PRESIDENTIAL ADDRESS

What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?

By Shula Marks*

Reading through the abstracts for the Society’s 1996 conference on ‘Medicine and the Colonies’ one cannot but be struck by the enormous range and rich diversity of the offerings, and of the astonishing development of the field over the last dozen or so years. The catchall title brought together a glittering array of papers, revealing the scope and variety of work currently being done on medicine in colonial settings. Even ten years ago, I think such a conference with so varied a programme would have been impossible. Certainly when I was invited by the WHO in 1978 to participate in a project to look at the impact of apartheid on health in South Africa and began to think seriously about the social history of medicine in South Africa, it would have been inconceivable.¹

At that time, the secondary literature on the history of health care in South Africa consisted of a handful of articles and couple of histories of colonial medicine before 1900, and biographies and autobiographies, with such titles as My Patients were Zulus,² or Tropical Victory.³ At best these were valuable compilations of fact, at worst, they were old-fashioned, narrowly conceived and somewhat triumphalist volumes celebrating the progress of ‘European medicine’ in South Africa, the lives and achievements of individual medical men, and the establishment of western medical schools and hospitals.⁴ If there were rather fewer medical discoveries to report than in their metropolitan equivalent, there were—to compensate—the triumph of science and sewers over savagery and superstition, as one might paraphrase much of the celebratory history of colonial medicine in the early twentieth century. Nor do I think South Africa was much of an exception, either for the rest of Africa or even more broadly for ‘the colonies’.

One can perhaps highlight four or five major impulses for the increasing interest

* School of Oriental and African Studies, University of London, Thornaugh Street, Russell Square, London WC1H 0XG.

This is a revised version of what I said at the Medicine and the Colonies conference. I owe the first question in the title to discussions with Sally Swartz about her own work on the history of psychiatry in the Cape Colony. Unless otherwise noted, the references are to papers given at the conference.

¹ This led to the WHO monograph, Health and Apartheid (Geneva, 1983), which I wrote with the epidemiologist, Dr Neil Andersson.


and changing focus in the writing of the history of colonial medicine over the past generation: the development of social history and with it the social history of medicine as an academic subject in Europe and the USA over the last thirty years or so; the growth of social constructionist analyses in the social sciences under the influence of Foucault, which have underlined the importance of medical discourses, and shown their centrality in the evolution of the modern state and its powers of surveillance; the creativity of medical anthropology and the increasing recognition of the centrality of health and disease as social metaphor and biological condition—made all the more urgent with the rise of new infectious diseases, such as AIDS and the resurgence of old ones, such as tuberculosis and chloroquine-resistant malaria.  

The extent of this change can be seen not only from the spate of monographs from the 1980s on a variety of aspects of ‘imperial medicine’, but also from the publication in 1988 of two watershed collections on the history of ‘imperial medicine’: Roy MacLeod and Milton Lewis’s Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion and David Arnold’s Imperial Medicine and Indigenous Responses. Both these volumes reflected the growing interest in imperial medicine as a distinct area of research, although as David Arnold warns in the introduction to his account of the polemic and practice of medicine in colonial India, Colonizing the Body we should be wary of establishing too rigid a barrier between colonial and metropolitan medicine:

It would be pointless to deny that much of what is described here in a colonial context has its precedents and parallels in nineteenth century Europe particularly Britain itself and was by no means unique to India. . . . the diverse array of ideological and administrative mechanisms by which an emerging system of knowledge and power extended itself into and over India’s indigenous society [was] in many respects characteristic of bourgeois societies and modern states elsewhere in the world. . . . There is indeed a sense in which all modern medicine is engaged in a colonizing process. . . . It can be seen in the increasing professionalization of medicine and the exclusion of ‘folk’ practitioners, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases.

These observations are borne out in Hilary Marland’s fascinating paper to the conference on the Dutch Catholic midwifery school which opened in the small town of Heerlen in the south of the Netherlands in 1913. Marland shows that one of its purposes was to send ‘missionary’ midwives into poor, Catholic regions, to rid the poor women they delivered of dangerous, superstitious and dirty practices, as well as to eliminate their traditional attendants. Often, what is read as charac-
teristic of 'colonial medicine' then may be characteristic of biomedicine more generally. As Heather Bell remarked in her paper on yellow fever in the Anglo-Egyptian Sudan: 'the distancing of scientific interest from patient experience occurring in this story resulted less from the colonial context than from the methods of laboratory based medicine.'

If, however, there is a large a degree of overlap, what if anything, is specifically colonial about colonial medicine? This is not an easy question to answer. As Roy MacLeod and Milton Lewis remark in the introduction to Disease, Medicine and Empire, there is as yet no 'coherent agenda, let alone an agreed theoretical basis' to the field of imperial or colonial medicine. What they are concerned with is to show how 'medicine served as an instrument of empire, as well as an imperializing cultural force in itself.' Thus, for MacLeod and Lewis, imperial medicine is about 'the experience of European medicine overseas, in colonies established by conquest, occupation and settlement.'

Doubtless the formulation of this agenda is established by virtue of their vantage point in the Antipodes: from an African or Indian perspective there are perhaps different priorities as David Arnold's introduction to his not dissimilarly titled collection suggests. There is a fair degree of overlap, but here indigenous experiences and agency take a more central position. For Arnold the focus is on the impact of western medicine on indigenous healing practices, as well as on the indigenous experiences of, and responses to, western medicine. Many of the papers for the 1996 conference develop further those topics in the collections which have both reflected and shaped our field of endeavour.

Some of the themes encompassed by 'medicine and the colonies' was also very helpfully set out in the agenda of the conference organizers. They called for papers dealing with military medicine and colonial conquest; race and colonial medicine; missionary medicine; indigenous practitioners and colonial rule; colonial medical profession; alternative and irregular Western practitioners in the colonies; nursing in the colonies; colonial hospitals and extra-institutional care; the history of psychiatry in the colonies; 'tropical' and 'temperate' medicine; and the role of international health care in the colonies and ex-colonies.

Despite the absence of a chronological or geographical frame in the call for papers, the hundred years between roughly the mid-nineteenth and mid-twentieth century formed the focus of the majority of the papers to the conference. This is where most recent research has been concentrated. Nor is this emphasis

9 'Yellow Fever Research in the Interwar Anglo-Egyptian Sudan'.
10 R. MacLeod and M. Lewis, 'Preface', in MacLeod and Lewis (eds.) Disease, Medicine and Empire, p. x.
12 Looking through the back numbers of the Society's journal, Social History of Medicine, for example, there is not a single article either on the Americas in the colonial period or the Caribbean.
pure coincidence, for this century both marked the heyday of European empires
and saw the emergence of an effective and apparently all-conquering biomedicine, each the product of Europe's technological revolution. And while
recent historians are by no means as sure as their forebears that medical advance
accounts for the markedly reduced European mortality in the tropics in the mid-nineteenth century, this reduction and the growing belief in human adaptability
to climatic variation were essential preconditions for the expansion of empire, as
Philip Curtin has shown.13

As the reference to Curtin's *Death by Migration* serves to remind us, perhaps the
most overwhelming fact of empire, one which is perhaps so obvious that we tend
to take it for granted, was the enormous movement of peoples—sailors and
soldiers, slaves and settlers, merchants and missionaries—that the expansion of
Europe entailed. Curtin's concern is with the impact of disease on the agents of
empire, colonial soldiers, in the nineteenth century. Yet the expansion of Europe
overseas had a far more dramatic disease impact on the non-immune populations
of the New World: American Indians from the late fifteenth to sixteenth century,
Australian Aborigines and Pacific Islanders from the late eighteenth century.

As Mark Nathan Cohen, has remarked:

overwhelming historical evidence suggests that the greatest rates of morbidity and death
from infection are associated with the introduction of new diseases from one region of
the world to another by processes associated with ... transport of goods at speeds and over
distances outside the ranges of movements common to hunting and gathering groups.
Small-scale societies move people among groups and enjoy periodic aggregation and dis-
spersal, but they do not prove the distances associated with historical and modern religious
pilgrimages or military campaigns, nor do they move at the speed associated with rapid
modern forms of transportation.14

The effects were clearly most dramatic in the first colonial encounters, as both
Alfred Crosby and William McNeil have shown.15 In our concern with the
heyday of empire we should not forget that in some parts of the world—the
Americas, the Caribbean, the Dutch East Indies, the Cape Colony, parts of
India,—colonial medicine has a history stretching back to the sixteenth and
seventeenth centuries.16 It would be unfortunate if as a result of this chronologi-
coals foreshortening we were to lose a sense of the momentous demographic
onslaught of early colonialism or neglect the very important continuities between
the earlier and later colonial history of medicine.

---

16 Michael Worboys also points to the neglect of these areas in his contribution on 'Tropical Diseases', in Bynum and Porter, *Companion Encyclopedia*, vol. 1, p. 528.
As Crosby puts it, the colonial histories of Old World pathogens . . . [provide] the most spectacular example of the power of the biogeographical realities that underlay the success of European imperialists overseas. It was their germs, not these imperialists themselves, for all their brutality and callousness, that were chiefly responsible for sweeping aside the indigenes and opening the Neo-Europes to demographic takeover.\(17\)

Have we really said the last word on these ‘catastrophic . . . epidemic invasions of virgin populations’ which, McNeil has argued, were of ‘key significance . . . in the complex of factors sustaining Europe’s expansion’?\(18\)

Microbes continued to accompany the movement of men and manufactures on the world’s seaways into the nineteenth and twentieth centuries. The era of industrial capitalism witnessed what Eric Hobsbawm has called ‘the greatest migration of peoples in history’: from the metropole to the colonies and between and within the European empires men (and some women) moved with their pathogens and parasites, to become workers on the mines and plantations and factories of empire. And while epidemic disease continued to devastate more isolated communities, as Donald Denoon’s paper to the conference incidentally reminded us,\(19\) the expansion of colonialism and the colonial city brought their own harvest of disease, as the many papers on public health, epidemic disease and colonial rule bore witness.\(20\)

\(II\)

In 1992 Charles Rosenberg set out the areas which he felt had been of concern to professional historians of medicine over the past couple of decades. Of these, ‘perhaps the most widely influential’, according to Rosenberg, has been an interest in ‘the way disease definitions and hypothetical etiologies can serve as tools of social control, as labels for deviance, and as a rationale for the legitimation of status relationships.’ This in turn has been associated with the swing towards a social constructionist view of disease and is an aspect of the wider concern with the

\(17\) Crosby, Ecological Imperialism, p. 196.
\(19\) ‘Divorce and Remarriage. Western Medicine and Anthropology in Melanesia’.
relationship between 'knowledge, the professions and social power' in the social sciences.21

It is indeed with these issues that many of us concerned with 'medicine and the colonies' are at present engaged. In many ways this emphasis in colonial medicine is not entirely surprising. After all, the colonial context provides a particularly fertile ground for exploring the relationship of medicine and its discourses to issues of colonial power and control, as Megan Vaughan has most elegantly suggested.22 Medical discourses in turn draw us to the very heart of what Frederick Cooper and Ann Stoler have recently termed the 'tensions of empire': 'tensions' which are 'particular to the universalizing claims of European ideology and the particularistic nature of conquest and rule, the limitations posed on rulers by the reproduction of difference as much as the heightened degree of exploitation and domination that colonization entailed.23

As a spate of recent work makes clear, western biomedicine has undoubtedly played a major role, both in making universalizing claims, and in creating and reproducing racial and gendered discourses of difference.24 The historical connections between biological science and racial science can hardly be doubted, and the study of race, gender and 'difference' has become a veritable growth industry. By the late nineteenth century, notions of racial difference intersected with newer Social Darwinist anxieties in the metropoles about the declining fitness of the 'imperial race', reductions in fertility and birth rates, as well as high infant and maternal mortality, and led to the upsurge of interest in motherhood and an interest in eugenics.

These ideas influenced even those dominions like New Zealand, which were least affected by racism in the inter-war years, at least at a conscious level, and where we can see the influence of eugenics in a perhaps somewhat less sinister light. As Milton Lewis pointed out in the 1988 collection 'rising interest in infant health was in part a result of fears that an unfit metropolitan people (including the white Dominions) would be unable to defend and develop imperial possessions.25 Similar themes emerge from Philippa Mein-Smith's paper to the conference on 'Good New Zealand Milk, 1890s to 1960s' where the interlocking configurations of political economy, colonial dependence and cultural constructions of whiteness and fitness were brilliantly illustrated, and Linda Bryder's analysis of the relative failure of New Zealand's Plunket Society to address Maori infant health. In settler

22 Megan Vaughan, 'Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa', Social History of Medicine, 7 (1994), 289.
25 Milton Lewis, 'The "Health of the Race" and Infant Health in New South Wales: Perspectives on Medicine and Empire', in MacLeod and Lewis (eds.) Disease, Medicine and Empire, p. 302.
What is Colonial about Colonial Medicine?

society, as in Britain itself, eugenic concerns led to increasing concern with infant welfare, and maternal responsibility.

If, in the dominions, 'good, white milk' was believed to be necessary for good, white settler stock, in tropical Africa, as Megan Vaughan has remarked in *Curing their Ills*, 'the power of colonial medicine lay not so much in its direct effects on the bodies of its subjects... but in its ability to provide a “naturalized” and pathologized account of those subjects.'\(^{26}\) Moreover, this 'pathologizing' of the 'other' is not simply a matter of history. The resurgence of medicalized racial discourses in our own day, as the media treatment of AIDS and the Ebola virus so clearly reveal, and the 'repolitization of the notion of racial difference', lend a certain urgency to our consideration of scientific racism.\(^{27}\) Indeed in answering the question 'What is colonial about colonial medicine' the temptation is to give the priority to questions of race and eugenics. Yet the current search for a 'criminal gene' among the 'underclasses' in the metropole suggests that here too the dialogue between home and empire is far from simple.

This pathologized account is perhaps most marked in the responses of colonial doctors to the problems of gender and madness, as Vaughan suggests in her brilliant discussion of colonial discourses around syphilis and madness.\(^{28}\) The slippage between the mad and the bad, the black and the feminine has deep roots in European thought, and historians concerned with the discourses of colonial medicine have, like their European and American counterparts, have found the history of madness and of venereally transmitted diseases fruitful fields of investigation.\(^{29}\)

On these many readings, 'racial anxiety' is clearly as intimately bound up with metropolitan as with colonial concerns. And most relate racial discourses to specifically nineteenth- and twentieth-century concerns. This is also a central argument in Kenan Malik's thought-provoking new book, *The Meaning of Race*. For Malik, the contemporary meanings of race emerged out of the paradox of the Enlightenment belief in equality, and the difficulties in the way of its realization in capitalist society. Race, he asserts, 'developed initially as a response to class differences within European society, and was only later applied to difference

---


\(^{29}\) There were no fewer than four papers on colonial madness at the conference; this contrasts as we shall see with the virtual exclusion of discussion of the industrial diseases which took a far larger toll of life and limb in the mines and plantations of the colonies. See Lynne Marks, 'Sexuality, Gender and Religious Insanity in Canada, 1850–1900'; Cathy Colebourne, 'Gender and Patients in the Lunatic Asylum in Colonial Australia'; Waltraud Ernst, 'Gender, Madness and Colonialism: the Case of Female European Asylum Inmates in 19th Century British India'; and S. Swartz, 'Marking the Lunatic Body: Race and Gender in the Management of the Insane, Cape Colony, 1891–1920.'
between Europeans and non-Europeans, and hence became marked by colour differences.\(^{30}\)

Yet the dialogue is surely more complex if one takes a longer and more dialogic view of empire. Racial ideas, if not systematic racism, had a more complex aetiology, generated as they were in the long conversation between Europe and its colonial worlds, from the late fifteenth century. Thus, Stoler and Cooper suggest:

As we begin to look at the similarities and differences in social policy in Europe and the world it made colonial, it is clear that the resonance and reverberation between European class politics and colonial racial policies was far more complicated than we have imagined. . . . If there were places where the European languages of class provided a template for how the colonized racial 'residuum' was conceived, sometimes the template worked the other way around. The language of class itself in Europe drew on a range of images and metaphors that were racialized to the core.\(^{31}\)

In his paper to the conference, Jorge Canizares deals with the beginnings of this 'intricate dialogue' in Latin America. As he shows, from the very beginning of their colonial enterprise 'Spanish intellectuals deployed secular and naturalistic explanations to justify the exploitation of the Amerindian labour force' . . . If there were places where the European languages of class provided a template for how the colonized racial 'residuum' was conceived, sometimes the template worked the other way around. The language of class itself in Europe drew on a range of images and metaphors that were racialized to the core.\(^{31}\)

Echoing some of Nancy Stepan's arguments about eugenics in Latin America, and suggesting some of the deeper roots of its racial thought, Canizares maintains that in Spanish America 'local white elites (creoles) . . . sought to contradict the Spanish views of American degeneration by manipulating the very medical discourses used by the peninsulars to justify their rule for the metropolis'. 'Local scholars argued that the American stars caused Indians to be sloths' and creoles to be more intelligent than their 'peninsular brethren'. 'This . . . allowed the creoles to represent America as their own paradise and . . . to colonize the past of the peoples they were subjugating'.\(^{33}\)

Julyana Peard's paper on medical ideas in nineteenth-century Brazil fitted well with Canizares's arguments for Spanish America. Peard maintains that while in the first half of the nineteenth century the Brazilian elite replicated European—especially French—medical ideas and practices in order to prove they were 'civilized', by the 1860s a group of doctors known as the Tropicalistas emerged in opposition to develop 'a distinctive medicine of the tropics'. At the heart of this new medicine was a rejection of environmental determinism and ideas of tropical degeneracy. This enabled them to reformulate notions of disease in the tropics, and thus 'to reconceptualize Brazil as a nation with the chance of becoming an advanced civilization in the tropics'.\(^{34}\)


\(^{32}\) J. Canizares, ‘Medical Theories and Views of Race in Colonial Spanish America’.


\(^{34}\) ‘Medicine and Politics in the Torrid Zone: the Pre-Cruz Era in Brazilian Medicine, 1860–1900’. 
III

Interestingly, the emergence of the ‘Tropicalistas’ occurred some thirty years before the emergence of a systematically defined ‘tropical medicine’ in the British context, although speculations about the effect of the tropics on health arose with the earliest encounter of European traders with tropical climes and tropical peoples. By the late nineteenth century the diseases which attracted most attention from British doctors in the tropics were—hardly surprisingly—those which took so large a toll of white lives in Africa and Asia, and it was the conquest of these diseases which of course made the penetration of the tropics a possibility: malaria, yellow fever, hook-worm. Sleeping sickness, too, which was seen to threaten the reproduction of the labour force was an early candidate for the practices of tropical medicine, and, as Michael Worboys has shown, is an excellent example of the divergent medical approaches of different colonial powers in east and central Africa, ‘and the ways these were rooted in different medical approaches and colonial structures’: Belgian, German and British.  

In the late nineteenth- and early twentieth-century British empire, then, ‘tropical medicine’ came to have a rather more specialized scientific connotation, and was readily adopted by the advocates of imperial expansion. While in Latin America, settler physicians manipulated metropolitan notions of ‘tropical medicine’ to assert their own superiority and specialized knowledge, so in Britain research into a newly defined discipline of tropical medicine was used by a small number of physicians in order to advance their own authority and status. As a result, according to Worboys:

The investigation and teaching of the etiology and treatment of tropical diseases was developing in an environment and culture totally different from the tropics. Work on etiology became exclusively scientific, based upon parasitological studies and the germ therapy of disease. The clinical treatment of these diseases took precedence over prevention and epidemiological studies on disease incidence and control. In the metropolitan situation, remote from the practical problems of the tropics, the study of tropical diseases became increasingly preoccupied with scientific problems rather than the problems of poor health.  

If ‘tropical medicine’ provided British medics with a new channel for their ambitions and energies, in Australia’s Northern Territories, according to Suzanne Parry’s paper to the conference, the discourse of ‘tropical medicine’ was—like its Latin American predecessors—used both to assert the capacity of settlers to survive in the tropics and to justify the control of a ‘pathologized’ Aboriginal people and their confinement to reserves. Thus, as in Africa, tropical medicine was used to justify segregation and highly coercive forms of medical intervention at times of epidemic disease; by attributing ‘disease’ to their tropical environment and racial


inheritance, the social and economic aetiology of most Aborigine of ill-health was obscured.37

What this suggests is that, as in the case of eugenics, we need to look for the shape and substance if not the genesis of tropical medicine in specific colonial imperatives in the dialogue between metropole and colony.

IV

The development of arguments around eugenics and tropical medicine are perhaps more easily traced in colonies of settlement than in the tropical colonies themselves. Nevertheless, at a broader level, colonized peoples also engaged in a complex set of contestations, negotiations and adaptations in their encounter with western biomedicine. And, while by the late nineteenth century Western medical practitioners had come to believe in the single ‘universalizable truth’ of their own understanding of health care, and to show little tolerance for alternatives, non-Western medicine whether Chinese, Ayurvedic or African, showed itself far more tolerant and accepting of new ideas.38

Much new work is about the very complex responses of indigenous people to colonial medicine, and indeed a considerable number of the conference papers, celebrate indigenous agency and the bricolage of indigenous medical practice. Indeed the entire history of healing in Africa, as elsewhere, contradicts the confident judgement of John Fitzgerald, the Superintendent of Grey’s Hospital in the Eastern Cape in 1876, that ‘it is impossible that ignorance and superstition can long compete with science and skill in the treatment of the sick’.39 Far from the struggles over medical hegemony ending in the triumph Fitzgerald predicted and in the ‘erasure’ of indigenous subjectivity which some post-colonial writers lament, many of the conference papers reveal instead the varieties of successful resistance to, and the selective incorporation/adaptation and manipulation of, Western medical traditions by colonized peoples.40 For the most part, at least in

39 Cape House of Assembly, G.64–77, Annexure to Votes and Proceedings, King William’s Town, Grey’s Hospital, Report of the Superintendent of the Native Hospital, for the year 1876, p. 1. Fitzgerald had honed his skills on the Maori before coming to South Africa. His role in the Eastern Cape and African therapeutic choice were the subject of David Gordon’s paper to the conference (‘Transformations in Disease Patterns and Therapeutic Traditions in Colonial Xhosaland, 1847–1891’).
the short and medium run, the outcome was closer to what Luise White has recently referred to as ‘tantalizing hints of an intellectual community in which aspects of Western biomedicine were unpacked, examined, accepted and reinterpreted according to local meanings’.

All this suggests that the history of medicine in the colonies is often an illuminating way to examine aspects of the power and limitations of colonialism and its ideas and discourses. Yet an over-emphasis on the role of ‘medicine’ as a way of exploring colonial ideas and discourses and the nature of colonial power, risks a retreat from a political economy of disease and some of the major issues in the broader history of medicine and the colonies which concerned historians in the 1970s and 1980s. In our recent concern with discourses and texts, we may be in danger of forgetting that there is another history of actual morbidity and mortality, difficult as these may be to determine especially—but not uniquely—in colonial situations, and of actual therapeutic practices and institutions, in all their ambiguities and contradictions.

Demography, the changing patterns of disease and its social causes as well as its relationship to political economy, remain crucial areas of enquiry, if perhaps underrepresented ones in the recent literature. Indeed, when I began working in this field with Neil Andersson in the late 1970s, the ‘political economy’ of medicine seemed to reign supreme. To understand, for example, the impact of apartheid on health, one had to understand the fundamental social, economic and political institutions which shaped the disease environment and controlled the availability of health services and therapeutic choice.

In South Africa, there could be little doubt of the material basis of much of the disease and ill-health, and its relationship to conditions of production and reproduction; nor could the patterns of health care delivery be divorced from the relations of power in society. The great killers were malnutrition and the nutritionally associated infectious diseases, or diseases associated with poverty—gastro-enteritis, tuberculosis, measles. In the widest sense, we saw in the particularities of South Africa’s mineral revolution, commercialization of agriculture, and urbanization the source of much of its preventable ill-health: apartheid was indeed the way in which the burdens of that process of capitalist growth were transferred to the black population, and the rewards reaped by whites, although not all whites equally. The inequalities in health care/medicine were not a simple reflection of these conditions but equally could not be divorced from them.

Given the dominance of this paradigm in the early 1980s, it is perhaps a little

surprising that there is so little on the social production of disease and the social costs of production in our recent work.\(^{44}\) Indeed, there seems to have been a certain silencing of class issues as a result of our concentration on discourses around race and gender—a reflection perhaps of broader contemporary intellectual trends. As Eric Hobsbawm has recently remarked, we seem to be living in an age in which discussion of class has vanished as 'the old class-based political parties and movement have been weakened.'\(^{45}\) And with this seems to have come a kind of collective amnesia about the importance of class, and a displacement of class politics by the politics of identity in which race, gender and ethnicity have moved centre stage.

Yet to decenter class issues in the history of medicine in the colonial world, as in the metropole, is to leave much unexplored and unanswered. I have already referred to the complex relationship between class, race and gender in the evolution of eugenic thought. Can it be that because the discourses of medicine privilege bodily markers like gender and race, they serve, especially in a colonial context, whether consciously or unconsciously, to occlude considerations of class? Is there perhaps a danger that for many of us, as for imperial doctors the fascination lies with those diseases which afflicted Europeans in the tropics and those new forms of knowledge constituted around them construed as tropical medicine? Is there not a danger that we are being lured by the glamour of 'tropical' and epidemic disease—where the evidence is easier to come by and where we, too, can lay claim to a specialized field—and, like the aficionados of 'tropical medicine', neglect the more mundane but also the more pervasive killers? After all one does not have to be a Marxist to recognize that a prime motivation for colonialism (if not the prime motivation) has been economic—whether one understands this to arise from 'gentlemanly capitalism' or from the need for markets and raw materials, and that the exploitation of material resources and the expansion of capitalist modes of production have carried a high social cost. As Gwyn Prins has pointed out,

the social costs of productive activities may be calculated as openly as the material ones. Thus part of the cost of a switch to cash crops in eastern Tanzania [and Zambia as Vaughan and Moore have recently shown] is paid in increased perinatal mortality, itself a result of increased demands on women's time . . . colonial development projects in northern Ghana and increased pressure to use river-valley land carried a price of increased onchocerciasis (river blindness); part of the cost of power and irrigation dams is paid in increases in schistosomiasis [and malaria]; a heavy part of the cost of gold-mining in South Africa was the wholesale introduction of tuberculosis into African recruiting grounds; part of the cost of urban growth in Zambia is paid, in the encircling shanty towns, in infant malnutrition, resulting from . . . a culturally induced decline in breast-feeding and degradation of diet to one of fizzy drinks and shop bread.\(^{46}\)

\(^{44}\) As far as I could tell from the abstracts, there were only one or two conference papers devoted to these issues in the colonies: Harold Drayton's account of the colonial origins of health underdevelopment, and slightly less obviously, Diana Wylie, 'The Threat of Race Deterioration: Nutritional Research in South Africa, 1900–1970'.

\(^{45}\) This is the burden of Hobsbawm's 'Identity Politics and the Left', \textit{New Left Review}, 207 (1996), 40.

The current silences are surely significant and raise for me the issue of how we as social historians of medicine engage with what must be the most important legacy if not of colonial medicine then of imperialism on health: the continuing and widening inequalities in health and health care both within and between different countries across the world. It is salutary to recall that, despite the optimism of the 1993 World Bank Development Report that since 1950 ‘life expectancy has improved more than during the entire previous span of human history’, these disparities continue to widen. In 1993, of the $23 trillion global GDP, $18 trillion is in the industrial countries; only $5 trillion in the developing countries, which contain 80 per cent of the world’s population, while the assets of the world’s 358 billionaires in 1996 exceeded the combined annual incomes of countries with 45 per cent of the world’s population.

In its report the World Bank spelt out the good news: in the mid-century life expectancy in ‘developing’ countries —for which read ‘ex-colonial’ countries of Africa and Asia—was 40 years; by 1990 it had increased to 63. In 1950 28 out of every 100 children died before their fifth birthday; by 1990 this had fallen to 10. Smallpox which had killed more than 5 million people annually had been eradicated completely, and vaccination had drastically reduced the occurrence of polio and measles. Unfortunately these advances have not been sustained.

1990 was probably a relatively good year in which to measure progress—before the eruption of civil strife and ethnic cleansing which has made a mockery of health care in large swathes of Africa and Eastern Europe. By the mid-1990s, social scientists were less optimistic, estimating that mortality in developing countries from AIDS would rise to 1.8 million deaths annually by the year 2000, thus eliminating the improvement made over the last half century. Nor is AIDS the only health hazard on the increase. The increase in chloroquine resistance means that deaths from malaria are now estimated to double to nearly 2 million a year by the year 2000 while the number of tobacco-related deaths from heart disease and cancers are also estimated to double by the first decade of the next millennium to 2 million a year. Figures for TB are also set to rise.

Quite apart from the increasing health hazards hanging over the next millennium, however, any sense of euphoria evaporates quite quickly once the 1990 mortality statistics are disaggregated. As the World Development Report put it:

Absolute levels of mortality in developing countries remain unacceptably high: child mortality rates are about ten times higher than those in the established market economies [i.e. North America, Western Europe including the UK, Japan and Australia]. If death rates among children in poorer countries were reduced to those prevailing in the rich countries, 11 million fewer children would die each year. Almost all of these preventable deaths are a result of diarrhoeal and respiratory diseases, exacerbated by malnutrition. In addition every year 7 million adults die of conditions that could be inexpensively prevented or cured. About 400,000 women die from the direct complications of pregnancy and childbirth.

50 Ibid., pp. 1–3.
Maternal mortality ratios are on average thirty times as high in developing countries as in high income countries.\textsuperscript{51}

Moreover if one begins to disaggregate the global figures for the 'developing countries', the good news looks far less good for certain of these countries than for others. While, for example, life expectancy has increased from 42 to 68 years in China and from 40 to 61 in the Middle Eastern Crescent, in sub-Saharan Africa average life expectancy is still only 52 (and set to decline to 47 by the year 2000 as a result of AIDS); or—again to choose a single example cited by the World Development report—while in 1960 in Ghana and Indonesia about one child in five died before the age of five, by 1990 Indonesia's rate had dropped to one child in ten, while Ghana's had only fallen very slightly.\textsuperscript{52} And it will not surprise you to learn that progress in health is directly correlated to increases in income—and to the improved nutrition, housing and education that comes with increased affluence, although manifestly improvements in public health and advances in medical knowledge have played a part.\textsuperscript{53} According to the World Development Report, economic indicators seem to be the most important predictors of mortality decline, but surely here is a field crying out for comparison by historians of colonial medicine familiar with the debate among historians on the relative importance of a rising standard of living and public health interventions in explaining demographic change in nineteenth-century Britain.\textsuperscript{54}

Ironically, as the emphasis in our field has shifted from class and political economy—and I am talking mainly of a shift of emphasis—it seems that the issue of inequality in health among economists and sociologists has moved again to centre stage. As the 1980 Black Report on inequalities in health made clear, the relationship between mortality and occupational class is 'most unequivocal' even when controlling for age, gender, race or region. Moreover, this remains true even when controlling for the effect on health of lifestyle—education, diet, smoking and alcohol—or the provision of medical services.\textsuperscript{55}

Yet health is not only a matter of absolute income. In a recent major analysis of the evidence, Richard Wilkinson has shown that in industrial societies which have crossed the epidemiological threshold, 'social, rather than material factors are now the limiting factors on the quality of life.' Thus while within the same society, occupational class remains the best predictor of individual differences in mortality and morbidity, across societies it is inequality itself—and the degree of social dislocation which inequality signals—which is of crucial importance. As Wilkinson puts it, 'once a country has passed the threshold of income associated with the

\textsuperscript{51} Ibid.
\textsuperscript{52} World Development Report, pp. 1, 23.
\textsuperscript{53} Ibid., p. 34.
\textsuperscript{54} Ibid., p. 2.
\textsuperscript{55} See, for example, Peter Townsend and Nick Davidson (eds.) Inequalities in Health. The Black Report, and M. Whitehead, The Health Divide (Harmondsworth, 1992 [joint publication, revised edition]). The Black Report, named after its chairman, was the report of a Working Group on Inequalities in Health set up by the Labour Secretary for State for Health and Social Security, and was first published in 1980. The health inequalities which it noted in the late 1970s had increased by the 1990s.
What is Colonial about Colonial Medicine?

epidemiological transition, its whole population can be more than twice as rich as another without being any healthier.' Thus, 'life expectancy is higher in countries like Greece, Japan, Iceland and Italy than it is in richer countries like the United States and Greece.'

Fascinating as these findings are, here is neither the time nor the place to analyze them in detail. In any case, you might ask, what relevance do they have to those of us who are working on colonial societies where for the most part people did not have the minimum living standards necessary to escape the nutritional, infectious and epidemic diseases? Clearly we have to be careful in drawing too precise an analogy between the industrialized world and colonial societies. Yet I do think a broader set of issues arises out of Wilkinson's work which sheds a new light on forms of indigenous healing and indigenous understandings of health and disease, and gives a new meaning to our understandings of the universal and the particular.

Very briefly, Wilkinson argues that unequal economic growth and inequality bring intolerably high levels of social stress—job insecurity and a crippling sense of powerless, broken families, increased violence and accidents, drug abuse, crime and juvenile delinquency, and, above all, loss of a sense of community. If he is correct—and the argument is supported by a remarkable range of cross disciplinary findings—this opens up a wide range of comparative questions for historians. Not only does it revitalize the dialectical relationship of the biological and the social, and the epidemiological and the political; it also suggests most interestingly that biomedicine may well have much to learn from the experience of those non-Western healers who see the need to treat social disease as well as individual ill-health, and understand that resolving social tension is part of the healing process.


57 See, especially, Wilkinson, Unhealthy Societies, ch. 8.