this was a recipe for disaster for care home staff and patients alike, as was seen in the spike in care homes deaths.

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[3] *PHE Strategy 2020 to 2025. This strategy sets out Public Health England's priorities for the next 5 years*, p.27: https://www.gov.uk/government/publications/phe-strategy-2020-to-2025.

[4] https://theconversation.com/the-reinhart-rogoff-error-or-how-not-to-excel-at-economics-13646; https://peri.umass.edu/fileadmin/pdf/working_papers/working_papers_301-350/WP322.pdf.

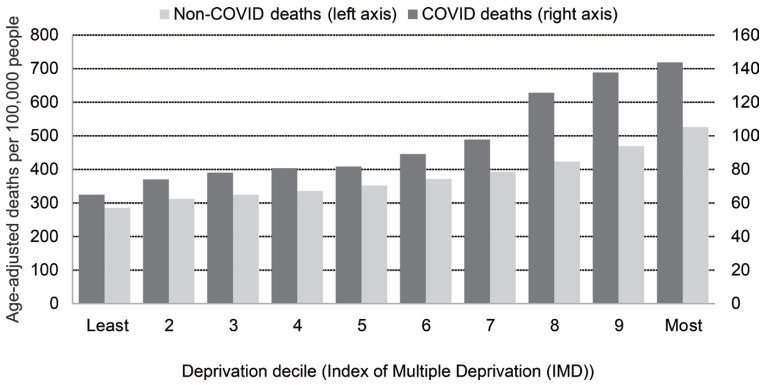

Figure 2. Deaths by local area deprivation, 1 March to 31 July 2020. Note: Age-adjusted deaths per 100,000 people using different scales on left axis (non-Covid) and right axis (Covid).

Source: Johnson, Joyce and Platt (2021), Institute for Fiscal Studies

With the degrading of trade-union power since the early 1980s, the casualisation of the workforce had greatly grown– the 'gig' economy of zero-hours contracts. This left such lower-paid workers with minimal or no sick pay, unable to afford to take time off sick or to isolate, maximizing the risks of infection. Those in front line jobs without these protections were often living in deprived communities and close-knit households with high levels of pre-existing health risks.

When combined with the UK's later lockdown than nearly all comparable countries – as the government continued to prioritise keeping the economy going at all costs - and the government's extraordinary failure even in mid-March to stop large scale public events taking place, it is no surprise that the UK's infection and death rate was among the worst in the world during the first 3 months of the pandemic's global impact. Deaths from COVID-19 were heavily concentrated among the poorest 30% of the nation with the populations in the most deprived 10% of local areas suffering over twice the COVID-19 mortality rate of those living in the least deprived 10% as Figure 2 shows.

B) Deeper history of Britain since c.1600.

Since the 1980s a revisionist early modern historiography is radically changing our understanding of the relationship between the welfare state in England and its long-term social and economic history. We can draw on this history to question fundamentally the neoliberal approach of the last four decades because it is based on largely unexamined or obsolescent assumptions about British economic history.

This is the view that the free market and private enterprise creates 'wealth',

while public services are inefficient burdens (taxes) on the 'productive economy'. Welfare states are seen as a late 'luxury' (even a misguided one as far as the more extreme libertarians are concerned) for wealthy nations, invented by William Beveridge and implemented by a socialist Labour government in the late 1940s. They can – and should - be cut back to increase economic productivity and reduce the 'burden' of high taxes. According to this viewpoint economic growth began with a range of institutions established by a British parliament of landowners in the Glorious Revolution of 1689-90. This both secured financial control by parliament over the country's sovereignty and affirmed the sanctity of private property. This it was argued provided the constitutional and institutional basis for the industrial revolution to subsequently occur. This, in turn, was primarily due to heroic individual entrepreneurs and capitalist innovation: the Matthew Boulton and James Watt steam engine-making partnership from 1775 being a paradigm example. There was no room in this account for any positive role due to a national social security system, supposedly for the compelling reason that it was irrelevant because there was no such thing until the mid-C20th.

However, new historical research on early modern England and the Old Poor Law has been over-turning this previous negative account established by the likes of Adam Smith and Malthus and repeated in Sidney and Beatrice Webb's monumental *History of English Local Government Part I* (1927). What has now been fully documented by scores of historians is that the Elizabethan Poor Law statutes 'For the Relief of the Poor' of 1598 and 1601 constituted a unique English institution in early modern Europe: a statutory universal welfare system, created almost 250 years before Beveridge and the NHS.

The Elizabethan Poor Law statutes were in fact the culmination of 60 years of experiments since the Anglican Reformation, first attempted by Thomas Cromwell under Henry VIII in the 1530s, and finally brought into an effective form from 1601 onwards. The fundamental principle that was brought into practice around the realm was that it was illegal for any subject to be allowed to starve. Orphans, widows, the old, disabled, and ill, and the involuntarily unemployed were all covered. Administration of this duty to preserve life was devolved to the 10,000 Anglican parishes, who were each to appoint (unpaid) Overseers of the Poor from among their ratepayers to collect and dispense the local funds. The funding was raised by the poor rates, a progressive local taxation levied on the rateable value of all land occupied in the parish. The already-existing office of the Justices of the Peace- the hundreds of locally-resident Magistrates appointed by the Crown - were responsible for monitoring the legality and probity of the unpaid Overseers in each parish. High Court Circuit Judges from London made quarterly visits to every county to oversee the uniformity and effectiveness of the law dispensed by the J.P.s and to adjudicate on appeals and in other contentious cases.

Evidence of levels of outlay and effectiveness of Britain's first welfare state

Although the Webbs had disparaged the Old Poor Law as a chaotic local shambles and doubted its effectiveness, they did not carry out the painstaking research in local archives which has been undertaken mostly since the 1960s by a large number of revisionist historians. Among the most recent publications Brodie Waddell has shown from a national sample of parish accounts that real (inflation adjusted) expenditure on the Poor Law grew by an average rate of 2.77% per annum across the two centuries from 1601 to 1801.[5] The national welfare system was therefore growing faster than either the national economy or population, such that Poor Law expenditure doubled as a percentage of modern estimates of GDP every half-century, reaching 1.84% of GDP by 1800. Independent parliamentary sources confirm that this equates to as many as 1 million persons (11% of the total population of England and Wales) being supported by Poor Law relief during the difficult year of 1802-3 in a period of high grain prices during the Napoleonic Wars.

Moreover, this revisionist research has shown that as a result of this effective system of relief for the poor England was free from famine mortality after 1624. Food security for the whole population was assured over 150 years earlier than anywhere else in the rest of Western Europe, where no similarly comprehensive system existed. This was achieved without state granaries or price control. Instead, the wealthier among local populations were taxed to provide for the poor so they could afford their provisions.

Furthermore, and quite contrary to Adam Smith's influential supposition, the Poor Laws created a collectivism at parish level which fostered individualism and occupational and geographic mobility among each successive cohort of the younger generation. How did this occur? This endemic labour mobility was facilitated by the security that the Poor Law mandated for all in the parish. This meant that the young were free to move away for jobs knowing their parents would be cared for by the parish in their old age; and the elderly knew this, too. Furthermore, the young could afford to take risks and try their luck elsewhere because they could not be allowed to fall into utter destitution if their search failed. At the worst the parish poor law authorities in the community they had moved to would be legally obligated to either sustain them or remove them back to their parish of settlement – and they could always try their luck again.

Under this collective insurance regime, England's economy was truly transformed c.1600-1800 through the specializing division of labour of its young people flooding into its provincial towns and cities. This is demonstrated by England's

[5] Brodie Waddell, 'The Rise of the Parish Welfare State in England, C .1600–1800', *Past and Present*, 253, Nov. 2021, 151-94.

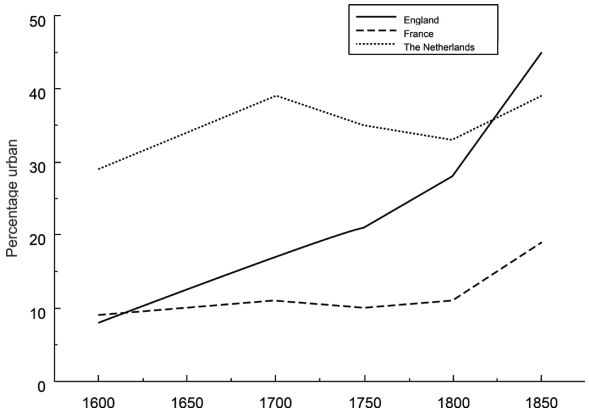

Figure 3. Urban growth in England, France and the Netherlands, 1600 to 1850.
Note: Urban population is the percentage of the total population living in towns with 5,000 or more inhabitants. Source: E. A. Wrigley, *Cambridge Economic History of Modern Britain* (2004), Figure 3.8, p.89

extraordinary demographic record c.1600-1800 which combined strong overall population growth with exceptional urbanization. These two centuries witnessed 350% growth in the proportion of the English population living in towns, defined as settlements with more than 5,000 residents. This compared with less than 35% increase in that same statistic in all other European populations across this period (proxied in the graph by the line for France). Consequently, although Holland had been clearly the most commercially advanced economy in Europe in 1600, by 1800 England had entirely caught up Holland and demonstrated much greater dynamic momentum over these two centuries.

The Old Poor Law abandoned 1834-1945

However, these positive aspects of the history of the Elizabethan Poor Laws were lost from historical memory for most of the succeeding C19th and C20th. In 1834 the Elizabethan Poor Law was radically reformed by parliament. Historians refer to this as the 'New Poor Law'. It was the original 'austerity' project imposed on the working class from Westminster. A Royal Commission on the Poor Laws, provoked in part by the rising costs of the system, sat from 1832 and produced its report in 1834 which was swiftly enacted as the Poor Law Amendment Act (1834). Its most influential Commissioners were: Nassau Senior, first Professor of Political Economy at Oxford; Edwin Chadwick, leading Utilitarian (Jeremy Bentham's amanuensis); and John Bird Sumner, evangelical future Archbishop of Canterbury

Its reasoning was informed by a reductively individualist ideological amalgam of Benthamite utilitarianism and the classical liberal economics of Smith, Ricardo and Malthus. The economy could only grow through the free exchange of commodities, which included variable prices of both land and labour, as well as capital. The Benthamite pleasure-pain utilitarian calculus was invoked to justify an incentive system to promote the work ethic in the production factor of labour. Within this system of thought humans were abstracted to *homo economicus*. They were primarily seen as workers and consumers, motivated to work more or less and buy more or less, depending on prices in the market for their labour and for various goods. The New Poor Law was also infused by an evangelical variant of Christianity, which viewed manifestation of the work ethic as vital for religious worth: 'Self-Help' was its common-sense gospel. Consequently all those asking for public social assistance from the Poor Law, unless evidently physically or mentally disabled, were stigmatised as 'paupers', a word which for the Victorians conflated material poverty with moral degradation.

This legitimised the introduction of a new harshly-deterrent system of workhouses, memorably captured in Charles Dickens' denunciatory novel, *Oliver Twist*, published in 1838-9 in immediate reaction and repulsion at the new regime, just as the film director Ken Loach rapidly produced his two critiques of the modern Conservative austerity regime, *I Daniel Blake* (2016) and *Sorry We Missed You* (2019). In the prison-like conditions of life in the Victorian workhouse husbands and wives were separated in sex-segregated dormitories, with a gruel diet and tedious labour. This further reinforced the view that the dependent poor were a form of social criminal. The Victorian working classes consequently learned to avoid the Poor Law at all costs, which was precisely the aim of the new system: to incentivise all workers to remain in the 'free' labour market, supposedly ensuring economic efficiency through cheap labour costs.

Thus, the period 1834-38 saw a radical re-organisation and reduction in expenditure on 'an over-generous' pauperising Old Poor Law, with a further 'Crusade against outdoor relief' after 1870 keeping costs down as much as possible. The 15,000 parishes in England & Wales dispensing 'outdoor relief' in 1834 were reconstituted into 630 'Unions' (of parishes) offering 'indoor relief' in the Workhouse, designed to deter. The real per capita costs of the Poor Law were radically reduced by almost 50%.

Was this era of classical liberal political economy after c.1834 an economic success, removing the supposed inducement to indolence of the Old Poor Law? Did the new liberal political economy and its deterrent, incarcerating welfare policy work to boost economic productivity as classical economics expects? The answer is in the negative. Productivity growth per worker subsequently stalled as poverty and poor health took their toll and economic risk taking and mobility were no longer enabled. UK productivity growth per worker had been pretty constant at 1.0% per annum c.1830-60 (the highest in

world history so far at the beginning of that period). Despite the UK's substantial global lead by a margin of several decades into the industrial revolution and its unmatched imperial possessions, once the impact of the new Poor Law started to manifest itself productivity in the British economy then fell back to average 0.85%, 1871-1937. UK productivity was overtaken by both USA and Germany, each averaging over 1.2%, 1871-1937, as these nations stepped up their investment in social support and education of their populations.[6] Furthermore, both interwar decades were a harsh experience for the poor in Britain when unemployment was over 10% of the workforce for much of the time.

The new welfare state of Beveridge

Against a backdrop of 110 years of begrudging and minimal support for the poor in society, along with little economic payoff, in terms of the liberal economic ideology that justified it, the post-war welfare state was a revolution. Yet, unbeknownst to its principal architect, W.H. Beveridge, it also bore some key similarities to the ways in which the Old Poor Law had operated to provide social security and welfare for the poor and vulnerable throughout the centuries before 1834.

Beveridge's declared aim was to eradicate the '5 Giants' of Want (poverty), Disease, Ignorance, Squalor and Idleness (unemployment). In the context of the previous 110 years of the Old Poor Law regime it constituted a 'democratic' transformation in the relationship between citizen, state and elected government. Central government was now to guarantee full employment to its citizens- sanctioned by the new Keynesian economics. Family allowances were to be paid to mothers; free secondary schooling for all was added to the universal free elementary schooling that had only been available since the 1890s; free health care was of course a key policy with the inauguration of the NHS in1948; and there was a vigorous house building programme.

All of this was funded by progressive taxation of wealth, inheritance and incomes: top marginal rates of taxation were running at 90% from the later 1940s through to the 1960s. Not only were the social results impressive in terms of educational enrolments and rising life expectancy, but also economic productivity in the period 1950-1973, rising at 2.4% p.a. per worker, was the highest in UK history, all the more remarkable as it was achieved in the context of full employment.

[6] For productivity rates: 1700-1860 (Brian A'Hearn, *Cambridge Economic History of Modern Britain (CEHMB)*, 2014 edn, Vol I, Table 1.2, p. 6); 1871-1995 (N. Crafts, *CEHMB*, 2014 edn, Vol II, Table 2.2, p. 28).

Lessons from a different history: the first and second welfare states

Collectivism and individualism are usually seen as philosophical opposites. However that may be, it does not mean that the two principles cannot simultaneously inform different working parts of a complex social system, which is composed of many interlocking institutions, norms and practices. British history shows that Britain's economic productivity has been greatest when combining the two as 'collectivist-individualism'.

British society – and its economy – has flourished most when it has embraced both universal, collectively-provide social security and a facilitative nurturing welfare state, to which all contribute proportionately through progressive taxation. This helps all individuals to thrive and, in particular, enables the individuals of each younger generation to respond to the changing opportunities available to them as they see fit – hence facilitating individualism alongside collectivism.

This happened in two key periods in British history – first, in the long lead into the industrial revolution c.1600-1834; and once again 1945-1973, when productivity, social mobility and growth took-off in a manner which spread prosperity and empowered individuals widely.

What needs to happen now?

The UK needs a nurturing state investing to overcome health, educational and deep regional divides. For this to happen it needs to replace the small state obsession with cutting public services and reducing taxes on the wealthy. The benefit system must be completely reformed to deliver dignity and security, ending child poverty and benefit debt. This has to start by removing immediately the devastating Treasury-imposed 5-week wait for universal credit payments, which has been little more than a recruiting sergeant for the loan-shark and gambling industry. But is also needs to address the freezing of welfare benefits and housing support in the years leading up to the pandemic, such that their real value has been eroded by thousands of pounds, while for families the imposition of the 'two child limit' which has been in place since 2017 has added to child poverty by refusing benefit payments under the universal credit system for all children after the first two. Child hunger and family food bank use are now at record levels in recent history.

A reinvigorated welfare state requires fair contributions – including reform of wealth taxation. Private wealth has grown from 3 times national income to 8 times its value in just a few decades, but wealth taxation has not caught up.

We need a new morality - ethical capitalism – and new laws to change the way businesses are run, focused on creating value for society and employees, not extracting

value for CEOs and shareholders.

Communities and young people must be fully included within a participative democracy, via citizens' assemblies and giving the vote to all aged 16 and over so as to stimulate civic and political education in schools. Empowered and properly resourced elected local government energized by the device of participatory budget-setting is an important innovation.

We must understand and live within our environmental limits, protecting our precious natural resources and measuring success against sustainable goals. Greater equality and genuinely valuing greater equity, sharing, and diversity of activities among all citizens is needed to damp-down and restrain resource-using and carbon-profligate material consumerism. Radically progressive and redistributive income and wealth taxation is needed to remove the motor from the runaway emulative incentives that rising inequality feeds. Rather than the commercially-driven glorification of inequality through adulation for personal riches and the socially-isolating and de-humanising worlds of 'celebrity' and exclusionary ownership, civic contributions to improving the natural environment and to the lives of the poor should be the principal objects of public admiration and praise.

Conclusion:

Now that the immediate danger has passed Covid-19 cannot be consigned to folklore as an unpredictable 'Black Swan' event. COVID-19's impact in the UK revealed the deep problems with the hands-off neoliberal state, the paring back of public investment, poor governance and mounting inequalities; and especially the dangers to democracy that follow rising wealth inequalities and resultant cronyism in politics.

It should be treated as a dress rehearsal for the profound environmental challenges we face, including the crises of food security, migration and war that will increasingly accompany the ravages of climate change and biodiversity loss and the responses we must make to that.

We need to learn from Covid-19 and apply that learning to help us turn away from the high-carbon, high-inequality, globalized economy that worships GDP growth and personal wealth accumulation.

We must work nationally and internationally to replace it with nurturing and mutually supportive values that protect and enhance both people and all other species and their environments

In Britain we have done this before, not once, but twice. We can do it again.

The most important British historical achievement to inspire our 21st century future was not the industrial revolution with its energy-profligate carbon economy and

associated rampant individualism.

It was the world's first ever universal welfare state and its principles of nurturing collectivist individualism.

Emergency Medicine in a Time of Disaster: The Case of Dublin during the Great Irish Famine*

Shunsuke Katsuta

Introduction

I find Professor Szreter's argument based on his recent book insightful and far-reaching. One of the principal points of his argument is that the New Poor Law of 1834 put an end to the period of long-term economic growth in England by replacing the comprehensive and collective Elizabethan poor relief system with a more individualistic and punitive system. He also points out that the same restrictive poor relief system introduced in Ireland in 1838 played a major role in the Great Irish Famine of 1845–1850, when the Irish government abandoned initial emergency relief measures such as public works or soup kitchens and resorted to providing indoor relief to hunger-stricken people in workhouses. He is right to do so: historians agree that this drastic reversal of the policy of famine relief was a major factor in the tragedy of the Great Famine.[1]

In this paper, I would like to shed light on emergency medical relief, another dimension of relief during the Great Famine. I focus on Dublin City. The Great Famine was caused by successive failures of the potato crop, the main staple of the Irish people in the countryside, which meant the famine was primarily a rural phenomenon. However, the Great Famine also had urban dimensions. Hunger-stricken people moved to towns to seek relief. Many came to Dublin. In addition, the Great Famine was, as is usual with famines in general, accompanied by epidemics because distressed people were less immune to diseases than they were during normal times, and the movement of people increased the incidence of infection. Hence, during the Great Famine Dublin suffered

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* This paper is a revised version of the paper read at the UTokyo-Cambridge Voices Workshop, April 2022.

[1] Joel Mokyr, *Why Ireland starved: A Quantitative and Analytical History of the Irish Economy, 1800–1850* (Abingdon: Routledge, 2006, first published in 1983), pp. 290–291; Mary E. Daly, *The Famine in Ireland* (Dundalk: Historical Association of Ireland, 1986), p. 95; Cormac Ó Gráda, *The Great Irish Famine* (Dublin: Gill & Macmillan, 1989), pp. 38–39; James S. Donnelly, Jr, *The Great Irish Potato Famine* (Stroud: Sutton Publishing, 2001), p. 121; Cormac Ó Gráda, 'Ireland's Great Famine. An Overview', in Ó Gráda, Richard Paping and Eric Vanhaute (eds.), *When the Potato failed: Causes and Effects of the 'Last' European Subsistence Crisis, 1845–1850* (Turnhout: Brepols Publishers, 2007), pp. 48–49.

from epidemics brought in by those flooding into the city, with emergency medical relief becoming a challenge for the authorities.

In Ireland, the historiography of the Great Famine began to flourish in approximately 1995, prompted by the 150th anniversary of its outbreak. Aspects of the Great Famine in Dublin City were also analysed.[2] In addition, there has been a considerable accumulation of studies on the history of medicine, including that of Dublin City.[3] However, emergency medical relief in Dublin during the Great Famine remains a relatively neglected subject.[4]

The fever

The principal epidemic diseases before and during the Great Irish Famine were typhus and relapsing fever, collectively called 'the fever' by contemporaries.[5] The census

[2] Raymond J. Raymond, 'Dublin: The Great Famine 1845–1860', *Dublin Historical Record*, vol. 33, no. 3, 1980; Cormac Ó Gráda, 'Famine in Dublin City', in Ó Gráda, *Black '47 and beyond: The Great Irish Famine in History, Economy and Memory* (Princeton: Princeton U. P., 1999); Timothy W. Guinnane and Cormac Ó Gráda, 'Mortality in the North Dublin Union during the Great Famine', *Economic History Review*, vol. 55, no. 3, 2002; Margaret Preston, '"We cannot but regret the Great Delay": Reflections on the Writings of the North Dublin Union Guardians during the Famine', in David A. Valone (ed.), *Ireland's Great Hunger, Volume 2: Relief, Representation and Remembrance* (Lanham, MD: University Press of America, 2010); Emily Mark-FitzGerald, Ciarán McCabe and Ciarán Reilly (eds.), *Dublin and the Great Irish Famine* (Dublin: University College Dublin Press, 2022).

[3] T. P. O'Neill, 'Fever and Public Health in Pre-Famine Ireland', *Journal of the Royal Society of Antiquaries of Ireland*, vol. 103, 1973; Joseph Robins, *The Miasma: Epidemic and Panic in Nineteenth-Century Ireland* (Dublin: Institute of Public Administration, 1995); Greta Jones and Elizabeth Malcolm (eds.), *Medicine, Disease and the State in Ireland, 1650–194*0 (Cork: Cork U. P., 1999); Laurence M. Geary, *Medicine and Charity in Ireland 1718–1851* (Dublin: University College Dublin Press, 2004); Gary A. Boyd, *Dublin, 1745–1911: Hospitals, Spectacle and Vice* (Dublin: Four Courts Press, 2006); Davis Coakley and Mary Coakley, *The History and Heritage of St James's Hospital, Dublin* (Dublin: Four Courts Press, 2018); Margaret DeLacy, 'Fever Hospitals in Ireland, 1780, 1797–1806', SHS Web of Conferences 136, 02007 (2022), Matters of Containment 2020. There are biographies of eminent medical men during the Famine: Eoin O'Brien, *Conscience and Conflict: A Biography of Sir Dominic Corrigan 1802–1880* (Dun Laoghaire: Glendale, 1983); Selwyn Taylor, *Robert Graves: The Golden Years of Irish Medicine* (London and New York: Royal Society of Medicine Services, 1989); Davis Coakley, *Robert Graves: Evangelist of Clinical Medicine* (Dublin: Irish Endocrine Society, 1996).

[4] William P. MacArthur, 'Medical History of the Famine', in R. Dudley Edwards and T. Desmond Williams (eds.), *The Great Famine: Studies in Irish History, 1845–52* (Dublin: Lilliput Press, 1994, first published in 1956); Peter Froggatt, 'The Response of the Medical Profession to the Great Famine', in E. Margaret Crawford (ed.), *Famine: The Irish Experience 900–1900: Subsistence Crises and Famines in Ireland* (Edinburgh: John Donald Publishers, 1989). These pioneering works do not deal specifically with Dublin City.

[5] MacArthur, 'Medical History of the Famine', pp. 265, 278; Robins, *Miasma*, p. 33. Geary adds typhoid

of Ireland recorded 192,937 deaths by 'fever' for the years 1845–1850 (inclusive) as the biggest cause of the total deaths of 1,072,266 in these years.[6] The death figures of the 1851 census have been examined closely by modern historians, who confirm that 'the fever' was the most important single factor.[7] The fever was not new to contemporaries; Ireland was hit by massive outbreaks of typhus several times in the first three decades of the nineteenth century.[8] The worst outbreak, between 1816 and 1819, may have killed 65,000 people.[9] The years 1831–1841 saw no major epidemic, but fever spasmodically occurred in various locations, resulting in 112,072 deaths.[10] These facts do not indicate that Ireland lacked medical resources; the medical limitations of the day did not allow medical institutions to effectively suppress fever. Robert Graves, a distinguished contemporary physician, may have been a little premature to declare in 1835, 'in no country in Europe is the treatment of fever so well understood as in Ireland, and in no country does medical science achieve such wonderful victories over this formidable antagonist'.[11] At the same time, however, on the eve of the Famine, the medical profession and legislators of Ireland could congratulate themselves on the work of the past forty years, which had provided the country with 101 fever hospitals, workhouses open in all 130 unions (each with an infirmary), a comprehensive if uneven network of 664 dispensaries with a backup of county infirmaries, elite teaching hospitals (mainly in Dublin), and distinguished staff. These institutions offered free medical treatment, with expenses covered by local taxes and voluntary subscriptions. Although in many ways deficient from today's point of view, according to a medical historian these facilities were adequate for normal demand; by the standards of much of Europe, they were lavish.[12]

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to the list, *Medicine and Charity in Ireland*, p. 70. However, the senior physician of Cork Street Fever Hospital allegedly recorded that only one case of typhoid fever was seen there. Cited in MacArthur, 'Medical History of the Famine', p. 282.

[6] The figure of 192,937 was originally given by MacArthur, who referred to the census without specifying the volume or page numbers. MacArthur, 'Medical History of the Famine', p. 308. The sum total of the death figures by fever given for each year between 1845 and 1850 in the census correspond to his figure. British Parliamentary Papers, *Census of Ireland 1851, Part V, Table of Deaths*, vol. 1, 1856, XXIX.261, table I, pp. 660–663.

[7] Cormac Ó Gráda with Joel Mokyr, 'Famine Disease and Famine Mortality', in Ó Gráda, *Ireland's Great Famine: Interdisciplinary Perspectives* (Dublin: University College Dublin Press, 2006), pp. 74–76.

[8] Robins, *Miasma*, p. 32.

[9] O'Neill, 'Fever and Public Health in Pre-Famine Ireland', p. 10.

[10] Robins, *Miasma*, p. 115.

[11] R. J. G. [Robert James Graves], 'Review of *An Exposition of the Nature, Treatment, and Prevention of Continued Fever*, by Henry M'Cormac, M. D.', *Dublin Journal of Medical and Chemical Science*, vol. 7, 1835, p. 456. I am grateful to Professor David Dickson for informing me about this source.

[12] Froggatt, 'The Response of the Medical Profession to the Great Famine', pp. 135–139.

The fact was that 'the fever' during the Great Famine was not a normal phenomenon. While the government was far from blameless for the Famine's huge death toll, misjudgement should not be confused with neglect, at least as far as emergency medical relief was concerned. Between 1847 and 1850, a total of 373 temporary fever hospitals were opened using grants advanced by the government in various places throughout the country, and 473 medical doctors were employed to deal with famine fever.[13] During this period, 579,721 patients were treated in these hospitals,[14] a huge number for a country with a population of about 8.5 million people in 1845.[15]

Situation in Dublin

What happened in Dublin City during the Great Famine? It is estimated that the city suffered 24,288 excess deaths from various causes between 1846 and 1850, a relatively light number of casualties compared to the same author's calculation of the total loss of 800,645 people in Ireland.[16] However, the death figures do not tell the entire story. Some contracted fever but did not perish. How many people entered and were then discharged from Dublin fever hospitals? According to one report, 14,766 fever patients received medical treatment in various places in Dublin in March 1847.[17] This is an extraordinary figure for a city with a population of 232,726 people (as of 1841).[18] In fact, the author of the article in which the figure was presented did not specify any sources, and I found no evidence to corroborate the figure. Parliamentary papers reported that

[13] Cecil Woodham-Smith, *The Great Hunger: Ireland 1845–1849* (London: Penguin Books, 1991, first published in 1962), p. 198.

[14] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850, Presented to both Houses of Parliament by Command of Her Majesty* (Dublin: Her Majesty's Stationary Office, 1852), p. 69. The number is reached by adding that of those remaining at the end of the preceding month and that of those admitted newly in the next. Hence, a patient staying for longer than a month was double counted. The average duration of stay for a fever patient at a temporary fever hospital of Dublin was 23 days in the north and 24.5 days in the south. [Henry Kennedy], 'Report on the Recent Epidemic Fever in Ireland', *Dublin Quarterly Journal of Medical Science*, vol. 8, no. 1, 1849, footnote, Information from Dr. Nalty, pp. 60–61. This double counting may account for the gap between the two different numbers of patients presented in the report. See pages 22–23 below.

[15] Cormac Ó Gráda, *Ireland: A New Economic History 1780-1939* (Oxford: Clarendon Press, 1994), p. 69.

[16] S. H. Cousens, 'Regional Death Rates in Ireland during the Great Famine, from 1846 to 1851', *Population Studies*, vol. 14, no. 1, 1960, pp. 67–68.

[17] [E. Evans], 'History of Dublin Hospitals and Infirmaries, from 1188 till the Present Time, No. XXVI. Fever Hospital and House of Recovery, Cork Street', *Irish Builder*, vol. 39, no. 906, 15 Sept. 1897, p. 183.

[18] British Parliamentary Papers, *Report of the Commissioners on Census of Ireland, for the Year 1841*, 1843, XXIV.1, p. 18.

Dublin City had four hospitals capable of treating fever patients: Cork Street Fever Hospital with thirty-six rooms containing 257 beds, and Meath Hospital and County of Dublin Infirmary with wards of thirty-six beds for fever patients, were both in the south of the city,[19] while the north of the city had Whitworth Fever Hospital (not to be confused with Whitworth Hospital, one of the city's three House of Industry hospitals), which could hold 128 fever patients, and Hardwicke Fever Hospital with 120–144 beds.[20] Of course, the city could expand its medical capacity in an emergency by setting up temporary accommodation, as it had done in 1817–19, 1826, and 1837,[21] but in the case of the Great Famine, it was only after May 1847 that emergency medicine, capable of treating thousands of patients, was ready in Dublin, as will be discussed below.

Regardless of whether the figure of 14,766 is true, there is no doubt that fever patients greatly overcrowded the capacity of ordinary hospitals in Dublin during the Great Famine. The question is, how did the civil and medical authorities try to cope with the situation before and after May 1847? In fact, the government was not slow to act. In the early nineteenth century, the connection between famine and epidemic fever was a 'well known and frequently observed' medical topic, as a contemporary medical doctor commented.[22] Hence, in December 1845, the Poor Law Commissioners, the central poor relief organisation, issued letters to local poor law guardians suggesting the establishment of temporary fever hospitals.[23] Furthermore, the government established a Central Board of Health in March 1846 under the Temporary Fever Act (9 Vic. c. 6), by which the board had the authority to require local poor law guardians to establish temporary fever hospitals in regions where epidemic fever was likely to break out. Dominick Corrigan, an influential medical doctor and the key figure on the board, considered famine and fever to

[19] British Parliamentary Papers, Charitable Institutions (Dublin), *Copy of a Letter from the Under Secretary to the Lord Lieutenant of Ireland to the Commissioners Appointed to report on Certain Charitable Institutions in Dublin; of the Warrant Appointing the Commission; and of the Reports of the Commissioners*, 1842, XXXVIII.7, pp. 98, 136. Dr Steevens's Hospital also temporarily admitted fever patients at the government's request by setting up tents to accommodate them. *Ibid.*, pp. 90–91.

[20] British Parliamentary Papers, Poor Law Commissioners, *Report on Medical Charities, Ireland; Supplementary Appendix*, 1841, XI.1, 101, p. 79; Do., Select Committee on Dublin Hospitals, *Report, Proceedings, Minutes of Evidence, Appendix, Index*, 1854, XII.1, Q1777.

[21] O'Neill, 'Fever and Public Health in Pre-Famine Ireland', pp. 10, 15–16.

[22] 'Dr Black in Reply', in F. Barker and J. Cheyne, *An Account of the Rise, Progress and Decline of Fever Lately Epidemical in Ireland, together with Communications from Physicians in the Provinces, and Various Official Documents* (London: Baldwin, Cradock and Joy, 1821), vol. 1, p. 357. See also O'Neill, 'Fever and Public Health in Pre-Famine Ireland', pp. 1–2.

[23] British Parliamentary Papers, Poor Law Commissioners, *Appendices to the Twelfth Annual Report*, 1846, XIX.33, pp. 92–94.

be cause and effect, although he did not take a contagionist view of epidemics.[24]

The epidemic fever at this stage was not as widespread as it was later. A member of one of the two poor law boards of guardians of Dublin testified in a parliamentary committee in March 1846, 'At present I think there is quite enough accommodation in our hospitals for all fever patients in Dublin and in the county.'[25] The total number of applications from localities to the Central Board of Health for intervention amounted to only seventeen over a period of five months, and only four of the 130 poor law unions had set up temporary fever hospitals by the end of August. Since the numbers were not large, the board ceased its sittings, and the Temporary Fever Act was allowed to expire in August.[26]

The spread of epidemic

In hindsight, the government was too soon in dissolving the board and too slow in remedying its mistakes. In January 1847 the Irish Chief Secretary made a surprising declaration in parliament, stating 'the country was never more free[*sic*] from fever in its true character than it was at present'.[27] It should be added that the medical profession was not without blame in this regard. The *Dublin Medical Press*, an influential medical journal, had criticised the government in August 1846 for overestimating the possibility of an epidemic fever outbreak.[28] A medical doctor recollected in 1849 that 'the epidemic fever' in Dublin had begun about the turn of the years of 1846–47.[29] In fact, the situation seems to have been deteriorating rapidly in the city, as well as in the country, in the latter half of 1846.[30] Cork Street Fever Hospital was treating 262 patients at the end of September;[31] the corresponding numbers were 203 and 201 at the end of July and August,

[24] D. J. Corrigan, *On Famine and Fever as Cause and Effect in Ireland; with Observations on Hospital Location, and the Dispensation in Outdoor Relief of Food and Medicine* (Dublin: J. Fannin & Co., 1846), esp. p. 32; Froggatt, 'The Response of the Medical Profession to the Great Famine', pp. 145–146.

[25] Evidence of John Barlow, 10 Mar. 1846, British Parliamentary Papers, Select Committee of House of Lords, on Laws relating to Relief of Destitute Poor, and Operation of Medical Charities in Ireland, *Report, Minutes of Evidence, Appendix, Index*, 1846, XI Pt.I.1, XI Pt.II.1, 697, Q. 3133.

[26] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, p. 1; Froggatt, 'The Response of the Medical Profession to the Great Famine', pp. 141–142.

[27] Cited in Froggatt, 'The Response of the Medical Profession to the Great Famine', p. 142.

[28] Froggatt, 'The Response of the Medical Profession to the Great Famine', pp. 140–141.

[29] [Kennedy], 'Report on the Recent Epidemic Fever in Ireland', p. 47.

[30] Froggatt, 'The Response of the Medical Profession to the Great Famine', p. 142.

[31] *Saunders's Newsletters*, 6 Oct. 1846.

respectively.[32] Given that no patient could enter the hospital without the diagnosis of a physician belonging to the institution,[33] we can say that an epidemic of fever broke out in Dublin in early autumn. The number rose to 299 by the end of November;[34] consequently, the hospital set up temporary sheds of 180 beds to accommodate excess patients in January 1847.[35]

However, the situation continued to worsen. At the end of January, Cork Street Fever Hospital was treating 347 patients, and the number of patients soared to 458 a month later.[36] In March, the guardians of the North and South Poor Law Unions complained that they were troubled by delays in transferring patients who contracted fever in the workhouses to the hospital.[37] At one time, there were up to 400 outstanding tickets to enter the hospital and as many as eighty applications for admission could be made in one day.[38] Many of those who were not permitted to enter may have perished in their homes or on the roadside, but their numbers cannot be confirmed. Dublin seems to have been approaching the so-called collapse of the medical system, which necessitated more dynamic actions from its medical institutions and relief organisations.

The poor law guardians were the first to act, presumably because having fever patients in their crowded workhouses was potentially dangerous. On 22 March 1847 the South Dublin guardians decided to rent Tenter House, a building originally constructed as a weavers' workplace, near Cork Street Fever Hospital.[39] In May, it became fully operational and approximately fifty patients were treated for fever.[40] However, it soon became evident that the house was not sufficiently large to cope with the situation.[41] In North Dublin, the poor law guardians decided on the 31st of March to procure some type of building to treat fever patients in the workhouse.[42] What came out of this decision is unclear, but North Dublin could also use Hardwicke Fever Hospital, one of the three hospitals of the Dublin House of Industry (workhouse), which set up sheds on the 22nd of

[32] *Saunders's Newsletters*, 3 Aug., 2 Sept. 1846.

[33] Eugene Dudley, 'A Silent Witness: Cork Street Fever Hospital', *Dublin Historical Record*, vol. 62, no. 1, 2009, p. 111.

[34] *Saunders's Newsletters*, 2 Dec. 1846.

[35] *Hereford Times*, 16 Jan. 1847. The 'sheds' may have been tents. Select Committee on Dublin Hospitals, *Report, Proceedings, Minutes of Evidence, Appendix, and Index*, 1854, XII.1, Q1361; MacArthur, 'Medical History of the Famine', pp. 297–298.

[36] *Saunders's Newsletters*, 2 Feb., 2 Mar. 1847.

[37] *Freeman's Journal*, 5, 18 Mar. 1847; *Saunders's Newsletters*, 5, 18 Mar. 1847.

[38] [Kennedy], 'Report on the Recent Epidemic Fever in Ireland', p. 48.

[39] *Freeman's Journal*, 23 Mar. 1847.

[40] *Saunders's Newsletters*, 14, 21, 28 May 1847; *Freeman's Journal*, 22 May 1847.

[41] *Saunders's Newsletters*, 12 June 1847.

[42] *Freeman's Journal*, 1 Apr. 1847.

April to accommodate fever patients.[43] However, it soon became overcrowded and began to refuse new admittances in May.[44]

Second, some Dublin voluntary hospitals other than Cork Street Fever Hospital also attempted to deal with the crisis. By April 1847, Whitworth Fever Hospital was treating patients in tents.[45] Sir Patrick Dun's Hospital allocated thirty beds for fever patients,[46] and a total of 676 fever cases were admitted there in the year of 1847.[47] Dr. Steevens's Hospital treated eighty-eight patients between 1847–1848.[48] Although the precise details of the medical treatment at these hospitals remain unclear, the number of patients they accepted was not large.

Finally, but most decisively, the Dublin relief organisations utilised the authority given by the new Fever Act (10 & 11 Vic. c. 22) passed belatedly in parliament in April 1847. The act stipulated that the re-appointed Central Board of Health could send a certificate of the necessity of medical relief for the fever patients to the Relief Commissioners, the central administrators of the Great-Famine relief. The commissioners would issue a warrant to a local relief committee, a body appointed by order of the Irish Lord Lieutenant, to set up and run a temporary hospital and a dispensary for fever patients. The expenses of such temporary fever hospitals and dispensaries were to be covered by the government. The act in effect suspended local poor law guardians' authority and burden of relief and placed these on the shoulders of local relief committees, but in certain regions, including Dublin, the functions of the two local organisations were not so clear-cut.[49] In any event, in September 1848, when the situation became less tense, the management and financing of temporary fever hospitals and dispensaries was returned to local poor law guardians by a subsequent act (11 & 12 Vic. c. 131).

Fever sheds

From February 1847 to September 1849, 576 applications were made from various localities across the country for the intervention of the Central Board of Health in the provision of temporary fever hospitals, and the board issued 373 certificates in response. Between 1847 and 1850, 332,462 fever patients were treated in these

[43] Information from Dr. Nalty, p. 62.
[44] *Saunders's Newsletters*, 6, 18 May 1847; *Freeman's Journal*, 18 May 1847.
[45] *Freeman's Journal*, 24 Apr. 1847.
[46] *Saunders's Newsletters*, 12 June 1847.
[47] Information from Dr. Nalty, p. 60.
[48] Information from Dr. Nalty, p. 60.
[49] Woodham-Smith, *The Great Hunger*, p. 201.

hospitals.[50] The North Dublin Poor Law Union applied for a certificate from the Central Board of Health to set up a temporary fever hospital on the 4th of May, and on approximately the 14th of the same month, the South Union applied.[51] Dublin was not much behind the other regions; a large majority of the total applications from the entire country were made after South Dublin.

Shortly after they applied to the Central Board of Health, the North Dublin poor law guardians began investigating several places to set up sheds as a temporary fever hospital.[52] A property belonging to a medical doctor of the union was chosen, but on the morning of the day the building contractor began the work, approximately 500 people who were fearful of contagion assembled on the site to oppose the erection of the sheds, and the proprietor was obliged to apply to the board of guardians for the cancellation of his contract.[53] In the evening of the same day, a meeting of nearby residents was held, where the doctor explained his offering the site by saying that he had a non-contagionist view of fever.[54] After toying with the idea of a different place, the North Union eventually decided on the 24th of May to use the site in Drumcondra.[55] Table 1 lists the number of admissions (Ad.), discharges (Di.) and deaths (De.) at this temporary hospital between June 1847 and July 1848, when the hospital was closed.[56]

Table 1: Drumcondra Temporary Fever Hospital, June 1847–July 1848.

	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Ad.	302	794	820	1077	749	652	781	336	306	261	167	72	2	0
Di.	281	486	608	907	732	634	789	479	270	276	198	102	38	6
De.	15	32	38	76	80	49	86	37	31	22	20	8	0	0

The total numbers of admissions, discharges, and deaths were 6,319, 5,806 and 494, respectively. As the average period a patient with fever spent at a temporary fever

[50] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, pp. 2–4. According to the table in Appendix A of this report (p. 66), the final application was made in October 1849.

[51] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, p. 60. Although this report says that the applications were made by both North and South on the 4th of May, newspapers tell that the south lagged behind. *Dublin Evening Mail*, 24 May 1847; *Freeman's Journal*, 24, 25, 29 May 1847; *Saunders's Newsletters*, 29 May 1847.

[52] *Saunders's Newsletters*, 18 May 1847.

[53] *Freeman's Journal*, 20, 21 May 1847; *Saunders's Newsletters*, 20 May 1847.

[54] *Freeman's Journal*, 21 May 1847.

[55] *Freeman's Journal*, 22, 25 May 1847; *Saunders's Newsletters*, 22 May 1847.

[56] *Saunders's Newsletters*, 27 July 1848.

hospital in Dublin was 23–24.5 days,[57] the admission of 1,077 patients in September 1847 meant that medical relief was being provided on a massive scale.[58]

Because the South Union was lagging behind the North, it was urged by a newspaper to follow its neighbour's example.[59] On 28 May, South Dublin Union acknowledged the arrival of a warrant from the Relief Commissioners dated 18 May. Subsequently, on 11 June, the relief committee decided to establish its own temporary fever hospital in sheds at Kilmainham.[60] Its report, based on a different calculation from that of Drumcondra Hospital report, gives a monthly average number of patients (Pa.) being treated there.

Table 2: Kilmainham Temporary Fever Hospital, June 1847–July 1848.

	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Pa.	n.d.	245	500	578	756	796	676	569	514	332	225	173	117	44

Kilmainham Hospital report provides other figures: between June 1847 and July 1848, the hospital received 6,878 patients, of whom 6,196 were cured and discharged, while 682 died in the hospital.[61] The largest number of patients treated in a single day was 852 on the 12th of November 1847.[62] The opening of the two temporary fever hospitals on that scale must have changed the medical situation of the city, which can be inferred from the fact that in the single month of June 1847, when the North Dublin temporary hospital began receiving patients, 778 fever patients were refused admittance at the ordinary fever hospitals in Dublin. Although the following month saw a slight improvement in the situation, 553 met the same fate.[63] In contrast, only 100 were refused at the temporary fever hospitals from August 1847 to November 1847.[64]

It seems that such sheds for temporary fever hospitals were constructed in many places throughout the country. A newspaper in Sligo observed, '"Fever sheds, fever

[57] See footnote 14 above.

[58] At the height of the typhus fever of 1817–1819, there were over 3,000 admissions in one month (October 1818) into various fever hospitals in Dublin. O'Neill, 'Fever and Public Health in Pre-Famine Ireland', p. 10.

[59] *Saunders's Newsletters*, 14 May 1847.

[60] *Freeman's Journal*, 29 May 1847; *Saunders's Newsletters*, 29 May, 12 June 1847. The lapse of ten days seems to have been caused by some administrative disarray.

[61] *Freeman's Journal*, 5 Aug. 1848. Because the latter figures are real numbers, they do not correspond with the sum total of the average numbers given in Table 2.

[62] *Saunders's Newsletters*, 7 Jan. 1847.

[63] MacArthur, 'Medical History of the Famine', p. 302.

[64] *Saunders's Newsletters*, 20, 21, 25 Sept., 4 Oct., 13 Nov. 1847; *Freeman's Journal*, 25 Sept., 13 Nov. 1847. This figure may be incomplete, and possibly an overstatement, but it seems to serve its purpose.

sheds" is now our cry. If they be not speedily erected, typhus fever will destroy one-fifth of the population in this locality.'[65] To design the sheds, Ireland had an energetic and efficient architect, George Wilkinson, who was employed by the Irish Poor Law Commissioners to design the country's workhouses.[66] Already in January 1846, the commissioners suggested to local poor law unions that they establish temporary fever sheds according to Wilkinson's plan.[67] When the necessity for temporary fever hospitals was widely recognised, the Central Board of Health instructed Wilkinson to prepare another plan of sheds of 'a simple and economical construction' (Figure 1).[68] Erecting sheds did not require significant construction time. It was reported from the South Union that one of the two contracted builders for erecting sheds for 200 patients finished the

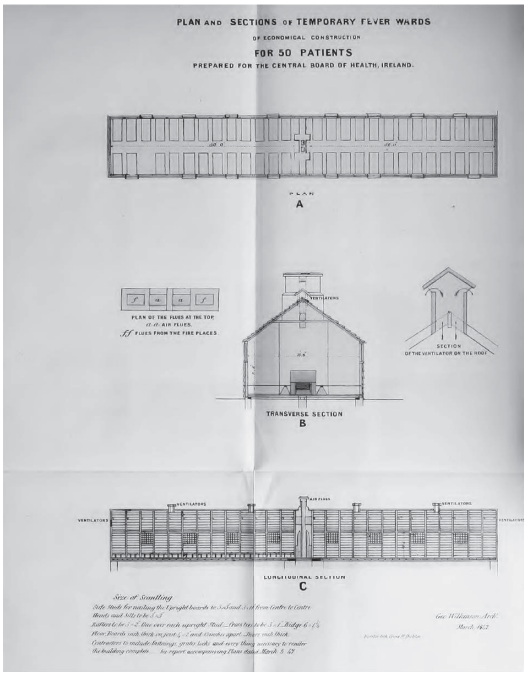

Figure 1: Plan of temporary fever wards (sheds).[70]

[65] *Freeman's Journal*, 18 May 1847; *Saunders's Newsletters*, 20 May 1847.
[66] Walter Raftery, 'Wilkinson the Workhouse Builder 1839–54', *Galway Roots*, 1995, vol. 3, pp. 127–132.
[67] *Appendices to the Twelfth Annual Report of the Poor Law Commissioners*, 1846, XIX. 33, pp. 92–95.
[68] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, pp. 26–7, 43–44.

process in four days and the other in eight days.[69]

Although Wilkinson's plan was not universally adopted,[71] it seems to have served as the model for Dublin's temporary fever hospitals. The above-mentioned Dr. Corrigan recommended that the North Dublin Union adopt Wilkinson's plan.[72] In the South, an accusation was made at a relief meeting that the cost of erecting the sheds exceeded Wilkinson's estimates.[73]

Medical care in Dublin sheds

According to the admission and death figures cited above, the death-admission rate was slightly above 1/13 (6,319 and 494) in the North Dublin temporary fever hospital, and approximately 1/10 in South Dublin (6,878 and 682). Considering that the figures related to temporary sheds in a crisis period, these rates do not seem particularly bad. The death-admission rate of Cork Street Fever Hospital was slightly below 1/11 (260/2,915) in an 'ordinary' year of 1845.[74] The worst 'mortality' rate for that hospital was 1/8 in March 1847, after which its record improved considerably; its mortality rate for the whole year of 1847 was reported as about 1/12.[75] The opening of the temporary fever hospitals may have contributed to this improvement. Dublin fared better than other regions. In Ireland as a whole, 332,462 patients received medical treatment at various fever hospitals, of whom 34,622 (slightly above 1/10) died between July 1847 and August 1850.[76]

The difference between the rates in North and South Dublin is too large to ignore. It appears that some confusion existed during the initial days of the temporary fever hospital in Kilmainham in South Dublin. In late August 1847, Dr. John Curran, a distinguished Dublin doctor, visited the site and highlighted its miserable condition in the following letter in the *Freeman's Journal*:

> . . . no less than twelve persons, men, women, and children, lying

[69] *Saunders's Newsletters*, 15 Sept. 1847.
[70] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, appendix.
[71] Robins, *Miasma*, p. 132.
[72] *Dublin Evening Post*, 6 Apr. 1847.
[73] *Freeman's Journal*, 22 Sept. 1847.
[74] George A. Kennedy, *Medical Report of the House of Recovery and Fever Hospital, Cork-Street, Dublin, for Two Years, from 1st of January, 1844, to the 31st of December, 1845* (Dublin: Webb and Chapman, 1846), p. 50.
[75] [Kennedy], 'Report on the Recent Epidemic Fever in Ireland', p. 50.
[76] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, p. 4.

> indiscriminately along the pathway, and in the gutter, awaiting their turn to be admitted. . . . Inside the hospital enclosure there is a considerable space of ground between the gate and the temporary hospitals or sheds, as they are called. This space I found strewn all over with building materials, straw, &c., whilst a little to the right of the entrance I observed a small shed roughly covered with boards, but completely open in front like the sheds used or in farmyards for covering dung and rubbish. . . . Hearing groans proceeding from it I went closer to it, and imagine my surprise and indignation at finding it filled by thirty-five human beings of all ages, who were heaped indiscriminately, some with their heads and some with their feet presented towards me on a little straw thrown down on the ground. The moment I was observed I was assailed with the most touching appeals for compassion and relief, whilst some of the poor creatures kept calling out for a little water to quench their thirst. On enquiry I was informed by several of those unfortunates that they had been lying thus for three days without there being any one to afford them the smallest relief . . .[77]

A few days later, the medical officer at the Kilmainham temporary hospital sent a letter of refutation to the same newspaper:

> Much credit would be due to Doctor Curran for making the matter public, but that he pictured everything in the highest colours, and was inaccurate in most. . . . It is impossible for a casual visitor, professional or otherwise, to estimate the difficulty and delay to be encountered in the management of an institution like this; he does not know the working of it, and, without reflection, hastily arrives at the conclusion that it is wise to turn alarmist, and raise public opinion against those who act to their best endeavours the length they are permitted to go.[78]

Half-admitting that there was dysfunction, the medical officer blamed the government for its ill-judged decision to shrink the temporary accommodation of Cork Street Fever Hospital, which increased the burden on the South Dublin temporary fever hospital. In fact, Curran's chief motive for writing his letter was to accuse the government of having made the wrong decision.

In any event, Dublin's temporary fever hospitals, once on track, seem to have

[77] *Freeman's Journal*, 24 Aug. 1847.
[78] *Freeman's Journal*, 27 Aug. 1847.

functioned as more than mere emergency hospitals. Their regulations stipulated that every patient should be provided with a separate bedstead, two sheets, two blankets, a rug, a pillow, and a night-shirt on admission. The night shirts, sheets, and bedstraw were to be changed at least once a week and the building cleaned every day. The most striking aspect of patient treatment was the meals. There were several types of meals, depending on the patient's condition. In the case of a full diet, three meals a day were provided, with a total of eighteen ounces (510*g*) of bread, 1/2 lb (227*g*) of meat, two pints (1.14*l*) of milk and one pint (568*ml*) of broth.[79] These meals were not particularly rich, but were enough to keep an adult healthy. What was planned was not necessarily actually offered,[80] but there is evidence that the temporary fever hospitals in Dublin were not stingy. A voice was raised at a meeting of the South Union criticising the over-richness of the shed meals.[81] A complaint was made to the North Union about the expense of meals offered in the sheds.[82] It should be added that the Dublin temporary fever hospitals were relatively well-staffed. The South Hospital at Kilmainham had two chaplains, three apothecaries, and one registrar and his assistant, together with one matron and eighty-four nurses and servants, forty-two laundress and ward-maids, and five men servants.[83] In short, being in a shed must have been physically better than being at home for the hunger-stricken people who came to Dublin during the Great Famine.

Medical relief on this scale and of this quality was expensive. The total cost of the temporary fever hospital in North Dublin from 31 May 1847 to 22 July 1848 was £11,653, and that of South Dublin from 24 June 1847 to 28 July 1848 was £15,100.[84] Added together, this represented a substantial amount; Dublin Corporation's annual budget for 1846 was estimated to be £30,321 (income) and £32,502 (expenditure).[85] It should be added that a substantial portion of the expenses for the two hospitals was covered by government grants, in accordance with the stipulations of the Fever Act (10 & 11 Vic. c. 22). In North Dublin, the grant amounted to £5,854 and in South Dublin, £7,256.[86]

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[79] *Report of the Commissioners of Health, Ireland, on the Epidemics of 1846 to 1850*, pp. 57–59.

[80] Robins, *Miasma*, p. 133.

[81] *Saunders's Newsletters*, 19 Nov. 1847.

[82] *Freeman's Journal*, 23 Sept. 1847; *Saunders's Newsletters*, 23 Sept. 1847.

[83] *Saunders's Newsletters*, 7 Jan. 1848.

[84] *Freeman's Journal*, 27 July, 5 Aug. 1848; *Saunders's Newsletters*, 27 July 1848.

[85] *Freeman's Journal*, 7 Aug. 1845.

[86] *Saunders's Newsletters*, 20 Jan. 1848; *Freeman's Journal*, 5 Aug. 1848. The grant of £5,854 for the North Union was reported in January 1848, well before the closure of the temporary hospital, while that of £7,256 for the South Union was reported in August 1848. However, the operating costs of the temporary fever hospital appear to have been covered initially by government grant, and subsequently

Financial matters lead to another important aspect of emergency medical relief during the Great Famine: the devotion of medical practitioners. It is true that bitter internal strife occurred among them, a well-known aspect of which was opposition to the emolument of five shillings per day, offered for relief treatment at temporary fever hospitals. Over 1,000 Irish surgeons and physicians, more than half the country's total, signed a petition sent to the Irish Lord Lieutenant, head of the Irish government, complaining about the emolument, which they judged below 'the great value and importance of the duties required of them'. The amount of five shillings was based on the Central Board of Health's recommendation and its central figure, Dr. Corrigan, was roundly blamed for not pressing for more.[87] Behind the quarrel seems to have lain envy of Corrigan and resentment of the government by the Dublin medical magnates who felt estranged for not being consulted over the appointment of the board staff.[88] However, a more fundamental cause can also be identified. The Poor Law had placed the medical profession under government control for the first time in Irish history.[89] This process, which was unwelcome to doctors, was accelerated by the Famine's emergency medical relief measures.

The medical practitioners did not desert their duties, however. The above-mentioned Curran found it degrading to receive five shillings and he preferred to work without emolument; subsequently, he contracted the fever and died in Dublin in September 1847.[90] His case was no exception. It is noteworthy that many others were undaunted by the prospect of contagion. Of the 473 temporary medical officers appointed during 1847–48, thirty-six died on duty,[91] a death rate (about 1/13) almost as high as that of the patients. As a historian of the Famine observed, the courage of those who came to help the people during the epidemic is 'beyond praise'.[92]

In medical history, it is always difficult to determine which measure would have been the most effective in containing a disease. However, it seems fair to affirm that what was offered at the temporary fever hospitals in Dublin City during the Great Famine may be regarded as the best available medical care of the time, when medicine effectively meant little more than countermeasures.

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by local taxation. British Parliamentary Papers, Relief Commissioners, *Fifth, Sixth and Seventh Reports, Correspondence*, 1847-48, XXIX.27, pp. 5, 11.

[87] Froggatt, 'The Response of the Medical Profession to the Great Famine', pp. 144–145.

[88] O'Brien, *Conscience and Conflict*, pp. 222–223; Taylor, *Robert Graves*, pp. 107–108.

[89] Robins, *Miasma*, pp. 116–118.

[90] Froggatt, 'The Response of the Medical Profession to the Great Famine', p. 155, note 76.

[91] Select Committee on Dublin Hospitals*, Report, Proceedings, Minutes of Evidence, Appendix, and Index*, 1854, XII.1, Q3250.

[92] Woodham-Smith, *The Great Hunger*, p. 192.

Government Medical Officers in Historical Perspective: The Different Systems in England and Japan*

Takeshi Nagashima

The role of medical officers is a major research topic for historians of public health policy in Britain.[1] This paper is chiefly concerned with Chief Medical Officers (CMO) at the central government level, although it is also important to examine the work of Medical Officers of Health (MOH) at the local level. The first central government medical officer in England, John Simon, was appointed in 1855 and remained in this post until 1876. Although there were several organisational changes in central government thereafter, the post of CMO still exists and is seen as playing an important role in anti-Covid-19 policy.

This paper briefly examines the history of English CMOs and points out that their assigned roles seem different from those given to senior government medical officials in Japan. There, such officials seem less visible, which may be related to the obscurity of the Covid-19 policymaking process over the past two years and possibly health policymaking in general in Japan.

Chief Medical Officers in England

Let us first examine English CMOs.[2] John Simon laid the foundations. A surgeon at St Thomas' Hospital, he held the post of MOH for the City of London from 1848 onwards, and was appointed the first Medical Officer to the General Board of Health in 1855 after Edwin Chadwick was obliged to resign from the Board. If Chadwick was 'the initiator of Victorian sanitary reform', Simon can be called 'the architect of

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* This paper was read at the UTokyo-Cambridge Workshop: Covid-19 in Historical Perspectives, hosted by the Strategic Partnerships Project and co-hosted by the Humanities Centre, University of Tokyo, held online, on April 5, 2022.

[1] In studying the social history of public health in Britain and Japan, I have been much stimulated by the works of Professor Simon Szreter, today's main speaker, particularly *Health and Wealth: Studies in History and Policy* (Rochester: The University of Rochester Press, 2005).

[2] For a useful account of the work and careers of successive English CMOs, see S. Sheard and L. Donaldson, *The Nation's Doctor: The role of the Chief Medical Officer 1855–1998* (Oxford: Radcliffe Publishing, 2006).

preventive medicine' in England. Under his guidance, the Public Health Acts of 1872 and 1875 were put in place, which, among other things, made compulsory the appointment of Medical Officers of Health by local sanitary authorities.

Simon did encounter some obstacles, especially after he became the Medical Officer of the newly founded Local Government Board (LGB) in 1871. The LGB was created by amalgamating the Medical Department of the Privy Council, headed by Simon and the Poor Law Board, the central government department supervising local poor law guardians. In the new LGB, the post of CMO was put under the control of the Permanent Secretary, who came from the Poor Law division, and Simon lost the right of free access to cabinet ministers. In addition to the Treasury's policy of balanced finance, the deterrent tendency of Poor Law administration from 1834 came to overshadow the entire LGB, including Simon's Medical Department. The department was constantly understaffed, and any plans for public health faced financial constraints.

These difficulties continued to annoy Simon's successors. According to the testimony of Arthur Newsholme, the 6th CMO of the LGB, there was a 'belief' among secretarial bureaucrats in Whitehall that 'technical advice is advice which is not to be given until called for by the secretariat who … are entirely competent to decide whether such advice is needed'.[3] In Whitehall, less importance was attached to advice from technical experts, including medical experts. In such a political and administrative culture, it was challenging for CMOs to propose innovative public health policies. During the years Newsholme held office, the influenza ('Spanish Flu') pandemic of 1918 took place. Newsholme failed to take drastic preventive measures promptly, most probably because the Lloyd George government's priority was clearly winning the war. Given the status accorded to the CMO, it was difficult for Newsholme to convince politicians and senior

England: Chief Medical Officers

		in office
1	John Simon	1855-76
2	Edward Cator Seaton	1876-79
3	George Buchanan	1879-92
4	Richard Thorne Thorne	1892-99
5	William Henry Power	1900-08
6	Arthur Newsholme	1908-19
7	George Newman	1919-35
8	Arthur MacNalty	1935-40
9	Wilson Jameson	1940-50
10	John Charles	1950-60
11	George Godber	1960-73
12	Henry Yellowlees	1973-84
13	Donald Acheson	1984-91
14	Kenneth Calman	1991-98
15	Liam Donaldson	1998-2010
16	Sally Davies	2010-19
17	Chris Whitty	2019-present

[3] A. Newsholme, *The Last Thirty Years in Public Health* (London: Allen & Unwin, 1936), p. 62.

officials to take preventive measures beyond routine public health work.

George Newman, the first CMO after the creation of the Ministry of Health in 1919, regained the right of free access to the Minister of Health without the mediation of senior secretarial officials. During Wilson Jameson's tenure (1940–50), the National Health Service (NHS) was established in 1948 by Atlee's Labour government. Jameson played a vital role in the planning of the wartime Emergency Medical Services and the creation of the NHS by acting as a bridge between the government and the medical profession. Thus, the scope of the CMO's work came to include not only the sphere of preventive public health but also health and medical service provision in general.

In the post-Second World War years, health policy became a matter of national concern and sometimes a point of contention in election campaigns; public health and medicine were no longer marginal issues in national politics. However, not all successive CMOs were successful in asserting their presence. This does not necessarily mean that some CMOs were inferior to others as the public role they were and are permitted can vary according to the political and administrative situation at the time, what issues are dealt with, and their personal characteristics and styles.

To date, there have been 17 CMOs in England, including the current holder of the position, Professor Chris Whitty. The post of CMO is now an independent position at the permanent secretary level, acting as the government's principal medical adviser and representing public health and medical officials working in the government sector. However, in practice, the CMO's opinions are not always properly listened to. According to a newspaper article, Professor Whitty was 'blindsided' by the government's decision in February 2022 to remove all Covid-19 restrictions. Scientists outside the government were concerned about this decision and demanded the CMO to explain the scientific evidence on which the decision was based.[4] Regardless of his own personal views, the CMO, as a government official, has to be accountable for every government decision related to health and medicine.

The post of CMO is unique. While CMOs are civil servants, supposedly part of a chain of command within the government department, they also have independence of speech as medical experts: they have the right to express their expert opinions from a specialist's point of view, independent of their superiors. CMOs have the right to publish independent annual public health reports and since John Simon's time, these reports have been valuable sources for historians. The independence of English CMOs is a point that I would like to compare with that of Japan's senior medical officials.

[4] 'Chris Whitty and scientists 'blindsided' by plans to scrap Covid rules in two weeks,' *Mirror*, 10 February, 2022; 'Demands grow for government science chiefs to reveal evidence backing move to lift last protective measures,' *The Guardian*, 12 February, 2022.

Many of these 17 CMOs were specifically recruited from outside to fill the office or had been recruited earlier with a view to filling this role at a later date. All had significant practical experience before becoming CMOs – for example, as local medical officers of health in earlier times and as clinicians or researchers in more recent years. Chris Whitty is an epidemiologist and was Professor of Public and International Health at the London School of Hygiene and Tropical Medicine before becoming CMO. Such career paths to CMO are another aspect that I wish to compare to the case of Japan.

Medical officials in Japanese government

The Meiji Period

If we are to pick out two heroes in the creation of Japan's public health system, they should be Nagayo Sensai (長与専斎) and Goto Shimpei (後藤新平).[5]

Nagayo was first trained as a medical practitioner by Ogata Koan (緒方洪庵) in Osaka and then by Dutch doctors in Nagasaki. In the early 1870s, the Meiji Government sent him to the United States and European countries to research public health and medical systems. He arrived in England in March 1872 when John Simon was still working at the LGB, just before the passage of the 1872 Public Health Bill. Nagayo appears to have been impressed by the principles of local self-government in the English public health system.[6] Upon returning to Japan, he was appointed the first Director of the Sanitary Bureau (衛生局) of the Home Ministry in 1875 and played a leading role in the implementation of preventive measures against cholera, which hit Japan severely from the late 1870s to the mid-1880s.

Goto Shimpei became Director of the Sanitary Bureau in 1892. As a hospital doctor in Nagoya, he was recruited to the Sanitary Bureau by Nagayo, who discovered the young Goto's zeal for public health reform. Goto was sent to Germany and learned the concept of the 'medical police' from Max von Pettenkofer at the University of Munich. Goto introduced the Infectious Diseases Prevention Act of 1897, a comprehensive law that was in effect until the end of the twentieth century.

The remarkable work accomplished by these two medical men, Nagayo and Goto, might give us the impression that the Director of the Sanitary Bureau was a post

[5] Useful accounts (written in English) of public health policy in modern Japan include W. Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge, Mass.: Harvard University Press, 1995), and C. Aldous and A. Suzuki, *Reforming Public Health in Occupied Japan, 1945–52* (London: Routledge, 2012).

[6] T. Nagashima, 'Central state initiative and local self-government in public health reform: Late-Victorian England and Meiji Japan in a comparative perspective,' *The Senshu University Annual Bulletin of the Humanities*, 37 (2007).

Japan

Directors, Sanitary Bureau, Ministry of Home Affairs

			in office	
1	Nagayo Sensai	長与専斎	1875-91	medical
2	Arakawa Kunizo	荒川邦蔵	1891-92	secretarial
3	Goto Shimpei	後藤新平	1892-93	medical
4	Takada Zenichi	高田善一	1893-95	secretarial
5	Goto Shimpei	後藤新平	1895-98	medical
6	Hasegawa Tai	長谷川泰	1898-1902	medical
7	Morita Mokichi	森田茂吉	1902-03	secretarial
8	Kubota Seitaro	窪田静太郎	1903-10	secretarial
9	Kohashi Ichita	小橋一太	1910-13	secretarial

Directors, Prevention Bureau, Ministry of Health and Welfare

1	Takano Rokuro	高野六郎	1938-42	medical
2	Katsumata Minoru	勝俣稔	1942-46	medical

equivalent to that of the CMO in England. However, there was an important difference: Sanitary Bureau directors did not have to be medically qualified. Goto was succeeded by Hasegawa Tai (長谷川泰) in 1898, who was a medical doctor. However, after Hasegawa, the Sanitary Bureau directorship became a post occupied by elite secretarial officials, most of them graduates of the School of Law at the Imperial University of Tokyo. While there were a number of medical officials working in the Sanitary Bureau, they were not promoted to Director. In the promotion system of the Japanese bureaucracy, technical officials in general were, and probably still are, graded somewhat lower than secretarial officials.[7] The fact that officials of higher secretarial grades were accorded more important and respect than that accorded to medical officials was similar to the frequent experiences of Simon and his successors. However, while the post of CMO was always occupied by a medical expert in England, there was no specialist post exclusively for medical experts at the senior director level in Japan's central bureaucracy.

The Early Showa Period

In 1938, the Sanitary Bureau was integrated into the newly founded Ministry of Health and Welfare to consolidate health policy under the wartime regime. In the new ministry, the Prevention Bureau (予防局) became responsible for preventive measures against infectious disease and health promotion in general. At this point, medical experts

[7] 新藤宗幸『権力にゆがむ専門知―専門家はどう統制されてきたのか』(朝日新聞出版，2021年)〔M. Shindo, *Expertise Distorted by Power: How have experts been controlled*, Asahi Shimbun Press, 2021〕.

returned to the directorship. Takano Rokuro (高野六郎) became the first Prevention Bureau Director, and was succeeded by Katsumata Minoru (勝俣稔).

Both were medical school graduates from the Imperial University of Tokyo but their profiles differed slightly. Takano had been a professor of bacteriology at Keio University and then moved to the Sanitary Bureau as a senior medical official. On the other hand, Katsumata became a Sanitary Bureau junior official at a younger age and then obtained promotions within the Home Ministry Sanitary Bureau and the Prevention Bureau of the new Health and Welfare Ministry. While Takano was an established bacteriologist when he joined the Bureau, Katsumata was less academic than Takano. Instead, Katsumata had good administrative skills and the political know-how required to work within the complicated power structures of government organisations.[8]

Katsumata's career seems to have become the archetype for elite medical officials in Japan's central bureaucracy. Most entered the Ministry soon after their medical internship and were promoted to higher ranks, with occasional temporary work periods outside for experience. They are medically qualified but are career administrators rather than researchers or clinicians.

The present

In 2001, the Ministry of Health and Welfare amalgamated with the Ministry of Labour to become the Ministry of Health, Labour and Welfare. In this new ministry, Director of the Health Service Bureau (健康局) is a post usually occupied by medically qualified officials. The Director of the Health Policy Bureau (医政局), another bureau within the Ministry, is currently a medically qualified official. However, this bureau had non-medical secretarial directors in the past, which means that the Health Policy Bureau Director does not have to be medically qualified. Until 2017, these director posts were the highest positions ministry medical officials could be promoted to.

Several changes were made in 2017. A new post called *Imu-gikan* (医務技監) was created; the official English version of the title is 'Chief Medical and Global Health Officer'. Prompted by the outbreak of Ebola fever in West Africa in the mid-2010s, the Minister for Health, Labour and Welfare decided to create a new post to which a medical expert should be appointed to consolidate arrangements for global health risks. It is ranked 'Permanent Secretary level', which means that the Japanese CMO is supposed to have the right of access to cabinet ministers without having to seek the Permanent

[8] 株本千鶴「衛生局技術官僚の特性―官僚制における専門性について」副田義也編『内務省の歴史社会学』（東京大学出版会，2010年）〔C. Kabumoto, 'Technical experts in the Sanitary Bureau: Specialisation in the Bureaucracy', in Y. Soeda (ed.), *Historical Sociology of the Ministry of Home Affairs*, University of Tokyo Press, 2010〕.

Secretary's permission. Two have assumed this post to date, both promoted internally from among the Ministry's senior medical officials.[9]

A comparative perspective

According to media reports, the post of CMO in Japan was introduced following the example of the UK's CMOs, but there is at least one significant difference. The UK's CMOs are assured of independence, to at least a certain degree, so they can speak publicly based on their expert knowledge; such independence is not associated with CMOs in Japan. The English CMO occasionally appears at press conferences on Covid-19 with the Prime Minister or the Health Secretary; it is difficult to imagine this happening in Japan.

Chris Whitty has summarised his and the politicians' respective positions as follows: 'I'm only presenting the health advice. I passionately believe in the health side of things, and I strongly believe that good science leads to good political decisions. But the economic side [and] the societal issues are also important. The political leaders who have to represent the public have to balance all these different elements together'.[10]

Japan's CMOs do not have this degree of independence and their right to speak independently is not assured. It is rare for a Japanese CMO to explain something directly to the public and I have never seen the CMO appear at Covid-19 press conferences in the past two years; they have no visible public presence in Japan. In addition to the CMO, the Japanese government has appointed temporary medical advisors for anti-Covid measures. Notable among these, Dr. Omi Shigeru (a retired MHLW official and WHO Executive Board member), the chairman of the Cabinet Office's special committee on COVID-19, is a relatively familiar face to the people in Japan, having appeared at press conferences with the Prime Minister several times.

This invisibility of the Japanese CMO does not mean that he has been inactive in the creation of anti-COVID-19 measures. According to media reports, the CMO played a significant role in supporting the Prime Minister in deciding what to do and not to do. However, some commentators have doubts about this role, as the CMO's advice may have been based mainly on conventions and precedents within his Ministry rather than

[9] In the personnel change in July 2023, a third CMO has been appointed. Again, he was promoted from within the Ministry. Each of his two predecessors held office for less than three years, in contrast with the ten-year average tenure of a CMO in England.

[10] The *BMJ* interview, 'Chris Whitty, England's chief medical officer,' *The British Medical Journal*, published online, November 4, 2020.

scientific evidence on the new virus which is renewed daily.[11] At present, however, we cannot confirm whether this is true, as it is difficult for us to be sure about the CMO's own views.

The purpose of this paper is not to evaluate which country's system is better but to suggest that the ways in which medical officials are involved in policymaking could be a good focal point for an examination of anti-COVID-19 policies from a comparative perspective.

In examining anti-Covid policies, it is also desirable to look at health policies over a longer time span, from before the 2020 outbreak. For example, the number of health centres in Japan has decreased drastically over the past 30 years. How this decrease has influenced the struggle against Covid-19 at the local level is an important point. The local health centre system was introduced in 1937. Every municipality used to have one or more health centres, which played an important role in the prevention of infectious diseases, mother and infant welfare, and health promotion at the community level. However, in the mid-1990s, under noticeable neo-liberal influence, restructuring began in the name of rationalisation. The absence of medical officials representing public health interests in Japan may have facilitated this rationalisation.

[11] 「罪深きはこの官僚：厚生労働省医務技監」『選択』(2017年12月号)〔'Sinful bureaucrats: Chief Medical and Global Health Officer, Ministry of Health, Labour and Welfare', *Sentaku*, December, 2017〕; 西川伸一「新型コロナ、医務技監はなにをしているのか」『週刊金曜日』(2020年6月5日号)〔S. Nishikawa, 'Anti-Covid-19 policy: What is the CMO doing?' *Shukan-Kinyobi*, June 5, 2020〕;牧太郎「誰も言わないから敢えて言う。大感染の責任は「医務技監」だ！」『サンデー毎日』(2021年1月31日号)〔T. Maki, 'The CMO is responsible for the spread of infection', *Sunday-Mainichi*, January 31, 2021〕.

Rinderpest Epidemics in the Early Modern European and East Asian Countries: Comparative Perspectives

Akihito Suzuki

COVID-19 was almost certainly a disease affecting animals in China, where it first appeared in late 2019. When it started to spread from one human to another in the world in early 2020, we watched TV reports on meat-packing factories in the USA, Brazil and other European countries. Many factories in these countries became the basis of local disease outbreaks, mainly because of closed workplaces for meat packers. Giant international companies such as Sanderson, Tyson, Smithfield, and JBS were hit by the first wave of COVID-19 and had to shut their factories temporarily. The labourers in these factories were often poor immigrants from Africa, Latin America, and other poor areas of the world. During the closures, they were often fired, and their loss of income created significant economic problems for the nations. The entire pandemic has resulted in approximately 7 million deaths and 680 million cases. Perhaps the most impressive was the number of vaccine doses administered to the world's population: 13 billion doses, about 1.7 times the population of 8 billion.[1] COVID-19 was huge in terms of deaths, cases, and vaccination.

Animals, the economy, politics, medicine, and statistics are integrated into the contemporary picture of the pandemic. Combining modern mechanisms such as livestock animals, large factories, immigrant labourers, state policies, and scientific discoveries in the early twenty-first century reminds medical historians of similar accounts in other areas. In the United States, in the late nineteenth century, very similar pictures were made: Large-scale farming of animals, capitalist industrial plants, immigration to factories from East European areas, slum poverty, government policies on the import and export of food, scientific discoveries, and public health measures. The classic works of James Harvey Young and William Cronon highlight the rapid economic growth and miserable situation

[1] Jacob Bunge and Jesse Newman, "Tyson Turns to Robot Butchers, Spurred by Coronavirus Outbreaks", *Wall Street Journal*, 9 July 2020; Iris Finci et al. "Risk Factors Associated with an Outbreak of COVID-19 in a Meat Processing Plant in Southern Germany, April to June 2020", *Euroserveillance*, 27, Issue 13, 2022. The data are taken from the Coronavirus Resource Center, Johns Hopkins University and Hospital. https://coronavirus.jhu.edu/map.html. (Looked at on 2 March 2024).

of immigrant labourers in industrial meat factories.[2] The cow, pig, and chicken meat industries multiplied and transformed meat production for society. Expanding food industries in Chicago, Cincinnati, and other areas occupied the massive land of Americans and Native Americans, and modernised systems of large cattle ranches and large factories of meat industries were connected to modern railways and grand paintings of cattle and pioneers. Labourers were attracted to factories, which forced them to have inefficient, dirty, and poor conditions. An overwhelming majority lived in slums. Social critics commented on immigrant labourers' poverty and harsh situation. Rudyard Kipling (1865-1936) published *From Sea to Sea* (1898), and included the horrible situations of labourers in Chicago. Upton Sinclair (1878-1968), a socialist and journalist, published *The Jungle* in 1906, which became an international bestseller.[3] Although public health measures have stopped deterioration, the combination of meat industries and the problem for labourers have remained. New agriculture in the early twentieth century was, according to Ellen K. Silbergeld, "new in methods, animals, feeds, work, food, economic and social organisation".[4] The meat of animals as an essential food for humans and medicine's attempts to control complications has quickly become a significant problem from the nineteenth century to the present. As Louise Fresco has emphasised, "[food] is a source of intense confusion these days".[5]

The questions of diseases in animals, food industrial factories, immigration, and pharmacological growth from the late nineteenth century are thus excellent historical perspectives, and further research should be conducted on these frameworks. However, historians should not just examine the food industry when studying animal diseases.[6]

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[2] James Harvey Young's Pure Food: Securing the Federal Food and the Drugs Act in 1906 (1989) and William Cronon's Nature's Metropolis: Chicago and the Great West (2009). For a somewhat similar history of food, see Ann Hardy, "Food, Hygiene, and the Laboratory. A Short History of Food Poisoning in Britain, circa 1850-1950", *Social History of Medicine*, 1999 Aug;12(2):293-311.

[3] Rudyard Kipling, *From Sea to Sea: Letters of Travel, in The writings in prose and verse of Rudyard Kipling* (C. Scribner's, 1899), volumes 15 and 16; Upton Sinclair, *The Jungle*, edited and introduced by Ronald Gottesman (London: Penguin Classics, 1985). The first translation into Japanese appeared in 1925. The translator was Maedakō Hiro'ichirō (1888-1957), who had travelled in the United States and became a proletarian critic after his return to Japan.

[4] Ellen K. Silbergeld, *Chickenizing Farms and Food: How Industrial Meat Production Endangers Workers, Animals, and Consumers* (Baltimore, MD: Johns Hopkins University Press, 2015). See also Katy Keiffer, *What's the Matter with Meat?* (London: Reaktion Books, 2017).

[5] Louise O. Fresco, *Hamburgers in Paradise: The Stories Behind the Food We Eat*, translated by Liz Waters (Princeton, NJ: Princeton University Press, 2016).

[6] Susan D. Jones and Peter A. Koolmees, *A Concise History of Veterinary Medicine* (Cambridge: Cambridge University Press, 2022); Kenneth F. Kiple and Kriemhild Coneè Ornelas eds, *The Cambridge World History of Food*, 2 vols (Cambridge University Press, 2000); Maguelonne Toussaint-Samat, *A History of Food*, translated by Anthea Bell (London: Wiley-Blackwell, 2009); Jeffrey M. Pilcher, *Food*

Animals had functions other than providing meat, such as contributing to religious rituals, providing leather as a material, supplying medicine for human diseases from their body, joining the cultivation of crops and carrying heavy loads. Other devastating epidemics of animal diseases occurred in the ancient, medieval, and early modern periods when the meat industry had a much minor role: nagana, trypanosomiasis of domestic animals mainly in West Africa, started in the medieval period witnessed by the Arab merchants; foot and mouth disease, a chronic infectious disease among cattle and pigs, started to be recognised by Girolamo Fracastro (1478-1553) in the mid-sixteenth century; sheeppox, a chronic disease of sheep caused by sheeppox virus, started in England in the late thirteenth century.[7] Recent studies have thus not concentrated on food and demonstrated the crucial importance of trade and war in animal the disease of sheep epidemics.[8] From the early modern period, domestic and international trade has expanded animal diseases while observing the impact of wars on the spread of animal diseases.

East Asian countries such as China, Korea, and Japan also provide rich historical materials on animal diseases, showing that food, trade, and war are all important, and this paper follows those historical viewpoints.[9] This paper also looks at the issue of everyday life for humans and animals.[10] It will examine an item that a large part of society used daily during the early modern period. Unlike war or the large quantity of meat, the use of former animal bodies will be examined. The author presents a speculative hypothesis of the crucial role of leather items in people's daily lives in the Tokugawa period.

This paper picks rinderpest, one of the most significant diseases of animals as

in World History (New York: Routledge, 2006).

[7] Dietmar Steverding, "The History of African Trypanosomiasis", *Parasites & Vectors*, 2008 1(1); Jones, *Concise History of Veterinary Medicine*.

[8] Jones and Koolmees, *A Concise History of Veterinary Medicine*, pp. 126*ff*.

[9] E. N. Anderson, *The Food of China* (New Haven, CT: Yale University Press, 1988); Frederick J., Simoons, *Food in China: A Cultural and Historical Inquiry* (n.p.: CRC Press, 1991); Calvin W. Schwabe, *Unmentionable Cuisine* (Charlottesville, VA: The University of Virginia Press, 1979). For Japan, see Susan Hanley, *Everyday Things in Premodern Japan* (Berkeley, CA: the University of California Press, 1997); Nishimaya Matsunosuke, *Edo Culture: Daily Life and Diversions in Urban Japan, 1600-1868* (Honolulu, HI: University of Hawai'i Press, 1997). Although the subject is not animal, Francesca Bray's *The Rice Economies: Technology and Development in Asian Societies* (Berkeley, CA: University of California Press, 1986) is still a classic work.

[10] The History of medicine and diseases in everyday life has not been discussed as the central theme. The author has looked at Kathryn A. Edwards ed., *Everyday Magic in Early Modern Europe* (Farnham, Surrey: Ashgate, 2015); Markman Ellis, Richard Coulton and Matthew Mauger, *Empire of Tea: The Asian Leaf That Conquered the World* (London: Reaktion Books, 2015). For everyday life in Japan during the Tokugawa period, see Hanley, *Everyday Things in Premodern Japan*.

the primary subject. It is an infectious viral disease that affects cattle, domestic buffaloes, and other species of even-toed ungulates. In 2011, rinderpest was eradicated, second only to smallpox.[11] Rinderpest is highly contagious and lethal, killing 60–90 per cent of infected animals. When it was an epizootic in early modern Europe, many farmers killed healthy animals to prevent further spread. Veterinary medicine also shows an interesting phenomenon: with the advancement of vaccination and public health in humans, they have begun to apply similar therapeutics and public health. Many arguments about the disease appeared in the late twentieth century, encouraging historical research on rinderpest. Historians have pointed out the essential aspects of rinderpest, especially their strong connections with economic trade and political wars from the early modern period in Europe and East Asia. This paper will speculatively examine the part of everyday life and argue that leather items significantly impacted the epidemics of rinderpest in the seventeenth- and nineteenth centuries.

First, we will examine the experiences of rinderpest in Europe. The most important book on the history of rinderpest was written by C.A. Spinage and published in 2003.[12] Rinderpest in Europe started in the medieval period, perhaps because of the invasion of the Mongol Empire into the eastern side of Europe.[13] Since then, rinderpest has affected European cattle. In the eighteenth century, Europe experienced three long pandemics of rinderpest in 1709-20, 1742-6- and 1768-86. Outbreaks and cases of rinderpest spread were due to transportation and several wars. Cattle were crucial in transportation and carried domestic and international trade items within a developed economic system. Their functions in the wars were also essential, as European countries have attached large numbers of cattle as carriers for soldiers. The rinderpest outbreak in the 1740s was caused by the movement of soldiers during the Austrian War of Succession. With the flourishing economy in European countries and frequent wars between significant countries, the movement of cattle was crucial. Mainly during wars, each country had to carry cattle for soldiers' food. Major outbreaks have occurred in the Netherlands and Germany, and the Netherlands lost approximately half a million cattle during these three pandemics.[14] In total, eighteenth-century Europe lost the lives of about two hundred million cattle. During the eighteenth century, rinderpest was integrated into European countries.

Lise Wilkinson and other medical and veterinary historians have shown that from the early eighteenth century, medical and veterinary practitioners started to

[11] Donald G. McNeil Jr., "Rinderpest, Scourge of Cattle, Is Vanquished," *New York Times*, 27 June 2011.
[12] C. A. Spinage, *Cattle Plague: A History* (New York: Kluwer Academic, 2003).
[13] Spinage, *Cattle Plague*, Chapter 3, The Seat of Infection.
[14] Spinage, *Cattle Plague*, p. 3.

reproduce something they already did to human beings and public health regarding animal disease and veterinary health.[15] They considered therapeutics for human epidemics against animal ones. During massive rinderpest outbreaks in the Netherlands from 1750, they had already recognised some, at least partially, effective public health measures against human diseases. In the late seventeenth century, they used sanitation and confinement to prevent plague epidemics. In the early eighteenth century, they began to inoculate smallpox. Doctors observed that the symptoms of cattle rinderpest looked like those of children's measles, another high-mortality infectious disease. People learned from these public health and preventive measures, and observations of human beings and society cattle were placed under similar measures. They attempted to control cattle plague by killing diseased animals and quarantining healthy ones. They attempted to inoculate cattle by developing and being close to measles in their symptoms. The first severe epizootic of rinderpest in Europe helped establish a similarity between medicine for humans and animals.

East Asia, particularly Korea and Japan, is a thought-provoking issue. Research on the history of rinderpest has not been conducted except by a couple of pioneering and excellent veterinarians with solid historical interests. The following account is based on the works of Miki Sakae (1903-1992), a physician who worked at Keijo Imperial University and later became an excellent historian of Korean medicine; Kishi Hiroshi (1925-1988), a veterinarian scientist who studied at Keijo University with Miki; and Yamanouchi Kazuya (1931-), an excellent veterinarian and virus specialist. Yamanouchi has also published an excellent book which integrates the situations of rinderpest worldwide.[16] Their works are based on a professional understanding of medicine and veterinary science.

In China in the mid-sixth century, *Seimin Yojutsu* [斉民要術], an extensive and detailed agricultural guide in ten volumes, mentioned cattle disease, which looks like rinderpest.[17] It took several centuries for Korea to catch up with the high standards of

[15] Lise Wilkinson, *Animals and Disease: An Introduction to the History of Comparative Medicine* (Cambridge: Cambridge University Press, 1992); *idem.*, "Rinderpest and Mainstream Infectious Disease Concepts in the Eighteenth Century", *Medical History*, 28, 1984, 129-150; C. Huygelen, "The Immunization of Cattle against Rinderpest in Eighteenth-Century Europe", *Medical History*, 41, 1997, 182-96.

[16] 三木栄『朝鮮醫學史及疾病史』（京都： 思文閣出版、1991）； 三木栄『朝鮮医事年表』（京都：思文閣出版、1985）；岸浩「寛文牛疫の復旧にいたる史的考察」『日本獣医学史雑誌』、16, 16-26, 1982；岸浩「寛永牛疫大流行史の序章」『日本獣医学史雑誌』、18, 20-37, 1984；山内一也『史上最大の伝染病牛疫： 根絶までの四〇〇〇年』（東京：岩波書店、2009）。

[17] 『斉民要術』熊代幸雄・西山武一訳（東京：農林省農業総合研究所、1957）上巻、pp. 253-271.

recorded agricultural and veterinary observations in China.[18] According to Miki's excellent work on the history of medicine and diseases and the timeline of diseases and medicine in Korea, rinderpest and similar diseases in animals were first observed in the mid-twelfth century in the provinces of Gyeonsang-do and Hamgyeong-do. In 1541, there were more explicit descriptions of rinderpest: Pyeongan-do and Hwanghac-do, two provinces in northwestern Korea, had ravages of rinderpest. In the same year, two books were published on protecting animals from rinderpest and other unknown animal diseases. In 1577, a more significant outbreak occurred in all eight provinces, killing thousands of cattle. These records of rinderpest were recorded until 1763, during which approximately fifteen outbreaks were recorded, suggesting the regular occurrence of rinderpest. Subsequently, for reasons Miki was unaware of, Korea stopped recording the disease.

Japan experienced rinderpest outbreaks slightly later than Korea. Kishi has surveyed this subject in a few previous studies. Kishi discovered three crucial mentions of the occurrences of rinderpest.[19] The first reference to rinderpest came from *The Japanese-Portuguese Dictionary* [日葡辞書] (1603-4), which shows that the Jesuit knew that the Japanese word "tachi" meant plague of the cattle.[20] Reference suggests that there was already rinderpest in southern Japan before 1600. Two significant outbreaks of rinderpest occurred in 1638 and 1672. Both started in the domain of Choshu, the present Yamaguchi preference. The outbreak in 1638-1642 was large-scale; it began in Nagato, spread to southwestern Japan, and was estimated to have killed approximately 500,000 cattle. The 1672 outbreak began in Nagato and spread to the large island of Shikoku, with a high mortality rate of more than ninety per cent. As for the development of veterinary medicine, there were several prints of *Protection of Cattle* [牛科撮要] from 1720 to 1800. [Figure 1] The causes of rinderpest outbreaks in Japan were probably the wars. Kishi suggested the war between Korea and Japan in 1592-98 [文禄・慶長の役] enabled cattle in Korea to infect Japanese cattle. The outbreak in 1638 was due to the Shimabara Uprising [島原の乱], a rebellion against the Shogunate by the Christian peasants and other warriors who had been fired from their former domain.

Now let us compare Europe, which had significant rural rinderpest outbreaks in the eighteenth century and East Asia, mainly Korea and Japan, which had as large rinderpest epidemics from the sixteenth- and eighteenth centuries, at least in Korea. The first important point is the economic prosperity and the wars. In Europe, the early modern period showed rapid economic and international trade growth: the expanding economy with the American Continents, India, and East Asia increased, and the cattle trade became

[18] 三木『朝鮮医学史』、pp. 75-79.
[19] 岸「寛文牛疫の復旧にいたる史的考察」; 岸「寛永牛疫大流行史の序章」。
[20] 『日葡辞書』(東京:岩波書店、1980)"tachi".

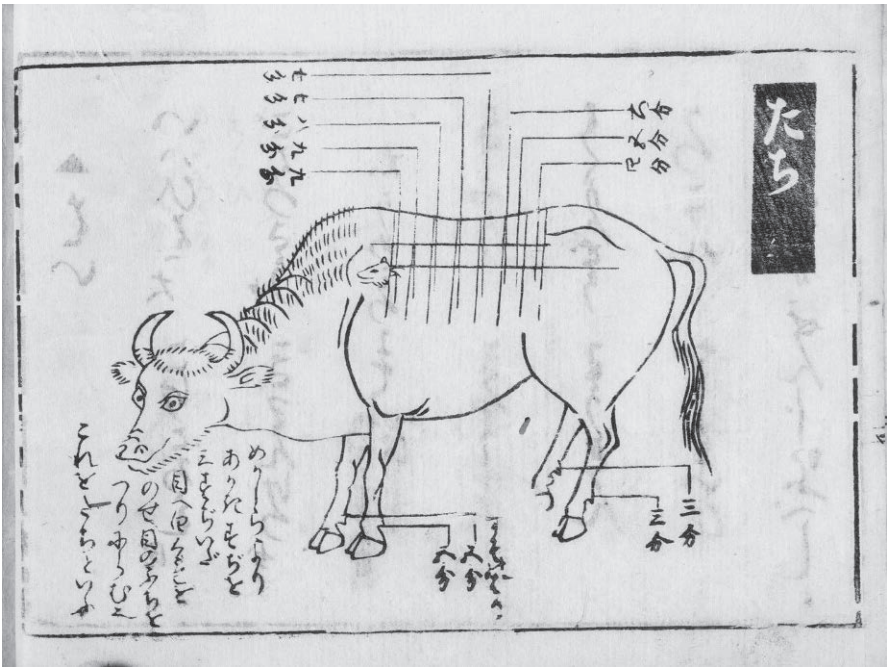

Figure 1. *Protection of Cattle*［牛科撮要］
From Kyoto University, Fujikawa Collection
https://rmda.kulib.kyoto-u.ac.jp/item/rb00001889?page=8

a solid part of it. As for wars, eighteenth-century Europe had a lot of wars. John A. Lynn has counted twenty-eight wars in Europe between 1700-1815.[21] In Korea and Japan, the period from the sixteenth to the seventeenth centuries was a period of unification and international coexistence. Korea achieved the unification of the country, and its economy made progress. Korean ginseng was a significant export, especially in medicine and drugs, and the government encouraged its growth. Japan also achieved unification due to the success of three famous warlords: Oda Nobunaga (1534-82), Toyotomi Hideyoshi (1537-98) and Tokugawa Ieyasu (1543-1616). They brought peace, and their economic and agricultural policies were successful. These reforms have encouraged national and

[21] Stephen Broadberry and Kevin H. O'Rourke, *The Cambridge Economic History of Modern Europe*, volume 1: 1700-1870 (Cambridge: Cambridge University Press, 2010); John A. Lynn, "International Rivalry and Warfare", in T.C.W. Blanning ed., *Short Oxford History of Europe: The Eighteenth Century* (Oxford: Oxford University Press, 2000), 178-217.

international trade. They also introduced a new agricultural system of smallholders, which helped in the rapid growth of the Japanese population from 15 million around 1600 to more than 30 million in 1720.[22] European countries,

The second important aspect was the crucial difference between European and East Asian countries. While European countries, especially Britain and the Netherlands, had reports of rinderpest, neither Korea nor Japan conducted regular surveys on the disease.[23] Although Korea sounds relatively systematic when one reads disease records from the late sixteenth century to the 1760s, the eighteenth and nineteenth centuries do not present much information. In Japan, reports were often sent to the provincial record office. They failed to send the report to the central Shogunate, mainly because of fundamental tensions between the local and central powers and between local powers. Due to the lack of reports on the number of deaths from rinderpest, the Koreans and the Japanese did not have any solid grasp on the situation of rinderpest, despite almost constant printings of the guide to the symptoms, veterinary medicine and public animal health for more than two hundred years.

From the mid-seventeenth century to the late nineteenth century, there were no records of rinderpest in Japan. The author does not argue about its presence or disappearance but wants to propose the system of rinderpest in Japan during the Tokugawa period. What might be crucial was not the cattle's meat but their skin. Artisanship and trade of leather developed in the seventeenth century. [24] During the Tokugawa period, leather was a small but valuable item in everyday life. The skill of getting the skin of animals for their dead body was introduced to Japan from Korea in the ancient period. In the medieval period, crucial parts of armour were connected with leather, which encouraged the development of the skill in regional terms. During the Tokugawa period, the actual development of the skill of treating leather became widespread and shared by society. Many consumer goods were produced from leather: clothes against fire, tabi sox, footwear, tobacco pouches, musical instruments of shamisen

[22] My account of the history of early modern Japan and Korea is based on Andrew Gordon, *A Modern History of Japan: From Tokugawa Times to the Present* (Oxford: Oxford University Press, 2003); Marius B. Jansen, *The Making of Modern Japan* (Cambridge, MA: Harvard University Press, 2000); Brett L. Walker, *A Concise History of Japan* (Cambridge: Cambridge University Press, 2015, pp.132-4.

[23] Mark Hornigsbaum's *A History of the Great Influenza Pandemics: Death, Panic and Hysteria, 1830-1920* (London: I.B. Tauris, 2014) makes an interesting argument about the relationship between reports and a grasp of reality.

[24] The information in the following two paragraphs is taken from two works of Takenouchi Kazuaki. 竹ノ内一昭「近世アジアの皮革　5. 日本の日用革製品」「近世アジアの皮革　6. 日本の皮革貿易」 https://www.hikaku.metro.tokyo.lg.jp/Portals/0/images/shisho/shien/public/174_2.pdf; https://www.hikaku.metro.tokyo.lg.jp/Portals/0/images/shisho/shien/public/175_2.pdf.

and drum, and a miniature *netsuke* sculpture. Leather artisans were trained as skilled artisans. Regions for artisans lived in Kyoto, Osaka, Edo and several other regions in the western part of Japan. In the 1871 survey, almost 360,000 artisans worked in the leather artisanship.[25]

The leather material was either imported from foreign countries or provided through the domestic system of getting animal skin from the dead body, which people did with the status of *eta* and *hinin*. The leather import from cattle was substantial, next only to that of dear and shark skin. In the domestic economy, getting skin from a dead animal's carcass was often performed by *eta* and *hinin*, providing the leather artisans with material for small and exquisitely prepared items. The connection between *eta* and *hinin* status and the factory of animal skin was relatively strong. Dan Naoki (1823-1889), the last leader of the status of *eta* and *hinin* in the eastern areas of Japan, tried to establish a leather factory in the northern side of Tokyo (former Edo) after the Meiji Restoration.

The situation is that Japan already had the structure of animal diseases during the Tokugawa period. The advancement of a large number of leather artisans was one condition. The existence of carrying imported or domestically prepared animal skin was another. A substantial number of *eta* and *hinin* that worked to get the skin from the carcass was yet another. The structure of the rinderpest epidemic after the Meiji Restoration had been already in Japan.

A significant turning point for Japan occurred after the Meiji Restoration when rinderpest came originally from Siberia in Russia in the 1860s. Russia expanded grain export to England and other central and western parts of Europe in the western part of the Eurasian continent, which caused large-scale epidemics of rinderpest. From European countries, rinderpest was carried to Africa and created massive disturbances in sub-Saharan Africa.[26] In the Eastern part, China and Manchuria had a lot of contact with the Central Asian areas and Siberia. Almost certainly, Korea experienced rinderpest around this period. In 1871, the new Meiji government received two messages about rinderpest from several governments in Japan. The first was a letter from Charles E. Delong (1832-1876), the American Embassy in Yokohama. This letter was originally written by Daniel Jerome McGowan (1815-1893), a missionary and medical practitioner in Shanghai. McGowan wrote to the embassy that rinderpest came from Russia and reached Siberia and Korea on the eastern side and European countries on the western side. Similar information came from Ishiguro Tadanori (1845-1941), who was to become a significant player in modernising Japanese medicine. Ishiguro translated some Dutch texts and asked

[25] 黒川真頼『工芸志料』前田泰次編集（東京：平凡社、1974）pp. 261-285.

[26] Thaddeus Sunseri, "The Entangled History of Sadoka (Rinderpest) and Veterinary Science in Tanzania and the Wider World, 1891–1901", *Bulletin of the History of Medicine*, 2015, 89(1), 92-121.

Figure 2. Prevention of contagious disease of domestic animals in foreign countries［外国流行伝染病豫防法］(1871)
From the Naito Museum of Pharmaceutical Science and Industry.
『目で見るくすりの博物誌』(1990), p.65.

the government to stop the import of cattle, both living and dead parts (e.g., leather and hides), which were turned into posters. [Figure 2]

Rinderpest was rampant in Korea and Japan in the late nineteenth and early twentieth century. In Korea, large outbreaks spread from Siberia in the 1870s. In the 1890s, a new wave occurred, and the entire Korean Peninsula suffered from rinderpest. In 1871, the government imported cattle from European countries for distribution to local cattle farms in Japan, despite advice from Ishiguro. The imported cattle had rinderpest, which caused rinderpest in Tokyo and other areas, causing more than 40,000 cattle deaths by 1877. In 1892, rinderpest again caused relatively long epidemics until 1910. Japan imported cattle with rinderpest from Korea, which spread rapidly to the central and southern parts of Japan. It brought the deaths in cattle to about 35,000.

The long-term development of leather artisanship and the business of carrying the carcass's skin, which had developed during the Tokugawa period, was crucial for the late nineteenth and early twentieth-century outbreak of rinderpest in Japan. A structure for spreading rinderpest had already been created during the eighteenth century in major cities. On the one hand, this was the development of the use of leather in people's

everyday life. On the other hand, there was the system of importing animals or their skin and getting the skin from the carcass by *eta* and *hinin*. When Japan became more open to foreign countries, including Russia, Korea, and China, it opened the rinderpest infection route.

In the early twentieth century, colonial veterinary medicine started to flourish.[27] Important countries, such as Britain, the United States, Russia, the Netherlands, Germany, and other European countries, expanded their empires, faced economic problems with cattle and other animals, and started laboratory experiments in veterinary science. Japan soon joined a group of empires and began conducting scientific observations and experiments on cattle in Korea. In 1911, just after the annexation of Korea by Japan (1910), a veterinary medicine and science centre was established close to Busan. It was called the Centre for the Production of Vaccination of Animal Diseases, which may have been a historical echo of the European pursuit of inoculation in the eighteenth century. Scientists such as Nakamura Junji (1902-75) were developing new vaccines for animal diseases using a sample of rinderpest in Korea. Nakamura's contribution to the vaccine against rinderpest and the world of veterinary science was crucial, and veterinarians still used the phrase "Nakamura III strain".[28] At the same time, rinderpest could be quickly developed into a biological weapon. During the Second World War, Japan tried to develop rinderpest as a biological weapon and thought about attacking the United States using the balloon to bring the disease.[29] In the first half of the twentieth century, Japan became an empire in the science and the production of biological weapons based on veterinary medicine. Rinderpest was the crucial measure of the two genres of science and massacre.

Conclusion

The contemporary situation of COVID-19 shows that the twenty-first century has the extensive power of animals as food and meat factories. The impact of immigration on the health of society is also problematic. The production of vaccines by international pharmaceutical companies is good news. This study selects the animal infectious disease of rinderpest as the subject and tries to have a comparative viewpoint of Europe and the

[27] Karen Brown and Daniel Gilfoyle eds., *Healing the Herds: Disease, Livestock Economies, and the Globalization of Veterinary Medicine* (Athens, OH: Ohio University Press, 2010).

[28] 中村稔治『一獣疫研究者の歩み』(東京:岩波書店、1975)

[29] For the international use of rinderpest as a biological weapon, see Amanda Kay McVety, *The Rinderpest Campaigns: A Virus, Its Vaccines and Global Development in the Twentieth Century* (Cambridge: Cambridge University Press, 2018). For the Japanese attempt to develop rinderpest, see 山田朗『陸軍登戸研究所〈秘密戦〉の世界: 風船爆弾・生物兵器・偽札を探る』(東京:明治大学平和教育登戸研究所資料館、2012)。

East Asia, mainly Korea and Japan. It also picked up a different perspective of animals or the animal body as a part of everyday life. During severe rinderpest outbreaks during the early modern period, the economy and wars had a crucial role in European and East Asian countries. The lack of systematic epidemiological reports in Japan and, to a lesser extent, Korea was different from more systematic European rinderpest reports. This paper has proposed the idea of the impact of everyday life on rinderpest outbreaks in Japan in the late nineteenth- and early twentieth centuries. That was the leather trade and the production of consumer leather items. The development of leather artisans' skills and import and domestic production of the skin from carcasses of animals were solidly established during the Tokugawa period. From about 1910, Japan became an empire and started to use rinderpest in the medical and veterinary laboratories in Korea, China, Taiwan and Manchuria.

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