Shifting Boundaries of Public Health

Europe in the Twentieth Century

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Chapter One

Can There Be a Democratic Public Health?

Fighting AIDS in the Industrialized World

PETER BALDWIN

During the nineteenth century, the connection between politics and public health was clear. In the heroic era of sanitary reform, reformers broke ground for new and, from a liberal point of view, drastic interventions. Private property rights were limited in the name of sanitary infrastructure. Individual behavior was curbed and controlled in the interest of public salubrity. The controversy over smallpox vaccination—a classic contest between individual and public goods—was one of the major political battles of the nineteenth century, though curiously forgotten now. The disputes over the Contagious Disease Acts during the 1880s laid the foundations for the women’s movement, providing a dress rehearsal for disputes over suffrage a few years later.

In the intervening century, however, public health became a victim of its own success. It became taken for granted, a matter of everyday, uncontroversial political decision making. No longer were there Chadwicks, Virchows, Pasteurs, or Kochs—reformers and scientists whose exploits made them heroes. No longer were there controversies, except at the margins of politics, as with the decision on mass roundups and other measures against prostitutes during the two world wars. One exception to this rule was the grotesque inversion of public health by the Nazis. They exploited the rhetoric of public health to provide an aura of scientific respectability for hatred and genocide. Hitler portrayed himself as the Robert Koch of politics and the Jews as dangerous microorganisms to be exterminated. The Warsaw
ghetto was walled off nominally as a typhus quarantine zone. And of course the supposed delousing showers in the death camps took this fiction to its extreme. The other side of the spectrum provided only a pale echo of such conjunctions. Lenin worried about the petty bourgeois bacillus. In their sexual prurience, Eastern Bloc regimes often lambasted the decadent West over the epidemics of venereal disease that were the result of their allegedly extravagant sexual habits. But generally for the First World, public health was no longer a concern.

Today, all this has changed dramatically. Public health is suddenly occupying the front pages again. Anthrax became a terrorist weapon after September 11, 2001. Military leaders worry that suicide fighters may infect themselves with smallpox, spreading it within the civilian population. Tuberculosis is transmitted in virulent forms that are resistant to antibiotics, and Directly Observed Therapy (whereby victims are required to take their medicine under official supervision) is mandated. The Spectator has spoken for the right wing of British opinion in warning that immigration, in the form of diseased asylum seekers, will be deadlier than terrorism. From the other side of the ideological spectrum, parents are beating the tom-toms of liberal individualism. Fearing that triple vaccinations cause autism in their children, they are willing to abandon the collective solidarities of herd immunity. During the Sudden Acute Respiratory Syndrome (SARS) epidemic of 2003, the traditional artifice of public health, with its drastic impositions on individual freedoms, was wheeled out once again.

Public health first became a major political issue again during the early 1980s with the onset of the AIDS epidemic. Two themes suddenly burst onto the agenda. The first was the epidemiological interconnectedness of the world. The First World discovered that it no longer lived in isolation from the rest of humanity. That it had installed sewers and built hospitals did not spare it from afflictions that began elsewhere and were then imported via the mass peregrinations of modern life. AIDS was in all likelihood first imported to the United States by gay tourists to Haiti and the Democratic Republic. The developed world outsourced its unfilled sexual needs—both gay and straight—to the Third World, then harvested the epidemiological results. Other diseases that arose, or arose again, in the Third World were now also imported to the First along with increased transmigration: cholera from South America, horrifying hot-button sicknesses such as the Ebola, Marburg, and Lassa viruses from Africa. The developed nations discovered that they were in a position similar to that of the middle and upper classes during the nineteenth century, endangered by the poor.

Second among the themes raised by AIDS were the dangers posed to their own health by the habits of First World citizens themselves. We are now, of course, all victims of our own success. Obesity, cardiovascular disease, some cancers, and so forth, are the products of too many calories and too little motion, the toxic products of prosperity, and generally the lifestyles of the well-off and sedentary. That we are largely responsible for our own chronic diseases is well known. But even so, it is better to have problems such as these, rather than the acute epidemics of the nineteenth century. The discovery of the 1980s was that our own habits, whether bad or not, could also worsen the situation when it came to transmissible disease.

Until surprisingly recently this realization was not a secret, but by the 1980s it had to be rediscovered. During the early 1990s, cholera was blamed on the nasty habits of the poor—overeating, filthiness, sexual immorality, and the like. Even as late as the early twentieth century, syphilis was not regarded as a sexually transmitted disease, but as an ailment spread through everyday contacts. In Sweden, Russia, and the Balkans—especially in the countryside of these nations—syphilis was thought to spread through unfortunate rustic habits: indiscriminate sleeping together of family members and visitors, child minders sucking the penises of infants to quiet them, mothers chewing the food of their infants before spitting it into their mouths, everyone sharing household implements, and so on. Sexually transmitted diseases were, in this sense, conceptualized as a distinct group of ailments not because of our puritan fixation on sexual matters, but because, during the process of civilization, we gradually learned to avoid intimate bodily fluid contact with one another to the point where such diseases were finally spread only via sexual contact.

This was the lesson the developed world relearned with the AIDS epidemic: that individual habits and customs contributed not only to chronic disease, but to contagion as well. The most generally noxious habit, shared by most, that poses epidemiological dangers is travel. With mass tourism, the airline and hospitality industries, and their spillover effects, travel is possibly the single largest industry in the world economy and one on which many nations increasingly depend. The economic consequences of restricting it, should that become even more necessary, would be devastating.

Certain more specific habits, however, also pose epidemiological dangers. AIDS was spread first, and in some nations foremost, through unprotected anal sex and intravenous needle sharing. Moreover, during the 1980s and early nineties, HIV infection rates ran parallel to those of epidemics of more conventional sexually transmitted diseases localized largely to the gay community. Gay sexual habits, in other words, were spreading not only AIDS, but the usual variety of STDs as well. In addition there were premonitory epidemics of intestinal ailments such as amebiasis and giardiasis among First World gays. These ailments were transmitted via the increasingly popular practices of fisting and rimming—and they were otherwise found only in the unwowered parts of the underdeveloped world. Similar epidemics of disease were found also among intravenous-drug users. In other words, a group of First World citizens with above-average access to resources—gay males—had
a disease profile similar to those of the urban underclass and the Third World. And it had this profile for reasons largely stemming from the chance introduction into its closed sexual circles of HIV, combined with the extraordinarily rapid and disastrous spread of the virus thanks to particular sexual habits, above all unprotected anal sex.

This raised a new and surprisingly political issue. Chronic diseases are of course private misfortunes, but also public problems. Insofar as they are public they tend to involve questions of distributing or redistributing the costs of illness and mortality. If I overeat and become obese and develop heart disease, I may incur costs that you have to pay as a member of a health insurance system. Some 90 percent of health costs are incurred by 20 percent of all insurance members. To the extent that disease is dependent on voluntary and avoidable decisions, it poses a major redistributive dilemma. But generally speaking, even if I overeat and incur costs that you have to pay, I do not damage you directly. When it became clear that our own habits also encouraged the spread of certain contagious diseases, however, each of us potentially became an immediate threat to our fellow citizens for reasons that we could control and possibly be held responsible for.

Contagious disease poses the political dilemma of reconciling the interests of the individual citizen with those of the community in the most immediate and unavoidable terms. Attempts to curtail epidemics arise—in the guise of public health—the most enduring political dilemma: how to align the individual’s claim to autonomy and liberty with the community’s concern with safety. How do the polity treat the patient who is both citizen and disease vector? How are individual rights and public goods pursued simultaneously? Public health is thus inherently, indeed unavoidably, political.

This is not a new claim. It is inherent in the argument put forth by Erwin Ackerman, the distinguished historian of medicine, in a uniquely influential article: that different styles of public health corresponded to different political regimes. He distinguished quarantinism from sanitationism and correlated them with autocratic or conservative regimes and liberal democracies, respectively. He characterized as quarantinist those regimes which sought to break chains of transmission via strict statutory interventions: quarantining travelers and goods, reporting the ill to the authorities and isolating them, tracing their contacts, disinfecting goods and houses, and in other ways violating the rights of the individual in the name of the public good. In contrast, sanitationist regimes sought to render healthy the immediate urban environment, allowing epidemics to gain no toehold. This, of course, involved major statutory interventions too, but mainly those of laying down infrastructure and violating the privacy of the domestic residence to ensure salubrious conditions. Such a view corresponded to a particular etiology of contagious illnesses as filth diseases. Once dirty conditions had been improved, according to this etiology, epidemics would largely disappear. Such a view fitted hand in glove with the desires of merchants for free trade, but also with a liberal democratic system that did not regiment or interfere with the individual.

Ackerman’s view was, broadly, that sanitationism was the system adopted by liberal Britain during the nineteenth century, whereas quarantinism was preferred on the still largely autocratic Continent. Whatever one may say about this argument, if there is a causal relationship here, then it would have been most consistent during the nineteenth century, when political regimes really varied. But what about the modern era, the postwar period when all Western nations are liberal bourgeois democracies? Do they all share the same approach to public health? If so, what is it? What is democratic public health?

It is commonly argued that modern polities in the developed world share public health assumptions and tactics. These are based on the fundamental premise that epidemics of contagious disease are no longer a major issue. Legislation remains on the books that allows for a more sparing, quarantinist approach, seeking to break chains of transmission. But such laws are notably above all as their own. Instead, the epidemiological sea change from contagious to chronic disease allowed a democratic, liberal, hands-off approach. Democratic public health has been based on self-restraint. It is one fact of social control in a democratic polity. Rather than having the state intervene from outside with a harsh hand, democratic citizens control their own behavior in a nominally voluntary way. Instead of statutory authority, we have governmentality. Such theories of democratic public health are based on the work of Max Weber, Norbert Elias, and Michel Foucault. Nikolas Rose is perhaps their most elaborate contemporary formulator, though not specifically in terms of public health. In his hands, voluntary self-restraint becomes the ethos on which democratic polities are possible. In his eyes, our freedom is not restricted by such social control; rather, it is made possible precisely through self-restraint.

The onus of precaution thus was transferred to the increasingly well-to-do and educated citizens of emerging democracies. Appropriate habits became part of the conduct of good burghers. Citizens could take responsibility for their actions; indeed, the democratic ethos required them to do so. Controls shifted from the outward impositions of a predemocratic state to the internal restrictions each person put on his or her own behavior. Merely a subsidiary role was reserved for harsh measures to be imposed on those marginal people who could or would not conduct themselves appropriately. This was the ethos caricatured as the reign of the monogamous jogger. Rather than the pest house, the quarantine station, mobile fumigation squads, and all the paraphernalia and impositions of the sanitary old regime, we now have James Fixx and Dr. Atkins, twelve-step programs and health clubs, designated drivers and condoms.

Those who refuse to be monogamous joggers are the new enemies of the people. Smokers, the overly carnivorous (but also the exclusively vegan, who
are blamed for their children's nutritional deficiencies), the obese, drinkers of more than the occasional glass of Chablis, drug users, the promiscuous: these are the new social outcasts, violators of the ethos of democratic restraint. Bodily hygiene has become our religious tic. Health has become the morality of modern bourgeois society. Earlier, the imperative was to act in accord with the precepts of religion. Now the requirements of health and clean living are the code, the bowels having replaced the soul as the source of the most potent anxieties. Those who long for the old regime of strict external control, combined with room for the indulgence of pleasurable bad habits, attack this ethos of behavioral autolimitation as "health fascism." But in the main most of us have succumbed to incert当たりng totalitarianism.

Take the antismoking campaign as an example. On the one hand are the massive attempts at mind control exercised by both the tobacco interests and their enemies. And on the other hand nonsmoking enforcement is among the most drastic of direct statutory incursions, forbidding behavior that a decade or so ago was socially acceptable. Tobacco smoking is now treated in the world's most liberalist societies—America's granola belt: Madison, Cambridge, Santa Monica, Berkeley, et al.—as it was in absolutist Prussia, with formal prohibitions in public, and sometimes in private too. This makes the example a bit ambiguous, of course, since antismoking campaigns combine informal control through education, advertisement, and attempts at public enlightenment with outright prohibition. It seems as though informal behavioral control is not trusted, so formal prohibitions are required as well. Given that smoking is inversely proportional to socioeconomic status, the antismoking campaign is perhaps the most overt, though wholly unacknowledged, act of class behavioral imposition since the antisputting campaigns of the late nineteenth century. If these campaigns have their desired effect, antismoking laws will become like antisputting ordinances, which were enforced a century ago, but no longer have to be. Almost no one, barring the occasional baseball player, spits in public. The same goes for antiuination laws, though these have come back into use as a means of controlling the homeless and vagrants. Will inhalation soon go the way of expectoration? Will ashtrays become quaint collector's items, like spittoons?

Democratic public health is thus something different from either of the two more traditional approaches, quarantinism and sanitization. It does not involve massive public interventions into civil society. It relies instead on the accumulated effect of millions of individual decisions, out of which comes a public good. Just as collective decisions are the outcome of many individual ones in a democracy, so too public health has individualized its collective goods. The dilemma that we face now is how democratic public health, based on self-restraint in an era when most health problems are those of chronic disease, deals with new challenges of transmissible and epidemic ailments. The political analogy is what we do in circumstances when democratic decision making may in fact end democracy. May democracy defend its basic principles with undemocratic means? Are democratic forms of public health up to the challenge of resurgent contagious disease?

With certain diseases, there is no problem: we just roll out the inherited quarantinist measures. When cholera cases arrive in California, or planes from Latin America, no one objects to quarantining or keeping them under surveillance. When hyperacute diseases such as Hanta, Marburg, or Ebola burn themselves out in horrifying swaths of destruction, few worry about the niceties of civil rights. With the SARS epidemic, the same proved true. In China, tens of thousands of people were quarantined, and the authorities threatened to execute anyone who deliberately spread the disease. Visitors to Singapore were passed through thermal scanners to detect the feverish. American authorities were granted powers to detain suspected victims against their will. In New York City, an arrival from Asia with symptoms who was detained involuntarily became, with one exception, the first nonvascular person in a quarter century to be compulsorily quarantined.10

But what about other diseases that are not spread quasi-involuntarily, through an offending cough or everyday contacts? What happens when transmissible disease is made epidemic in some measure by our own voluntary habits? That was the dilemma posed by AIDS. The disease spread most quickly and first became recognized as epidemic in very specific epidemiological ecological niches: among intravenous-drug users and especially in shooting galleries, and among gay males who practiced unprotected anal sex and especially when they did so in gay bathhouses. Just when the Eliasian civilized process appeared to be nearing its highpoint, with Apollo ascendant, our Dionysian instincts became a problem again. Whether we crave the oblivion of the needle or the polymorphous gesamtkörperliche and of the bathhouses, the id was racking the cage of the monogamous jogger. The fundamental public health dilemma posed by the early phases of the epidemic was brought into focus by disputes over shutting the bathhouses.

Gay males have challenged the heterosexual world in two fundamental ways. First, in the emotional economy of homosexuality, by being able to overcome the traditional male-female, active-passive dichotomy. Modern Western homosexuality differs from more traditional models of gayness in its role switching. Each partner takes both the penetrating and the penetrated roles. In traditional models, in contrast, one partner tends consistently to be the penetrated, the other the active. The former is generally considered homosexual. The active partner may not be thought of as homosexual and may live a completely conventional heterosexual life as well. Role switching has been celebrated by gay theorists as allowing male homosexuals to understand the mutuality of desire and fulfillment in a way impossible for either straights or lesbians. They see both sides of the act of love and understand

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10. The first nonvascular person to be compulsorily quarantined...
both aspects of an emotional relationship. But role switching is also epidemiologically precisely what puts gays at risk. In traditionally homosexual relationships, chains of infection would die out more quickly and harmlessly. An infected inserter might well infect the passive partner, but he in turn, so long as he remained passive, would be less likely to infect future partners. Those who switched roles, however, would have equal chances of passing the virus along to their next partner.11

Second, the gay world has challenged the heterosexual through its political economy. Gays have put to shame the fundamental Weberian-Freudian premise that there is a tradeoff between reason and instinct, a zero-sum distribution between energies going to different ends. Sublimation and the channeling of energies from pleasure to work, from instinct to reason—Western gays have put paid to such fundamental building blocks of the Protestant world view. They have shown the belief that sublimation is the key to worldly success to be a myth by combining above-average socioeconomic indicators with licentious abandon, experimentation, and innovation on a scale and intensity undreamed of in the heterosexual imagination.

The debate that raged both within the gay communities of the Western world and between gays and public health officials over the closing of the bathhouses brought such considerations to a head. No one would think twice about shutting down a restaurant with a typhoid-infected cook. Why should bathhouses be allowed to stay open, when brothels were often illegal in the first place? That was the sort of logic advanced by public health officials and the gays who agreed with them.

On the other side stood those who argued that gay bathhouses were not just the equivalents of straight brothels. The bathhouses were not merely a bottleneck where transmission could be stopped. The baths were not like brothels places where sex of the usual sort was consumed in unusual settings. They were the venue of sex without par in private, and thus emblematic of the gay world's rejection of received erotic values. Precisely the Dionysian erotic frenzy of the bathhouses, the anonymity and multiple coupling, was their point. Shutting them was therefore more than just a public health measure. Gay defenders of the baths argued that closing them attacked the heart of homosexual identity. It would be as though marriage had been forbidden in order to fight venereal disease, or like the attempt made by an enterprising rabbi in Posen during the 1832 cholera epidemic, who shut mikwas to keep orthodox women impure after menstruation and thus incapable of relations with their husbands.12

What did the democratic style of public health do when faced with the AIDS epidemic? A large literature claims that AIDS was dealt with in precisely a democratic fashion.13 When the epidemic broke out in the early 1980s, most nations had draconian laws on the books, inherited from the era when acute contagious disease was still a problem. These laws could have been applied and at first occasionally were. Nonetheless, most nations surprisingly quickly discovered that a disease such as this could not be handled in the usual way. It was at first transmitted primarily in situations of intimacy and often illegality, far from venues that the state could expect to control. Its first victims were members of social groups that were already stigmatized. To impose the heavy hand of traditional quareltantist remedies, so this argument went, such people and such behavior would have been driven even further into the epidemiological underground, thus defeating public health's own ambitions.

Instead, public health authorities developed a consensual model of prevention, educating high-risk groups about inherent dangers and encouraging them to undertake voluntary behavioral change. Such a new democratic approach to public health thus bespoke at least two changes. First was the peculiar nature of the new disease. There was as yet no cure and scarcely any treatment. Traditional public health tactics, which assumed a limited period of contagiousness or the possibility of treatment to justify identification and isolation of the infected, were thus of little avail. HIV's long latency period would have required an unfeasibly constant testing of all. Second, this approach testified to the political strength of some of the principal affected groups, above all gay males. The disease helped mobilize victims and potential victims, resulting in an unexpected concern paid to the wishes of the most victimized groups.

It would be easy to fall into a whiggish mode here. Saying that gays turned out to have surprising political clout and that their concerns left a mark on the public health measures adopted is not to take those things for granted—nor to underestimate the uphill battle it had been, and remains, for gays. Nor, of course, is it to turn away from the horrendous circumstances that gays faced as the initial victims, with their community devastated by the epidemic. It is rather to apply the logic of the commonplace observation that without the Holocaust, the state of Israel would have been unlikely to exist. Finding a silver lining does not minimize the horror of event.

In this case, an epidemic sparked political mobilization that went beyond the immediate problems of the disease. In that sense, AIDS was not like smallpox in the nineteenth century, when huge and turbulent resistance movements to vaccination arose in many European nations, especially Great Britain. These movements died out quickly, since there was no stable base for political mobilization beyond the possibility of being a victim of a particular disease.14 A better analogy is the campaign against the Contagious Disease Acts in the late nineteenth century. In this case, women organized on the basis of their sex. They consciously joined in gendered solidarity across class lines to fight what they saw as a battle against the selfish sexual interest of men in having uninfected women available for commercial sex. All women, whether prostitutes or matrons, workers or middle class, had common interests as women in the face of a disease spread among them by men. The fight
for suffrage drew heavily on these lessons. In this sense, an interest identity created in part by public health concerns lasted beyond its initial impetus.

The connection between AIDS and gay mobilization was similar. In some nations, especially the United States, but also somewhat in Germany, gay mobilization preceded the epidemic. In others, such as Britain and France, it was more of an outgrowth of the epidemic, or at least gained impetus by it. Nor were the results of gay mobilization the same everywhere. A somewhat consensual approach was the result in the United States, and also in the Netherlands, where gays were well organized. In Sweden, in contrast, where gays were also well organized, the outcome was nonetheless much more draconian. There was no one-to-one correspondence between gay mobilization and the tactics adopted. Yet it would be wrong to ignore or downplay the victories won by gay interests in a certain approach to public health.

One of the most widely accepted arguments of the AIDS literature is that out of this confluence of events—the peculiar nature of the disease and mobilization by directly affected groups of victims—emerged a new and successful form of public health adapted to modern democratic politics. Though widespread, this view deserves to be questioned. A few things are clear. First, nations responded with a much more varied palette of preventive techniques than is often realized.

For one thing, the timing of the response varied. It was more rapid in northern Europe, especially Scandinavia and the Netherlands, than in the United States or in the Mediterranean. Some nations introduced many new laws to deal with the epidemic: Sweden, for example, and America, with a greater variety. Other countries, such as Germany and Britain, passed almost nothing novel, relying instead on the existing armoury of precautions, however reinterpreted. In more specific matters, the differences were also drastic. All American states required the reporting of AIDS and about half the reporting of seropositives. The Germans and the Dutch did not institute notifiable notification of even full-blown cases. The Americans screened and excluded foreigners on the basis of serostatus, as did nations with which they generally did not compare themselves: Indonesia, China, South Africa and Japan, for example, not to mention the then-socialist nations of the Eastern Bloc. In contrast, with a few exceptions, their European allies did not. The Swedes, otherwise among the most draconic interveners, were laissez-faire at the borders. The Americans required screening of certain civil servants, as did, to some extent, the Germans. The French and British shielded away from any such measure. The military was screened in the United States, but, with a few exceptions such as French soldiers on duty in Africa, not in Europe. HIV screening was strictly anonymous in Germany; in Sweden anonymity was ruled out on principle. Testing, though voluntary, was considered much more important to preventive efforts in France and Sweden than in Britain. In Austria, Sweden, Bavaria, and some North American states, prostitutes were screened and forbidden to work if infected; they were left alone in most other nations.

Contact tracing was required in Sweden and some American states, but in few other countries. Still considered an absolute in France, medical confidentiality was so strictly upheld that sometimes patients themselves were not told. In other nations, especially the Anglo-Saxon ones, concern with warning endangered third parties limited patients’ privacy. Compared with the United States, all nations were laggards in terms of funding basic research, but many produced far franker and more effective public-health campaigns. Blinded seroprevalence studies were accepted without alarm in America, but hotly resisted in Britain, the Netherlands, and Germany. Transmissive behavior was criminalized and prosecuted in the United States and Germany, but largely ignored in Britain. Gay bathhouses were closed in some American cities, and in Sweden and Bavaria, yet left largely untouched in other American cities, as well as in France and the Netherlands.

To put the contrasts more pointedly: American soldiers were subject to one of the most draconian regimes of HIV surveillance anywhere. They were screened, obliged to follow rules of conduct to prevent transmission, required to inform their sexual partners and medical caregivers, and obliged to practice safe sex. Their spouses could be informed, their contacts traced; their sex partners could be identified, counseled, and tested without consent. They were, in other words, treated in much the same way as all Swedish citizens. Conversely, HIV-positive Dutch, non-Bavarian Germans, and French, other than being potentially excluded from private life insurance coverage and possibly sued for damages if they knowingly transmitted the disease, suffered few curtailments of their activities and rights.

Second among the points worth making about the public health response to the AIDS epidemic, the old bromide of how conservative governments took a stricter approach, whereas liberal ones were less draconian, simply does not hold. Reagan and Thatcher, though otherwise lumped together politically, presided over administrations that took quite different approaches, much more laissez-faire in the United Kingdom than in the United States. Even worse for this argument, those nations which took by far the strictest, most old-fashioned approach, were a very motley and unexpected crew: the liberalist United States, swinging from a Republican to Democratic president in mid-epidemic; Social Democratic Austria and Sweden (after the party’s return to power in 1982 and except for the bourgeoís interlude of 1991–94) and Christian Socialist Bavaria. Conversely, the most consistently consensual approach was taken in an equally polymorphous array of nations: Britain, shifting from Tory to Labour halfway through the epidemic; France, under the peculiarities of left-right cohabitation as of the mid-1980s; the Netherlands, moving from a center-right coalition to the Social Democrats in 1989.
It is, in other words, hard to spot any consistent political underpinnings of public health policy here.

Behind a common facade of democratic politics, stark differences remained in public health policies. To explain the variety of approaches to AIDS, we need something more than just the common democratic system shared by all Western nations, a system that ruled out the drastic impositions of old-fashioned public health. First of all, such impositions are very much with us, as we discovered with the SARS epidemic. Second, some nations were happy to use them against AIDS even as others shied away. We also need something more than a simple politics of left and right, conservative and liberal, to make sense of how modern politics have acted in terms of public health.

Let us start with the question of a technical fix. Solving the problem of AIDS by finding a cure or vaccination would have been the politically easiest solution. Yet the interest of nations in this approach was not uniformly keen. The disparities in research spending were stark. The United States and, at a great remove, France provided the bulk of research funding on AIDS. In the 1980s, American research, measured in monetary terms, was one hundredfold that of the British, ten times per inhabitant that of the Swedes. In 1993, the French spent only 3 percent (2 percent in 1997) what the Americans did, but even this modest sum was a third more than what the British (their nearest competitors) spent and thrice what the Germans spent.19 As one critic calculated, the French research budget for AIDS would have bought the construction of four kilometers of mountainous highway.20 Why was the disparity among nations' interest in and willingness to fund a technical solution so great?

One reason was that a technical solution threatened to raise political and moral problems. Could one in this way sidestep the behavior associated with the spread of disease, which many found ethically and socially questionable? A very similar problem had gotten Guibert de Prévôt expelled from the medical faculty of the University of Paris in 1772, when he claimed to have discovered a means of preventing syphilis. His detractors feared that, once this became known, libertinage would be given free rein. Such an approach had sent moralist observers of syphilis into frenzies of self-righteousness ever since. A cure, they worried, would lead to a spiritual syphilization more pernicious than the merely corporeal version.21

During this latest epidemic, such attitudes reemerged undaunted. A crash program for an AIDS vaccine, the neoconservative journalist Norman Podhoretz thundered, meant that in the name of compassion researchers would give "social sanction to what can only be described as brutish degradation." They would allow gays "to resume buggering each other by the hundreds with complete medical impunity."22 The externals of desire would be reduced to practically nil; allegedly immoral habits would be freed of their consequences. Social conservatives pinned their hopes for a socially regenerating effect from the epidemic precisely to the consequences it appeared to attach to immoral and illegal behaviors.

Such concerns with the lifestyle of infection were not monopolized by the socially conservative right. Less well known are the homosexuals who agreed that the liberties of the gay ghettos had perhaps been taken to an extreme. They argued that gays should seek to live more like their straight neighbors and could hardly be surprised if their excesses were attacked. Gabriel Rotello, Larry Kramer, and Philip Kayal gave voice to such ideas in the United States, as did Rosa von Praunheim in Germany. Randy Shilts, the author of the first popular history of the epidemic, And the Band Played On, was spot on by strangers in the Castro for arguing that gay sexual behavior was part of the problem. Even those who fanned themselves progressive, alert to the needs of the epidemic's victims and concerned with social reform, argued that curing AIDS, vaccinating against it, or even adopting the technical fix of condoms failed to address the fundamental problem raised by the conduct that spread the illness. Rather than advocating such narrow measures to avoid disease, they demanded broad social and sexual reform, including changes in behavior to eliminate IV drug use, promiscuity, and the anonymous anal sex at the root of the problem.29 Curing the disease also threatened radicals of the left, who were convinced that AIDS had social causes or at least cofactors. Without changing society as a whole, they insisted, the epidemic could not be vanquished. "Without institutional change, the virus wins." A cure would solve the problem "while allowing the distribution of power and health to remain the same."24

Why did the United States and France in particular take a biomedical approach to the epidemic, hoping to find a technical fix, even though in some ways it held out the potentially most radical, or at least amoral, solution? Most obviously, both were among the hardest hit industrialized nations. But such pure functionalism is not enough of an answer. Other nations were happy to freeload on research done elsewhere and spent their money on social science investigations that allowed more effective internal targeting efforts, rather than biomedical research of interest to all humanity. Influential for the French choice was the cultural predilection for seeing sexuality as an exclusively individual, personal, and private choice. The French regarded as illegitimate those intermediary social groups based on sexual identity—gays above all—that played important roles in the Anglo-Saxon, Dutch, and Scandinavian realms.25 Biomedicine and a technical fix promised to sidestep such issues.

The Americans, in turn, put their money on biomedicine in hopes that it might gloss over gaps in their health insurance systems. Pouring greater resources into medical research than any other nation had been an American tradition since the 1930s. Besides the universalist goal of pursuing public
goods, this approach had political payoffs as well. Voting for research funding was one way for American politicians to demonstrate their support for health, since other avenues of largesse—such as health insurance for all—were blocked. "Medical research," as Congressman Melvin Laird put it in 1960, "is the best kind of health insurance" the American people could have. For countries with universal and effective health care systems, in contrast, the epidemic posed less of a political problem. So long as citizens were entitled to reasonable standards of care and as the problem did not mushroom out of control, a new illness was just another blip on the political radar. For these nations, there was little political advantage to spending funds on biomedical research rather than, say, building hospices to ensure comfortable terminal care for the stricken. Even in France, the annual budget for indemnifying infected hemophiliacs was many times that for research; in America the proportions were reversed. For the United States, in contrast, a new epidemic was much less digestible. It suffered from perennial problems of insurance coverage—and the disease struck precisely groups that were least provided for.

More generally, the Americans found a biomedical approach consistent with the values of a pluralistic democracy. It appealed especially to a polity fraught with multiculturalism—social, cultural, and sexual balkanization—and consequently unable to rely either on the cohesion of traditional European cultural homogeneity, or even any longer on the classic assimilationist ethos of Americanization. In a heterogeneous nation, with multiple moral and religious standards, even the act of disseminating consistent information was loaded with delicate issues in terms of what could be said to whom. Informal behavioral control was even less reliable. Seeking biomedically to cure or avoid a stigmatized disease involved the least tinkering with civil society and its possibly mutually antagonistic proclivities. A biomedical approach thus promised to spare the United States vexing political choices. By intervening in nature, the country could dodge social interventions. The behavioral change that was unlikely to arise through informal social influence, and whose strict enforcement via rules and laws was difficult, could thus be avoided altogether.

Once it comes, a biomedical cure will solve the public health problem once and for all. In the meantime, however, other smaller technical fixes played a role in the prevention of the epidemic, illustrating the individualization of prevention. All medical admissions to hospitals were now treated as though potentially infected, and universal barrier precautions were instituted. This avoided the need to test individual incoming patients and reserve such measures only for the infected. Also, of course, it avoided discrimination against those who appeared to come from high-risk groups. Instead of the authorities testing prisoners or the arrested, each suspect was to be treated as a potential source of danger whom medical personnel would approach gloved and masked.

Most obvious among the technical solutions was the advocacy of safe sex and in particular the use of condoms. This, too, was not the only way of dealing with the problem. In the Netherlands, for example, public health authorities at first sought to discourage anal sex among gay men rather than insisting on condoms. They seemed to think that changing sexual behavior would be easier than encouraging the use of latex. In other nations it was widespread practice early in the epidemic to exhort gays to engage in non-penetrative sexual practices—what was licentiously known as outercourse. But in general, it must be said that public health officials showed breathtaking hubris in their belief that they could, by dint of sheer persuasion, convince gays to refocus their libidos from one orifice to another, or to none at all, and otherwise practice what could easily be seen as a new form of chastity. Attempts to reprogram sexual behavior without condoms did not work well. Gays wondered why such techniques were not recommended to heterosexuals. Long discussions ensued of whether penetration and what, in the unromantic vocabulary of social science, was called intercorporal emission were fundamental parts of sex, or just window dressing.

As a result, the use of condoms became the basic preventive technique of the epidemic, the heart of safe sex. And here too, other techniques were, in theory, available. It would, for example, have been possible to enforce legal regulations on transmissive behavior, holding the infected, and those who suspected themselves of being infected, to very strict codes of conduct, and punishing them severely if they endangered others or actually transmitted disease.

This was largely the technique pursued in Sweden. Here, widespread testing identified seropositives. It was impossible to take a HIV test anonymously. Medical personnel revealed to the authorities the identities of all who tested positive. The authorities then imposed a very strict regimen of behavior: seropositives could have sex only with a single, constant partner who had been informed of their serostatus. They could, in any case, have only safe sex (mutual masturbation was allowed, but oral sex was considered highly risky, and condoms had to be worn throughout intercourse). They must not use drugs and certainly must not share needles. They had to inform attending medical personnel of their condition. If they ignored such prescriptions, they could be reported and isolated in a hospital for up to three months, extendable in half-year segments thereafter. Those who had had sex or shared needles with someone they knew to be infected were to regard themselves as infected. They too must be examined and follow the physician's prescriptions.

Seropositives in Sweden who failed to inform their partners before sex or to follow the prescribed medical regimen could be incarcerated. Swedish law did not even require evidence that disease had been deliberately transmitted. A mere suspicion that the infected would not follow the rules was
enough. If an infected drug abuser, for example, said he would have unprotected sex, a court could jail him initially for three months. Very few other nations attempted anything as draconian. Sweden’s measure thus targeted the infected and those suspected of infection because of their lifestyle or their contacts with the infected.

In contrast to this focus on the infected, the dictats of universal safe sex were analogous to the idea that universal barrier precautions in hospitals made it unnecessary to test incoming patients or make decisions based on their apparent risk-group membership. The assumption was that any sexual partner, except perhaps the most intimate and trusted, could be a risk and that all should therefore protect themselves by means of condoms. In addition, people were urged to choose their sexual partners more carefully. Promiscuity, however that was defined, was discounted in favor of monogamy. This approach foisted an individualized technical and behavioral solution on all—high- and low-risk groups alike—with the goal of sparing certain especially endangered groups even further impositions.

In theory, the choice was between imposing legal strictures to forbid or control dangerous behavior, thereby sparing most citizens the need for individual precautions, and requiring all to throw up their own palisades against infection. As the German Society for Internal Medicine put it, why ask legions of uninfected citizens to change their behavior, rather than first and foremost seeking to change seropositives’ conduct? Whereas disease prevention had earlier been a public good, democratization and the obligations of modern citizenship increasingly privatized it. Public health now resulted from the interaction of millions of private decisions—in a kind of preventive Brownian motion—rather than the imposition of communal norms. All were required to take individual precautions to ensure that no one was ostracized. Rather than relying on publicly enforceable structures that permitted a private unencumbrance of behavior, authorities called on each individual to curtail and adjust his or her behavior—not only to prevent transmission, but also to avoid being infected by those who did not conduct themselves as expected.

During the nineteenth century, when victims of smallpox and other diseases were forbidden to expose themselves in public, legal strictures sought to preserve the public’s right to walk abroad without fear of infection. Similar measures could have been used against AIDS, but were tried and enforced in only some nations. The widespread assumption was that individual precautions such as using condoms or restricting sexual behavior were a small price to pay for avoiding measures that aimed instead to enforce monogamy, to impose widespread testing, and to punish endangerment or transmission. Whatever one may think of it, this assumption rests on a political, not a neutrally epidemiological, choice. Different nations with different political cultures met this decision in quite varied ways.

The logic of this new individualized, consensual, democratic public health mimicked that of American gun buffs who argue that, if all were armed, crime would decrease. During the mid-nineteenth century, when it was gradually accepted that cholera spread via water, and not miasmatically or indiscriminately, it followed that people could avoid the disease by not drinking infected water. John Snow, who is famous for having identified the waterborne transmission of cholera in the Broad Street pump episode during the London epidemic of 1853, put it thus: “Every man may be his own quarantine officer and go about during an epidemic among the sick almost as if no epidemic were present.” So too, in the AIDS epidemic, everyone could be his or her own quarantine officer, taking the precautions required to avoid transmission. As Britain’s chief rabbi, Immanuel Jakobovits, put it, it is like sending people into a contaminated atmosphere, but providing them with gas masks and protective clothing.

The individualized solution was the one chosen by some democratic polities—at least those with no desire to impose restrictions on their citizens. It was also a victory for the minorities that were hardest hit by the epidemic and testified to the perhaps unexpected political prowess and organizational talents of gays, at least in certain nations. On the other hand, this victory also brought about the mainstreaming of those minorities. The bathhouse dispute showed that if gays claimed the right of democratic citizens not to have strictures imposed on them, then they must assume the responsibilities of democratic citizenship—and that meant an end to the baths. Democratic public health rested above all on self-abnegation. It was autonomously chosen and thus not an imposition. But it remained an abnegation and a sacrifice of habits that were now judged to be contrary to the public interest.

Informal, voluntarily adopted behavioral norms differed from regulations prescribing certain conduct on pain of legal punishment. But they were a form of control nonetheless. Self-imposed strictures meant the adoption of a code of conduct that claimed purely epidemiological justification, yet into which moral, ethical, and other normative evaluations easily crept. Breaking chains of transmission was key, but did this mean monogamy or at least sexual parsimony? Or would sporting a condom at the orgy suffice? Who decided what behavior was within the pale? Social conservatives argued that the epidemic provided the perfect reason to crack down on noxious behavior altogether, both drug abuse and sexual irregularity in all its forms. Gays, not surprisingly, feared that arguments for sexual parsimony were simply veiled attempts to roll back hard-won erotic freedoms. As a new ritual of heterosexuality and the nuclear family, HIV screening was suspect as another attempt designed to stigmatize gays. Gays attacked safe-sex campaigns, whatever their virtues, as cementing the distinction between “normal” heterosexual behavior and “deviant” gay practices.
The very self-contradictions of the problem shone through when the German Green Party warned against moralization and social control if advisors from very different backgrounds provided counseling on behavior modification for high-risk groups. Their solution was to have self-help groups offer such services, rather than allowing, say, Catholic clergy to offer gays advice on the problematics of anonymous sex. But, of course, the dilemma was that either anonymous promiscuity was dangerous and to be avoided or it was not. Having fellow gays tell you not to go to the bathhouses was preferable to hearing it from Monsignor, if only because you were more likely to take their advice. The end effect remained the same: you were supposed to forgo the pleasures of the baths. If anything, gay counselors were imposing greater social control—however well-intentioned—than the church. Similar contradictions were inherent in the arguments for community-based, voluntarist approaches to the epidemic. These arguments assumed that behavioral norms characteristic of a specific subgroup might at one and the same time be epidemiologically safe, yet also differ from the standards of the general population. Removing the doors from the bathhouse cubicles—creating a panopticon of promiscuity—was emblematic of the dilemma: the intent was to force gays to police themselves in the inner sanctum of their most daring transgression, enlisting their own shame to defeat practices that broke the fetters of heterosexual sex but left them vulnerable to infection. At heart, the problem was that, however gussied up in the rhetoric of (multi)cultural sensitivity, certain behaviors were toxic and in need of change.

This shift of control from the outside impositions of an authoritarian state to the internal consensual behavior of governmentality particularly affected gays. Contemporary sexual freedom, such as it is, is based on assumptions of internal restraint that forbid certain behaviors that were formerly acceptable, or at least tolerated in the sense that they had to be outlawed rather than psychologically suppressed. For gays, who had been the primary motors of instinctual abandon in the culture of the late twentieth century, the implications were ambiguous. Resistance to self-restraint was not just risky behavior. It was not equivalent to the motorcycle rider who leaves the helmet at home, the driver who doesn’t fasten the seatbelt. Rejecting safe sex, or remaining promiscuous, indicated a more fundamental refusal to enter into the web of mutually inflicting self-control on which modern democratic politics rest.

From this vantage, the efforts of the most “advanced” and liberal governments to include homosexuals in formulating and implementing policy to bring about behavioral change made gays police themselves. Whereas the old-fashioned approach of forbidding risky behavior and enforcing prohibitions by law sought to impose social norms on homosexuals (and other perceived miscreants) from without, governmentality made gays responsible for their own conduct. Either gays could cooperate with safer sex strategies, or face the consequences of a crackdown on their behavior: so ran the implicit bargain offered. The voluntary strategy did not, therefore, require less statutory imposition on the individual than the coercive approach, but a different and arguably more thoroughgoing kind. Gays could no longer be sexual outlaws (in John Rechy’s romantic phrase), could no longer practice promiscuity as “the righteous form of revolution.”

In contrast, public health in the governmentalist mode may not have punished transgressions. But it sought to ensure healthy behavior by not only requiring all citizens to conduct themselves in much the same way, but also by requiring them to agree that this was only possible way to behave. The bourgeois habits of moderation, abstinence, and prudence became the conduct expected of all citizens. Self-restraint is the basic requirement of modern politics. One of the fundamental issues posed by the epidemic was whether behaviors such as promiscuity or IV drug use were compatible with democratic citizenship.

In terms of public health, the crucial political dilemma that the epidemic posed was whether to treat AIDS, and indeed all contagious disease, as a communal or an individual risk. If it was a communal risk, the solution was to restrict infected individuals sufficiently to render them harmless. If it was an individual risk, the strategy was to encourage everyone to take precautions rendering them resistant to infection, coupled with broad, but voluntary behavioral modification to reduce risk. Nations diverged in their tactics. Some places, such as Sweden, Bavaria, Austria, and the United States, tended to take a more communal approach than others, for example, France, Germany, and the United Kingdom. Despite common arguments that a new democratic form of public health spared the individual subordination to communal interests, no such policy was uniformly followed in the industrialized world. AIDS was dealt with quite differently in different nations.

Moreover, even the most consensual approach to AIDS may, in retrospect, turn out to have been an exception more than a sea change. Once the epidemic spread from gays to drug users, minorities, and others who were less able to mobilize on behalf of their civil rights, the old-fashioned approach regained favor. It did so once once medical treatments became more effective during the mid-1990s. As we have seen with SARS, as soon as a disease comes along that threatens everyone equally, and no identifiable group of vocal victims steps forward, communities show little political hesitation in clamping down.

In the developed world, AIDS has now gone from being an acute contagious disease to something more akin to a chronic disease such as cancer—managed, but not cured. In some senses, the seropositive has become emblematic for the human condition in this era of ever more unflinching knowledge of our own mortality. In a few years, once information about our genetic foibles becomes accurate and widespread, we will all know that we will likely die in a certain number of years of a specified cause. We will pass our lives in the
shadow of that insight—much as seropositives do now. All this goes beyond
the question of the role of gays, who in this epidemic had the horrifying role of
the miner’s canary. The broader question concerns the extent to which public
health solutions are inherently public goods and achievable only by commu-
nal means. In the era of governmentalism, public health remains one clear area
of statutory control where the average law-abiding citizen might expect to feel
the iron fist through the velvet glove. AIDS has not changed that.

Notes
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