

# From Cholera to COVID-19 the Issues haven't changed

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From eighteenth century yellow fever to twenty-first century COVID-19, pandemics raise the same question again and again: Is the primary responsibility of a democracy the health and welfare of its peoples or, alternately, the strength and growth of its economy? [1]

Earlier, in the days of royal fiefdoms and princes things were clearer. Governments ruled and that meant the response to a pandemic like plague was the government's responsibility. Responsibility became less clear in the mercantile world of the late 1700s when yellow fever devastated US coastal cities from the Carolinas to New York City. In the summer of 1793, for example, ten percent of Philadelphia's population died of the disease in a few weeks. "Why cities should be erected," asked Noah Webster plaintively, "if they are only to be the tombs of men?"

Nobody knew if yellow fever was imported on sailing ships from the Caribbean, where the disease was endemic, or born spontaneously in the fetid airs of urban streets in which animal and human waste was left to fester. If it was imported then maritime quarantine zones would be needed and the burgeoning trade with England would suffer. Some read with relief Dr. Valentine Seaman "proof," in 1796 that yellow fever arose spontaneously in the animal and human waste sites of New York's odiferous, unclean downtown streets [2]. Naval quarantines would therefore be unnecessary.

The responsibility for cleaning those four-smelling waste sites became the responsibility of city governments. The resulting sanitarian movement spurred

the development of local and regional health boards empowered to collect data on disease incidence and recommend remedies to elected officials.

Yellow fever was the precursor to a global pandemic of cholera which beginning in Peshwar, India, in 1818. Moved into the Middle East, Russia, and then Western Europe before arriving in England in 1831. Authors in *The Lancet* argued cholera was airborne and therefore quarantines would be ineffective. But even if they served, the authors said, better a bit of cholera, *The Lancet* authors concluded, than diminished international trade. Between 1831 and 1834 that "bit of cholera" cost Great Britain an estimated 50,000 lives [3].

US President Donald Trump unknowing echoed those same sentiments when, in March 2001, he insisted that, "The cure can't be worse than the disease itself" and that the economy, not the health of at-risk citizens was the government's first priority.

Reformers of the day argued cholera, fevers, and other epidemic diseases indicted the laissez-faire capitalism of the day. The industrializing nineteenth city, like today's, depended on trade and manufacturing in a society largely dependent on a "gig" workforce of interchangeable, often emigrant workers. Reformers argued for greater protection of those living in densely crowded, sub-standard tenements that served as hotbeds of disease incidence.

Manchester physician John Ferriari, for example, warned that "the dwellings and persons [of the poor] continually breathe contagion. And, too, contagion

did not stay within the most impoverished classes but inevitably infected the well-to-do. Attention to their care and needs thus served everyone, rich and poor alike. ... The safety of the rich is intimately connected with the welfare of the poor ... minute and constant attention to their wants is not less an act of self-preservation than of virtue [4].”

In the same vein, today, the high rates of infection among densely populated nursing home, in migrant camps, and processing plants have resulted in broader outbreaks of COVID-19 in various cities.

For reformers of that time, health was a yardstick of injustice and a barometer of democracy itself. As Christopher Hamlin put it in his monumental *Public Health and Social Justice in the Age of Chadwick*, “one could only be free to act if one were fit to act.” The poor and ill were, in effect, disenfranchised by poverty and resulting, persistent illnesses;

Opposed to them were industrialists who saw health and individual welfare as matters of purely personal responsibility. Like the *Lancet* authors, they saw economic growth as the principal focus of official attention. Coddling the poor through programs providing food, medical care, education, or housing would simply encourage classes of dependent and indigent persons serving and a calamitous drain on the nation’s economy.

Sir Edwin Chadwick, a social reformer and bureaucrat, charted something of a political compromise in his epic *Report on the Sanitary Conditions of the Labouring Population of Great Britain* [5]. In a dense volume of tables, maps, and charts he made clear the relation between infectious disease and income inequalities. Poorer people were more prone to infectious and endemic diseases, and thus less able to work. For him, their care made both political and economic sense. His answer was not a call for a wholesale reform of the social fabric but instead a more limited sanitarian program assuring safer sewage and water supplies.

We see these same issues today in debates over COVID-19 today. Those who argue for businesses to open prematurely and for everyone to “get back to work” echo the sentiments nineteenth century industrialists who saw cholera and fevers as short-term barriers to sustained economic growth. Those who have used evolving data on

COVID-19 to emphasize its greater incidence among the poor and marginally employed follow upon the thinking of the nineteenth century social reformers and physicians who argued infectious disease had a socioeconomic face to the detriment of all.

Today the debate is not only national but international. Diseases like Ebola afflicting the poor in Africa, China, India, or Mexico can expand to threaten the health of the well-to-do in North America and Western Europe. The globalization of disease occurs within the context of the same list of inequalities nineteenth century reformers identified. And so, we ask again: Is the role of government the health and welfare of its citizens, or the betterment of the economy? Should our foreign policy be one simply of trade, but assistance to improve the lives and thus the health of foreign partners? If the dichotomy is false, if good social policy creates good health creating good workers-why have we not acted accordingly?

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