Sirs—Szreter and Woolcock have argued that demographic history has a significant contribution to make in the debate about the role of social capital in shaping health patterns. They illustrate this by focusing on the impact of social welfare on mortality in Britain during the eighteenth and nineteenth centuries. While agreeing with the authors about the importance of history, we will present evidence to suggest different conclusions about the historical role of social capital.

The authors’ thesis on the historical relationship between social capital and mortality may be summarized in their own words as follows:

The British polity had by the beginning of the 19th century established itself as the most prosperous, socially cohesive, and socially secure in Europe, proven through the capacity of its national security system, the Poor Law, to protect its citizens from local famines since the 17th century... There was abundant and burgeoning bridging and linking social capital, particularly in the towns... For almost a century, from the 1730s until the 1820s... its average life expectancy also steadily improved... But then all these changes. For about a half a century, from the 1820s until the 1870s... the growing towns' physical environment were simply allowed to deteriorate as ever more workers crowded in to work in the money-making factories... the industrial urban workers and their families experienced a catastrophic crises in the second quarter of the 19th century... in the central parishes of cities such as Manchester, Liverpool and Glasgow, life expectancies dropped to about 25 years... The breakthrough did not come until the 1870s... pioneered in the city of Birmingham through the political leadership of Joseph Chamberlain... who legitimized the moral and politically energizing imperative for the collective attack on squalor, poverty and disease.

Increasing smallpox virulence may partly account for the low life expectancy in some areas in the second quarter of the nineteenth century. There is evidence that smallpox vaccination was neglected in Glasgow in this period, and it is possible that there were variations in the pattern of urban mortality depending on the practice of vaccination and other measures. Mortality was also higher in Liverpool, Glasgow and Manchester because of an influx of poor Irish escaping famine and disease, which elevated mortality levels in the 1840s. Additionally, birth registration was probably defective among Irish Catholics, artificially elevating infant mortality levels.

The life expectancy levels quoted by Szreter and Woolcock for these cities are not representative of all urban areas in the middle of the nineteenth century. In the 1850s, life expectancy at birth in seven other English cities with populations above 100,000 was in the range of 35–39 years, compared with the 31 and 32 years for Liverpool and Manchester.

Expectation of life at birth in England and Wales was 41 years in the 1850s, suggesting that the majority of urban areas did not suffer mortality significantly higher than elsewhere in this period. Gains in life expectancy in cities after the 1870s were not greater than for the country as a whole. For example, life expectancy in Birmingham increased from 37 to 42 years between the 1860s and 1890s, whereas the equivalent increase in England and Wales was 41 to 46 years, suggesting that public health measures in Birmingham were not of especial importance in the reduction of mortality.

There is also evidence that the fall in infant, child, and adult mortality in urban areas during the late eighteenth and early nineteenth century was much more significant than that which occurred after the 1870s, indicating that the latter was not a key period of ‘breakthrough’. The most important city in Britain during the eighteenth and nineteenth centuries was London. In 1821, it had a population more than two-and-a-half times larger than that of Manchester, Liverpool, and Glasgow combined, and dominated the economic, social, and cultural life of the country. A number of demographic studies have been carried out on London and they all indicate that infant, child, and adult mortality fell sharply between the middle of the eighteenth and nineteenth centuries. Approximately two-thirds of the children under the age of five died in the 1750s, a proportion which had fallen to about a third by the 1840s. Much of the fall occurred in the nineteenth century, some of it probably in the second quarter of the century.
An important part of the debate about the role of social capital is the controversy about the reasons for the decline in mortality in the eighteenth and nineteenth centuries. Szreter and Woolcock point to the importance of ‘bridging social capital’, reflecting the work of Wilkinson, Marmot, and others on the influence of social inequality on health. Wilkinson and Marmot have argued that social inequality has a general impact on mortality levels, and have made reference to links between poverty and high mortality in eighteenth and nineteenth century England. However, the minimal social class gradient in infant and adult mortality before the end of the nineteenth century suggests that social inequality was not a crucial dimension in the determination of health before the twentieth century.

It is possible that the epidemiological transition changed the relationship between social class and mortality in the twentieth century, although this does not easily fit with Wilkinson and Marmot’s argument about the impairment of immunity from ‘status stress’. Only further demographic research will help clarify these topics, but the debate on the history of social capital and health initiated by Szreter and Woolcock has made an important initial contribution to clarification of these central epidemiological issues.

References