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The Public Funding of Health Care: A Brief Historical Overview of Principles, Practices, and Motives

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Abstract
Nationally sponsored programs designed to fund health care for the general public are largely a twentieth century phenomenon. Yet a long glance backward at the medical and public health history of Western civilization, extending from the ancient Greeks to the twentieth century, reveals earlier periods when governments, religious institutions, and other groups provided some measure of medical relief for the sick, the poor, and the homeless. In this essay, I will provide not an exhaustive but rather an illustrative account of this oft forgotten fact. My objectives are threefold.

First, to remind us that the active concern of society for the health of its citizens is hardly a new development arising full born, as it were, out of the biomedical revolution and refined moral sensibilities of our present age. As I will suggest, our current interest in public health, and the related question of how to allocate medical resources fairly, is part of a larger evolutionary social process. Second, to conjecture that the impulse of caring for the sick and injured, using public or private resources, is typically driven by a variety of sometimes overlapping motivations, both religious and secular in origin. Third, to indicate that no single monolithic philosophy of providing medical care for the masses emerges from the historical record. That is, no unified pattern of health care organization or individual or communal motivation can plausibly account for this seemingly altruistic behavior, behavior which is putatively aimed at promoting the common good of all members of society.

Given the interdisciplinary scope of this discussion, my inquiry will weave together sociological, psychological, and philosophical strands of evidence. Constraints of length will limit us primarily to developments in Europe and the United States. In the end, a limited sampling of societal practices, individual or communal motivations, and philosophical considerations will indicate that no simple story can be told about the public or private funding of health care.

Proceeding more or less chronologically, I will introduce evidence demonstrating that redemptive, utilitarian, prudential, and charitable impulses (among others) are at work in the humane decision to use public or private funds to provide medical care for the benefit of the sick or infirm. While I do not claim that these four motivations constitute a complete list, they do emerge as a recurring and significant typology — helping to solidify the emerging modern public health movement in England, the United States, and elsewhere in the West by the late nineteenth century.

Keywords
health care, poverty, public resources, private resources, morality

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Distributing Health Care

Principles, Practices and Policies

Edited and Introduced by Niall Maclean

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Old age is a natural disease, while disease is an acquired old age. (Aristotle, *Generation of Animals* 5.49.784b.33)

**Introduction**

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The Public Health Movement and Distributive Justice

Struggling to survive amidst the social upheaval of the Industrial Revo-
lution from about 1750 and well into the next century, peasants, labour-
ers, share-croppers and others migrated from rural to urban areas—first
in Europe and later in America—in search of a better life and regular
employment. Instead, workers were routinely paid subsistence wages
and laboured twelve to sixteen hour days in grinding, suffocating facto-
ries and other industrial environments in cities like Manchester, Liver-
pool, Chicago, and Boston. What’s more, the unwashed masses were
frequently shunted into crowded, unsanitary tenements in major eco-

nomics centres such as Paris, London, and New York. Not surprisingly,
the poor, hungry, and homeless were usually the hardest hit by infec-
tious (communicable) diseases and other debilitating ailments. In fact,
their miseries were redoubled by overcrowded tenement housing in the
larger cities by the end of the eighteenth century and throughout the
nineteenth century as well. These squalid living and working conditions
contributed to new levels of urban blight and the inevitable spread of

involved funds from both the wealthier classes, acting charitably, and from
governmental sources, acting prudentially.
infectious diseases like cholera, diphtheria, tuberculosis, smallpox, yellow fever, and measles.

Indeed, the modern public health movement may be understood, in part, as a humane response to the collective misery brought about by the Industrial Revolution and its introduction of steam power to run the massive factory machines, and by the population shifts which it provoked as workers were lured from country farms and villages to, in effect, become willing cogs in those often dehumanizing machines. The public health ethos represents a response on the part of doctors, nurses, city officials, clergy, and governmental leaders who personally or professionally cared about the future of their cities and towns. Understandably, they cared, too, about the preservation of their own and their families' and their communities' health in the face of these profound demographic migrations and accompanying threat of the outbreak of epidemic diseases that left no one feeling secure. In addition, poor personal hygiene, foul drinking water, spoiled food, lack of sanitation, putrid air—these and other factors were also commonly thought to be involved in undermining the health of the masses. However prejudicial or misleading, the views of a growing cohort of public health officials held sway with the establishment as their opinions were echoed in newspapers and summarized in public health notices posted publicly during the 1800 and 1900s in both England and the United States, according to social historian Roy Porter (Porter, 1999, pp. 397–427 passim).

Hence, by the opening decades of the 1800s some reasonably helpful public health measures were deployed. These included educational tracts about the importance of personal hygiene (cleanliness, it turns out, really was next to godliness); church sponsored kitchens for the care and feeding of the displaced and the poor; and early feminist social campaigns that stressed the need for improved sanitation. These efforts culminated in the so-called 'sanitation movement' that lobbied for closed sewers, potable drinking water, and other important environmental reforms. In addition, many churches and other religious organizations sponsored sermons aimed specifically at the poor, widowed, and orphaned. These stressed the need for 'good work habits', 'clean morals', regular bathing or, if needed, de-licing, medical examinations, etc. To be sure, however mixed the overall results were in actually protecting lives against infectious diseases like cholera and smallpox, such public health measures did indeed cost the state and other sponsoring organizations money. While most of the revenues to cover these costs came from government treasuries, other funding derived from such non-governmental entities as churches, guilds, professional societies, and wealthy families. The latter tended to view their contributions as a
civic or religious duty if not also as an insurance policy against class warfare.

Furthermore, by the middle of the nineteenth century, what could be called the emerging public health movement and its tacit commitment to promote sound hygiene and public sanitation for all, began slowly to be codified into law. In England, this reform was embodied in three key pieces of legislation.

First, the (revised) New Poor Law of 1834. This was encouraged by the utilitarian reformer and founder of the Sanitary Movement in Britain, Edwin Chadwick (1800-90). Among other things, the law created a single scale of benefit to the poor across England, without local variations (Chave, 1984, p. 5). It also provided subsistence, medicine, work, and crude housing for the indigent but able-bodied poor who, unsurprisingly, suffered in disproportionate numbers from a variety of chronic and debilitating diseases. But Chadwick came to see that the revised workhouse conditions created by the New Poor Law, a law that was actually intended to reduce the number of families on public relief by creating harsh workhouse conditions involving the separation of families, long hours of employment, and the lowest possible pay, in point of fact increased the number of families seeking subsistence wages. This puzzled him. He studied the situation in great detail, culminating in his monumental Report on the Sanitary Condition of the Labouring Population of Great Britain (1842). This report to Parliament documented, among other things, that not fecklessness or sloth (as he and others had heretofore ruefully claimed) but rather disease and disability were overwhelmingly the primary causes of poverty. In addition, to overcome these unhealthy conditions, action needed to be taken by municipal governments to provide clean drinking water, rid towns and cities of cesspools and piles of garbage that bred disease, and eventually establish oversight and enforcement mechanisms. Disturbingly, Chadwick's report showed that the average age of death for the poorest laborer in London's worst slums was 16, while the better-off laborer lived to about age forty-five. 'Poverty could not be abolished, but the poverty due to preventable diseases could be', Chadwick declared. Given his powers of persuasion and careful documentation, he convinced Parliament that the situation among the urban poor was indeed dire (Porter, 1999, p. 411).

Second, this sense of urgency led to the passage of the England's first Public Health Act of 1848. This act created a central governmental authority, the General Board of Health. It compelled all cities and towns to establish boards of health responsible for implementing and enforcing sanitary conditions for drainage, water, garbage removal, housing, waste disposal, and the regulation of 'offensive trades' like butchering, slaughtering, tanning, etc. Shortly thereafter, in 1849, an English physi-
cian and epidemiologist by the name of John Snow (1813–1858), tested this law. He published his controversial On the Mode of Communication of Cholera. 'Questioning [Chadwick’s preferred] miasmatism, he argued that cholera could not be spread by a poison in the ambient air [as had been widely held], since it affected the intestines not the lung’ (Porter, 1999, p. 413). In fact, Snow suspected that cholera was not a contagion at all but rather a water-borne disease. A significant breakthrough occurred in August of 1854, when Snow traced 93 local cholera deaths to a single source, namely, contaminated drinking water drawn from London’s Broad Street Pump. Snow moved quickly. On September 7th, he persuaded the Board of Guardians in Soho to remove the offending pump. The Board was at first skeptical but reluctantly agreed. Within months, local cholera deaths in Soho dropped precipitously. Thus, Snow’s theory was confirmed in no small measure due to his persistent detective work and the regulatory governing structure created by the aforementioned Public Health Act of 1848 (Porter, 1999, pp. 412–3). Interestingly, in France the work of Louis Rene Villerme (1782–1863) almost paralleled the statistical conclusions of Chadwick. In fact, Villerme’s ‘... morbidity and mortality statistics also demonstrated a close correlation between health and living standards, and led the French government to establish a national public health advisory committee in 1848’ (Duffy, 2004, p. 2207).

Third, there was the further development in England of legislation leading to yet another consolidating piece of legislation designed to fortify public health regulations.

The sanitary legislation developed since 1848 was consolidated in the codifying Public Health Act of 1875, requiring the appointment of a medical officer of health to every sanitary district in England and Wales, while the Poor Law and public health administration were amalgamated in 1872 in the Local Government Board. [Hence], the medical expert’s role in public administration had been established, and local government had acquired extensive public health powers (Porter, 1999, p. 414).

And so the Public Health Act of 1875 formally and systematically acknowledged the role of government to provide minimal levels of sanitation and sound hygiene for all citizens. This astonishing moral, social, and scientifically informed commitment, based on the realization that the strength of society as a whole depends on the sound health of all its citizens, eventually paved the way in Britain to the establishment of the National Health Service by 1948, and in the United States to the establishment of the National Institutes of Health, during that same year. Coincidentally, the World Health Organization of the United Nations, dedicated to eradicating disease and stopping pandemics wherever they occur, was also established in 1948.
But compared to Great Britain, the rise of the public health movement in the United States developed at a somewhat slower pace. This was due in part to the fact that England was the first country in Europe to experience the displacing and dehumanizing social effects of the factory system. Then, too, the United States was a younger nation. Her westward expansion by rail from New York to California was not complete until about 1890, and steam power took a little longer than in England to be adapted for factory use. In due time, her major cities began to swell first with displaced labourers and farmers looking to improve their lot in the cities, and then with European and Asian immigrants seeking the greater economic opportunities promised by the American experiment. Hence, by the mid to late 1800s, this led to sanitation and related urban problems associated with overcrowding, squalid tenement conditions, and generally overwrought infrastructure. The rates of morbidity and mortality began to rise, especially in the larger cities. Medical historian John Duffy expands:

The movement to remedy these conditions was initiated largely by physicians, most notably Benjamin W. McCready, whose 1837 essay drew attention to the deplorable health conditions in the workplace and the slum housing the workers, and [also] by John H. Griscom, whose 1845 report, The Sanitary Conditions of the Labouring Population of New York, laid the basis for establishing the first effective municipal health department in the United States. [Another] ... outstanding layman of the early health movement was Lemuel Shattuck of Boston, who pioneered in the collection of vital statistics and promoted sanitary reform ... As in England, the public health movement was both a humanitarian and moral crusade. A few reformers emphasized improving the morals of the poor. [B]ut most recognized that immorality and intemperance were closely associated with the crowded and brutally degraded living conditions of the poor (Duffy, 2004, p. 2206).

Thus, America’s first National Board of Health was instituted in 1879. This occurred largely in response to the terrifying yellow fever epidemic of 1878 which spread like wildfire across state lines. In particular, yellow fever took its human toll up and down the Mississippi River. It was thought to be carried by commercial steamboats and their crews that plied the muddy waters from New Orleans to St. Louis. This outbreak killed over 50% of the people in some places. (Porter, 1999, p. 418) With the germ theory of disease (demonstrated in 1878 by Louis Pasteur, and expanded in 1882 by his arch rival Robert Koch) now equipping state-sponsored public health functions with a plausible new rationale for the scientific treatment and eradication of disease, ‘the USA was active in setting up publicly supported bacteriological laboratories for disease diagnosis and control’ by the last decades of the nineteenth century (Porter, 1999, p. 419). Partly as a result of this social upheaval and this revolutionary aspect of disease diagnosis, the role of the federal government expanded to include the coordination of state health...
boards. These entities typically consisted of a patchwork quilt of local and regional offices usually run by political appointees and overseen by at least one medical doctor. In 1912, President Theodore Roosevelt (1858–1919) acted decisively to bring these bodies into greater harmony with each other and with the public they aimed to protect. Specifically, he transformed the Marine Hospital Service, then under the limited authority of the surgeon-general, into the more powerful United States Public Health Service.

From this point forward, there was no turning back politically or philosophically. The federal government would increasingly play a critical role in monitoring and regulating health care standards throughout the United States. It would use public funds to achieve these goals and, at the same time, work in consultation with one of the most powerful professional lobbies ever established on the American scene, namely, the venerable American Medical Association (first established in 1847, and followed in 1872 by the establishment of the American Public Health Association).

What’s more, during the ‘New Deal’ reforms of President Franklin D. Roosevelt (1882–1945) in the 1930s, a series of public health laws were adopted that further expanded the federal government’s responsibility for the health and welfare of its citizens.

From June 1933, the Federal Emergency Relief Administration promoted rural sanitation and participated in schemes to control malaria and other diseases. Also, the Public Works Administration built hospitals and contributed to other public health projects. In 1935 the Social Security Act authorized the use of federal funds for crippled children, maternity and child care, and the promotion of state and local public health agencies (Porter, 1999, pp. 646–7).

But in 1945, John Duffy recalls that when President Harry Truman (1884–1972) proposed a national health insurance program, he ignited the ire of the powerful AMA which promptly denounced it as ‘socialized medicine’, something mainstream Americans felt skittish about since, at worst, it smacked of Soviet-like state control of people’s lives and seemed to threaten their personal privacy. Moreover, in 1948, when Truman again made national health insurance a campaign issue, the AMA hired a powerful public relations agency and activated a speaker’s bureau to defeat this measure—dubiously claiming that national health insurance would lead to a failure of medical services similar to Britain’s bureaucratic behemoth. Nevertheless, the AMA reluctantly ceded to the Kerr-Mill bill, ‘providing limited federal funds to help states pay for medical costs of the aged’ (Duffy, 1993, p. 322).

In addition, during President Dwight Eisenhower’s (1890–1969) administration of the 1950s, a central cabinet level office—the Department of Health, Education, and Welfare—was established. It brought greater order and accountability to what had hitherto been only a loose
association of multiple federal and state agencies. Collectively, these regulatory and enforcement agencies would now be anchored in Washington DC. They would continue to carry out their growing responsibilities, including public health services such as public education programs aimed at curbing alcohol abuse and cigarette smoking, along with the regulation of health and safety conditions in schools and factories, and the oversight of the safety and efficacy of food and drugs.

Later on, by the mid-1960s, the Democratic Party renewed its drive for a national health insurance program that Truman had earlier championed but failed to implement. John Duffy recalls that although the AMA was unsuccessful in blocking this second effort, it did manage to weaken its scope. So, in 1965, the Social Security laws were amended and Medicare and Medicaid became a reality. Medicare, which took effect in 1966, provided hospital and medical services to citizens who reached the age of sixty five. In contrast, Medicaid allocated federal assistance to state medical programs for the indigent poor. In sum, while Medicare made no attempt at a wholesale restructuring of the American healthcare system, it more than symbolized ‘that the public would henceforth have a voice in determining the nation’s health policy’ (Duffy, 1993, p. 322.).

To be sure, just how one defines ‘public health’, or the allied concept, ‘medical care’, is of critical importance. Let’s pause to clarify these key concepts. By ‘medical care’, I mean the use of any diagnostic, therapeutic, or prognostic tool, treatment, or service adopted by qualified healers in a given society. Although the therapies of these healers may change over time, it is essential that they are believed to be conducive to the restoration or preservation of health. For example, in 400 BC Athens, the use of leeches to stop bleeding from a wound or infection would qualify as medical care on this definition. But merely supplying to a soldier a well fitting saddle for his horse, would not. For in this latter case there is no medical treatment involved per se, no real therapy—even though the saddle doubtlessly does contribute to the health and safety of both rider and horse.

In contrast, ‘public health’ may be more broadly defined. John Duffy calls it ‘... the collective action by a community or society to protect and promote the health and welfare of its members’ (Duffy, 2004, p. 2206). Note that under this definition, the supply of a properly fitting saddle may very well qualify as a public health measure, assuming this was made available to other citizens, too. In addition, physician and public health historian George Rosen observes that

[2] In some cases, these concepts overlap in actual usage even though they retain their distinct meanings. Such ambiguities are usually resolved by paying attention to the contexts of use.
the major problems of health ... have been concerned with community life, for instance, the control of transmissible disease, the control and improvement of the physical environment (sanitation), the provision of water and food of good quality and in sufficient supply, the provision of medical care, and the relief of disability and destitution. The relative emphasis placed on each of these problems has varied from time to time, but they are all closely related, and from them has come [the notion of] public health as we know it today (Rosen, 1958, p. 25, my emphasis).

Given Rosen's orientation, which I am inclined to adopt, what are some related guiding principles or perspectives regularly associated with the field of public health today? At least three elements deserve our special attention.

First, the community health perspective is a key element in helping us understand the history and political influence of this field. It states that the health or disease of an individual citizen is, to some degree, the proper concern and responsibility of the larger community or government within which he or she lives and works. Notwithstanding the swaths of evidence from previous centuries that we will be exploring, the acceptance by many progressive governments during the twentieth century of some level of responsibility for the health of citizens constitutes a significant social and political commitment not matched in earlier epochs. Consider two examples: Plato, from antiquity, and Thomas More, from the Renaissance. They envisioned nothing even approaching a comprehensive community health perspective in their writings. Granted, in his Republic, Plato (427–347 BC) did criticize physicians who futilely treated their terminal patients, thereby implicitly bilking them and draining the medical resources of the state. But he nowhere systematically tackles the question of distributive justice in connection with the allocation of medical resources (Carrick, 2001, p. 7). Nor would such a question have naturally occurred to him: it was just assumed in ancient Greece that matters of personal health were not subject to interference or regulation by the state.

Similarly, Thomas More (1478–1535), in his imaginative treatise Utopia, advocated a limited public role for physicians in the lives of his citizens. He, too, implicitly emphasized that each person needed to accept responsibility for the state of his or her own health. Granted, More did advocate the option of voluntary euthanasia so that the terminally ill or decrepit could find some appropriate end to their suffering in the inglorious winter of their lives. But, again, neither Plato nor More entertained anything like a government directed public health ethos of the sort we are investigating.

Ironically, that formidable vision issued, with mixed results, from the pen of the nineteenth century social revolutionary Karl Marx (1818–83), and his capitalist backer, Friedrich Engels (1820–95). It is easy to forget
that in Marx’s provocative *Communist Manifesto* he held out the hope for social equality for all workers. He implied too that when the bourgeoisie and capitalism were overthrown by violent revolution, then the class distinctions that created double standards and inadequate systems of education and possibly health care would also be a thing of the past (Marx, 1848, pp. 47–50 passim). Hence, the Marxist-inspired institutions of pre-1992 Russia under the former Soviet Union, arguably administered the most extensive state-controlled public health care system in medical history. By most accounts, this resulted in a notoriously uneven, impersonal, and sometimes inhumane system of medical services for Soviet citizens (particularly in the areas of psychiatric, maternal, and geriatric medicine).³

Second, returning to our central discussion, I find that beyond the community health perspective just mentioned there is something that could be called the holistic health perspective. This constitutes another essential element in the field of public health. It states that an individual’s health properly concerns not simply her personal factors like exercise, diet, or genetic heritage. It also involves much larger societal factors such as adequate sanitation, decent housing, workplace safety, clean air and water, and a host of related external environmental factors. Holistically considered, these external, non-personal factors that contribute to a citizen’s overall health are seen as the government’s responsibility to develop and regulate, in accord with what is judged to be in the best interests of the people.

Third, philosophers, theologians, social reformers, and public health professionals, among others, will recognize the contentious role that the philosophical principle of ‘moral legalism’ has sometimes played in attempting to promote a healthier society. This is the third element of the public health movement. In many ways, it is the most controversial and contentious. Moral legalism is a liberty-limiting principle. It states that there is a moral duty on the part of governments to enact laws that would prohibit objectionable behaviour, especially behaviour that, if left unchecked, would pollute, harm, or disgrace the larger community.⁴ Anthropologically, moral legalism is said to have its root in the ancient human tendencies to label, ostracize, or banish members of a society as

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[4] This principle may be seen as an expansion of the harm principle, according to which individual liberty is justifiably limited only if it prevents harm to others. According to John Stuart Mill (1806-73) in his *On Liberty*, this is the sole legitimate principle that would warrant government to restrict the liberty of citizens. Mill would resist any expansion of the harm principle, and would view the principle of moral legalism as going too far by authorizing the state to engage in paternalistic practices which it has no business doing (Mill, 1859, 1971).
'outcasts' who break taboos or allegedly pollute others by carrying out behaviours deemed harmful to the tribe (Beauchamp, 2004, p. 2231.)

In the United States, as in the United Kingdom, such behaviours as the over-consumption of alcohol, cigarette or marijuana smoking, and homosexual or inter-racial marriage have, at various times, been judged 'morally objectionable' and been proscribed—in part, by appealing to the principle of moral legalism. Moreover, this liberty-limiting principle is sometimes also in the air when legislators and other architects of public policy try to ascertain what commonly held moral intuitions of their constituents, supplemented by the best scientific insights, would plausibly justify laws aiming to promote the public health and common good of society.

Consider an example: would requiring food handlers to thoroughly wash their hands every thirty minutes constitute a sound public health law? Or is this requirement too stringent and ultimately unenforceable? Obviously, any such deliberation within a democratic framework needs to be carefully balanced. On one hand, there is the constitutionally guaranteed (and potentially reckless) liberty-right of the individual citizen to be left alone to pursue life, liberty, and happiness (even if, in some cases, the citizen does things that are technically legal but offensive to others). On the other hand, there is the paternalistic (and potentially overzealous) duty and responsibility of the state to protect its citizens and affirm its vision of the common good. In this capacity, it may of course prescribe behaviours it deems harmful to the body politic. Therefore, concepts and schemes for promoting public health intersect in natural ways with higher order moral issues such as 'distributive justice'. For example, in a public health situation, consider this question: who ought to receive life prolonging heart or lung transplants when there may not be enough donor organs to go around for all those in need?

Lastly, what standards of social harmony and fair play ought we as philosophers, politicians, public policy analysts, legislators, and informed citizens to use when determining precisely what a just health care system should look like? Obviously, this is both a moral and legal question—and a question of great political and humanitarian intrigue in the United States where, astonishingly, nearly 20% of the population carries no health insurance whatsoever.

These and related social justice topics are taken up with considerable energy and insight in the ensuing chapters of this volume. It is my contention that almost all such medically-related social justice questions are either rooted in, or can be shown to be anticipated by, the public health movement we are examining. But before proceeding any further, I would like to affirm Daniel Beauchamp’s instructive list of four goals that any sound philosophy of public health must aim to accomplish.
1. A philosophy of public health must give a central place to the unique approach and method of public health, with its distinctive emphasis on community, and on the central role of the scientific method in formulating courses of action for social improvement.

2. A philosophy of public health must give priority to prevention, and must challenge and revise explanations for health problems with the community perspective, which is essential to effective prevention.

3. A philosophy of public health must set out and defend an adequate definition of the common good, taking into account public health’s pursuit of the common well-being—measured in terms of rates of disease and early death—as the object of group or common action.

4. While the philosophy of public health must acknowledge the claims of individual autonomy and justify actions that limit liberty and autonomy, it must do so in a way that leaves the community perspective and the common good intact (Beauchamp, 2004, p. 2211).

Let us turn, then, to some of the more significant pages of that long history. Our goal will be met if we locate and analyse several distinct occasions when redemptive, utilitarian, prudential, or charitable motives worked to provide a measure of funding aimed at helping to preserve or restore the general health of citizens.

The Redemptive Motive and Funding Hospitals

Today, we may rightly think of major hospitals as largely secular institutions; as showcases of scientific medicine aimed at restoring or prolonging human life by using the latest high tech therapies against the ravages of disease or hardships of injury; and, in America and elsewhere in the developed world, as largely public institutions receiving large portions of their revenues from government grants, matching funds, or reimbursements.

But among the earliest hospitals in the West were religious institutions and these were decidedly low tech. Their funding was generally not from governments, and their caregivers and sponsors were animated, at least in part, by the redemptive motive to care for the sick and suffering as God had ordained. By ‘redemptive motive’, I mean that an agent is acting in such a way that he earnestly believes that his action will elevate his soul in the eyes of heaven. This occurs by cancelling a personal sin or earning merit from the deity in accord with the specific prophesies or rituals of a particular religious tradition.

To illustrate, early Christian hospitals arose largely within the social milieu of religiously minded men and women who, in their personal acts of attending to the sick, were also seeking to fulfil God’s word. Was not Christ portrayed in the Gospels (see especially Luke) as a healer of the poor, one who restored sight to the blind, purged devils from the insane, and miraculously raised Lazarus from the dead? In fact, the first hospital
serving the general public was founded in 390 AD by a wealthy Christian woman, Fabiola (d. 399). As a new and spirited convert, she decided to sell all her worldly possessions to provide medical care for the sick and poor (Carrick, 2001, p. 224; Porter, 1996, p. 208) in an organized institutional setting. Hence, caring for the sick, lame, and hurting within a redemptive framework of belief created a pathway for the religious individual to simultaneously redeem herself from sin and also attend to ‘the least of these’, as the Christian Gospels command (e.g., Matthew 25: 31-46).

As for the funding of these early Christian hospitals, we know that by the fourth century they were supported by various bishops and other operatives from within the early Christian church in addition to some members of the landed aristocracy (Miller, 2004, pp. 1184–5 passim). Moreover, prior to the establishment of these first hospitals, by the fourth century AD Christian guest houses, also called ‘hospices’, were founded (Miller, 2004, p. 1184). These places of refuge were usually overseen by nuns or assistants who were dedicated to the care and sustenance of the poor, sick, or weary traveller. But hospices were not specifically providers of medical care. This fact distinguishes them from the later Christian hospitals which were generally overseen by at least one doctor (iatros) Yet hospices and later hospitals were both supported by the church and by donations from wealthier Roman families, and by others who were able to contribute something for their life-affirming services and care. Hence, it is fair to conclude that the redemptive impulse was a leading motivational factor for those who established, supported, and administered both hospices and hospitals during the late Roman Empire.

But was there an even earlier forerunner to both the early Christian hospital and its institutional predecessor, the hospice? Indeed so, the pagan temples of the Greek physician-god, Asclepius. A famous example still stands in ruins at Epidaurus on mainland Greece; it was built around 450 BC and operated until at least 395 AD. These religious temples (asklepieia), of which over 400 were built during Pre-Christian antiquity, once dotted the ancient landscape from Olympia to Constantinople (modern day Istanbul). Funding for the Aescleopian temples generally came from one of two sources: patients and their families seeking the hypnotic dream-sleep cure (incubation) for one of their own; or wealthy families seeking to fulfil their felt sense of civic virtue. In addition, there were probably occasional contributions from nearby sponsoring Greek city-states.

The physician-God Asclepius, son of Apollo, was said to have had the power to rescue the sick from the jaws of death, and make whole the ill and lame. But from the rational, non-superstitious perspective of traditional Hippocratic medicine—grounded on the humoral theory of dis-
ease according to which a proper balance of the four humors assured the patient’s good health—these Aescleopian temples were at best last ditch centres of care for those judged to be incurable. Therefore, hopeless, terminally ill patients often turned to supernatural Aescleopian remedies when the Hippocratic physicians judged that there was nothing more they could reasonably do. Can anyone doubt that these often desperate, religiously inspired patients, and their similarly inspired, well intentioned Aescleopian priests—who sometimes dressed in flowing robes in imitation of the god—both experienced some redemptive grace as they sought heaven’s divine cure? Whatever the outcome of this mystical God-centred therapy, votive offerings and payments were received by the Aescleopian healers from the suffering patient and her family. Thus, it is safe to conclude that a sense of redemption (and a wished-for spiritual and bodily wholeness) was involved in the funding and support of these renowned pagan health care centres, too.

The Utilitarian Motive and Funding Military Medicine

Alongside religious temples and related medical sites associated with the Greek god Asclepius, the Roman Empire saw fit to erect special infirmaries (valetudianaria) dedicated exclusively to soldiers. For example, it was well recognized by the Roman Senate that soldiers who were wounded in battle or faced other potential health emergencies needed immediate care. ‘A standard military hospital plan evolved’, according to Roy Porter, which had ‘... individual cells off a long corridor, a large top-lit hall, latrines and baths’ (Porter, 1999, p. 78). In contrast, the more affluent Roman citizen would usually receive medical care not in a hospital but at the private house of his physician. Yet the poor and destitute would be lucky to hobble or drag themselves to a religious shrine hoping for some sort of miracle. Thus, for all but the military, the medical marketplace of the Roman Empire was strictly speaking a laissez-faire situation and most uneven in its distribution of medical services to the hoi polloi.

Furthermore, the warrior-centred infirmaries were especially crucial in helping to fortify the military strength of Rome’s legionaries stationed along the northern borders—where barbarians began to take a deadly toll beginning in the fourth century especially (Miller, 2004, p. 1184). But if so, how could one fairly describe the political and strategic motivation of Rome (and later, many other countries) in creating and funding such strategically placed military hospitals?

In essence, I would argue that this motivation may be fairly called ‘utilitarian.’ That is, a person, group, or institution is carrying out a particular action or plan because, at bottom, it is believed to be helpful to
securing the common good of all. So here generals and politicians, under pressure from repeated waves of barbarian attacks, came to see that their society as a whole would benefit if soldiers (injured, or threatened in battle, or otherwise at risk of losing their strength in war) were provided competent medical care (relative to those times). Hence, these soldiers could be restored to the task of defending their communities as rapidly and efficiently as possible. What I am suggesting, then, is that Rome funded military infirmaries (as did the French during the Napoleonic Wars, as did the federal Congress during the American Civil War—the examples are endless) precisely because Rome realized that trained and experienced soldiers were valuable state assets. These human assets could do more effective work for the greater glory of the whole society if they had doctors and other medical assistants at their disposal when weakened or threatened by disease or wounds. In short, publicly funded military infirmaries had social utility: they were useful and productive medical institutions operated for the optimal benefit of the state, its soldiers, and its citizens—all things considered.

Furthermore, centuries later in the modern British Isles, the English medical doctor James Lind (1716–94) observed that ‘armies had lost “more of their men by sickness than by the sword”, especially through insanitary camp conditions’ (Porter, 1999, p. 294). In addition, the Scotsman and physician-general of the British Army, John Pringle (1707–1782), scientifically corroborated Lind’s insight by publishing Observations on the Diseases of the Army (1752). In it, Pringle stressed methods by which troops could adopt practical measures of hygiene in order to prevent the most common battlefield diseases such as typhus, dysentery, bilious fever, scabies, etc. Porter gives this estimate of the impact of Pringle’s Observations:

While not strikingly original, it captured the Enlightenment concern for hygiene, public health, and the value of life. Pringle is also remembered for developing the idea of the neutrality of the military hospital. At the battle of Dettingen (1743), he proposed to the French commanding officer that the hospital tents on each side should be immune from the attack. The idea stuck (Porter, 1999, pp. 294–5).

Are there other instructive examples of the utilitarian motive driving state policy in favour of medical care or medical experimentation—especially for those in the military? Examples abound: it is well established that medical insights and innovative surgeries, procedures, and therapies are often invented and tested in the crucible of war. For

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5 By using the term ‘utilitarian’, I mean this in the pre-philosophical, naïve sense of that word. I am not here referring to classical utilitarianism associated with the hedonic calculus famously authored by the nineteenth century English social reformer, Jeremy Bentham (1748–1832), and his philosophical disciple, J.S. Mill (1806–1873).
example, in the late nineteenth and early twentieth centuries, military personnel were among the first to benefit from programs of mass inoculations. These followed discoveries by Jenner, Pasteur, Koch, and others that such techniques could be effective in protecting against a myriad of infectious diseases. Indeed, this was one of the more humanitarian and dramatic benefits of discovering the germ theory.

For example, during the Boer War of 1899–1902, the British army suffered many disease-related casualties. Immunisation against typhoid was discovered by Almroth Wright (1861–1947) in 1897. Yet few British soldiers received the vaccinations due to irregular state policies that were in place at the time. This was tragic. Porter clarifies that in the South African theatre of the Boer War, 13,000 soldiers were killed by typhoid, whereas 8,000 actually died in battle (Porter, 1999, p. 443). As a result of this emergency, the British government formed a special commission to study diseases related to war casualties. Thereafter, in 1913, it adopted a policy of vaccinating all soldiers sent abroad against infectious diseases, including typhoid fever. In point of fact, during the Boer War, the incidence of illness from typhoid fever was around 10%. In contrast, after being vaccinated, the incidence of typhoid among British troops during World War I (1914–18) dropped to around 2% (Porter, 1999, p. 443).

Also, tetanus was known to be a particularly dangerous disease for soldiers, with the death rate of those infected usually standing at above 40%. So, by the beginning of World War I, decisive public health measures were taken to protect the troops against tetanus. In general, this disease had been especially hard on soldiers. The causal agent, later identified as tetanospasmin, is a toxin secreted by the bacterium Clostridium tetani which lives in the soil. Hence, when a soldier was wounded, very typically ‘the bacillus entered the body through gaping shell wounds. [But] from 1915 [on], practically every wounded soldier received the antitoxin, and so tetanus was dramatically reduced’ (Porter, 1999, p. 443). Again, the utilitarian motive to provide competent and immediate medical care for the military is seen to produce the best outcomes by helping to fortify the defences of a nation as a whole, whether at war or at peace. And there were other social dividends. Civilian populations in Britain and elsewhere were eventually protected by vaccinations, too, in medicine’s fight against the ravages of typhoid, tetanus, and other lethal diseases.

The Prudential Motive and Funding Quarantines

History records few things to be as frightening, alien, and disorienting to human communities and their governments as the large scale public health scourges known as epidemics. Epidemics may be defined as ‘concentrated outbursts of infectious or non-infectious disease, often with unusually high mortality, affecting relatively large numbers of people

within fairly narrow limits of time and space’ (Evans, 2004, p. 789). The most catastrophic epidemic in the entire history of Europe occurred during medieval times, spreading from rats to people, between 1347–51. I am referring to the Bubonic plague. It is also called the Black Death due to the telltale dark blotches that appeared on the faces of the doomed just prior to their deaths. Shockingly, in just over three years, this pestilence wiped out approximately twenty million people, about one quarter of the entire population of Europe and the Mediterranean (Porter, 1999, p. 123). It appeared episodically thereafter, too, arousing great fear and consternation, but never with such sweeping force.

The Black Death likely originated in China. Then, from central Asia, it spread via the Tatars to Italian merchants who were fighting the infected Tatars for preferred trade routes in the Crimea. In returning to their native Italy, the plague travelled with these Italian merchant-soldiers, breaking out first in Messina and then in Genoa. So virulent was the plague that most died within three days of being infected. Typically, the most vulnerable included peasant families and the indigent poor. Even without contracting such catastrophic epidemics, their average age at death in 1400 was not much over 30 years (Porter, 1999, pp.122–127 passim). And the unenviable truth is that these unfortunates were often left to rot in their own bodily fluids when they were ordered to be involuntarily quarantined. This happened in towns including Milan and Vienna during the most deadly outbreaks of the plague. Moreover, relatively few townspeople were lucky enough to flee in advance of these scourges: there was little advance warning and few alternative destinations seemed safe. Hence, in trying to survive this fourteenth century public health catastrophe, governments acted to protect themselves and their citizens in ways that were barely rational (by contemporary standards) and, from hindsight, often tragic, heartless, and futile.

To be sure, there were many factual misunderstandings about the true nature of the plague that made most medical and governmental responses ineffective. For one thing, the prevailing theory of health at that time was still the Hippocratic humoral theory, with significant refinements by Galen (AD 129–c. 216). This theory stated that if a person becomes ill with an epidemic disease or any other malady it was at least partly his or her own fault. Such vulnerability to disease was likely due to some weakness or imbalance of one’s four humors over which individuals have some rational control through proper diet, exercise, and sound hygiene. Following this logic, healthy people did not normally get sick; and if they did they were probably responsible for it on some level.

In addition, alongside the humoral theory there was a correlative environmentally-based theory known as the miasmic theory of disease (miasma was considered to be foul or polluted air). It held that conta-
gions arise from the stench of swamps, waste, and other rotting organic debris. Humans breathed in this putrid air and so it tended to make us sick—disturbing our internal humoral balance. More alarmingly, it was widely held that once a person becomes infected with the plague, others can acquire the disease just by touching that person or by standing in his immediate vicinity. In addition, besides this pair of naturalistic theories of disease (humoral and miasmic), there was still the influential supernatural theory of disease held by Christians and other mystics. This theory construed illness, and especially pestilence, as something sent by God to punish sinning humanity. Therefore, this supernatural view of disease only exacerbated the public’s personal sense of panic, guilt, self-loathing, and despair.

As a result of these theories of disease, citizens were sometimes advised by local governmental authorities to evacuate their cities and towns in advance of the relentless plague which, in fact, was caused (we now know) by flea-infested rats. In addition, local governments in Italy, France, Germany, and elsewhere enacted involuntary ‘quarantines’ (this term derived from the Biblical quarantinaria meaning forty days) against all those travellers and ships known to have originated from ports or cities already infected by the plague (Porter, 1999, p.126). Local governments also set up health boards in cities including Milan, Florence, and Lucca. Also, they closed their borders if at all possible against outsiders thought to be infected. In some cities, like Milan, they involuntarily quarantined and sealed their own plague-infected citizens in their own homes, leaving them to die. Both doctors and priests, who were entrusted to care for the sick or perform Last Rites, also sometimes fled for their lives in sheer terror of what might happen to them if they remained behind to perform their official duties.

Therefore, as we have just seen, one of the most commonly used, publicly funded methods of restoring health and preventing disease, was the state’s deployment of the quarantine. Typically, this restrictive measure could be applied to seaports or roads, halting shipping or commerce; or to individuals and their families, limiting their freedom to come and go as they pleased in their homes or neighbourhoods. Hence, the method of quarantine—however unfairly, unevenly or unnecessarily.

[6] One recalls that the humoral theory, according to which disease occurred when one of the four humors (yellow bile, black bile, blood, phlegm) became excessive, was completely overtaken by the germ theory by around 1880. The competing miasmic theory held sway even later, until gradually losing ground to Koch’s bacteriological model of disease by the late nineteenth century.

[7] The bacterial cause of the Black Death was subsequently discovered in 1894 during the Hong Kong epidemic by Japanese scientists A.Yersin and S. Kitasato. By 1898, the French epidemiologist P. L. Simond showed that the transmission of the bacillus, Yersinia pestis, was communicated from rats to humans via fleas: a single bite from an infected flea could be fatal (Rosen, 1958, p. 324).
ily applied in the fourteenth century — arguably embodied a prudent method of rationally imposing preventive medicine measures on citizens (and strangers) with the goal of stopping the spread of this unforgiving Black Death. (Again, the plague was thought to be a disease transmissible by contact with the miasmic breath, or through touching the open sores or even normal-looking skin of real or imagined victims who were thought to be exposed to the contagion).

In sum, I think it is fair to conclude that a ‘prudential motive’ was almost certainly at work in the decision to use state funds in deploying the restrictive measures of quarantine. These funds were needed to mount naval blockades of docks and ports, and to pay those workers involved in identifying, apprehending, and enforcing involuntary restrictions and other cordone sanitare for those suspected of being infected. In general, a person, group, or institution may be said to be acting from a prudential motive when their resulting behaviour shows evidence of skilful selection, adaptation, or use of an appropriate means to a desired end.8 Here, the desired end was halting the spread of the bubonic plague by skilfully using a means that conformed to the best medical thinking of the day. Unlike the ‘utilitarian motive’, cited earlier, the prudential motive does not require the actor to contemplate the more universal consideration of what constitutes the common good of society. Instead, prudential acts merely involve a scaled back, lower-order focus on what seems more or less appropriate to the situation at hand here and now. Thus, the scope of awareness (what I call the ‘epistemic scope’) of a prudentially motivated act is somewhat less encompassing than its utilitarian counterpart in the long run.9

The Charitable Motive and Funding Inoculations

Who can doubt that a fourth type of motivation, what I am here calling the ‘charitable motivation’, is also involved in carrying out humane acts of medical care? The charitable impulse has deep historical roots. We observe the author of the Hippocratic treatise Precepts, who practised medicine in Athens during the first century BC, admonishing his fellow physicians thusly: ‘And if there be an opportunity to serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art’ (Precepts 6; quoted in

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8 My definition is modified slightly from the Webster’s Third New International Dictionary (1965, p. 1824), to include the Aristotelian notion of ‘appropriate’ choice. Hence, the prudent motive leads to actions that are moral, not merely clever. Such actions, following Aristotle (384-322 BC), ultimately involve the larger issue of determining what is good for man. See also Copleston (1962, Vol. 1, Part 2, p. 86).

9 The possible objection that this scope of awareness may be more a matter of degree than kind is discussed in the penultimate section of this paper, below.
Carrick, 2001, p. xviii). Indeed, one can hear in these distant words a commitment to the importance of empathy and charity in the treating of the outsider, the sick, and the destitute. What’s more, the Homeric tales of Zeus, Dionysus, and Artemus, among other Olympians, fostered an awareness in the pagan mind that the gods themselves could appear incarnate as human strangers in need. So it would be wise to greet the stranger in need carefully but never meanly.

Nor can one ignore that a selfless response to the suffering of the stranger is affirmed both in the Hebrew Bible and the Christian Gospels. While charity is a Christian virtue endorsed in the parable of the Good Samaritan, Jewish tradition also affirms the importance of compassion toward those in need, as the story Jonah and the whale affirms. This type of other-centred, charitable motivation is characterized by a deeply felt impulse to extend a helping hand: to succour the sick and broken with a saving, caring touch.

Formally defined, ‘charitable motivations’ are those evidenced by a kindly and sympathetic disposition aimed at rendering aid to the needy or suffering.\(^\text{10}\) Such acts typically involve freely giving to others goods or services of value that could otherwise have been withheld. In addition, it is interesting to recall that the eighteenth century German philosopher Immanuel Kant (1724–1804) regarded acts of charity as imperfect duties.\(^\text{11}\) That is, properly speaking, such acts may never be morally required of another as would, by comparison, such perfect duties (in Kantian language) as the repayment of a personal loan. Again, perfect duties are always obligatory duties for Kant, never optional. And so, for Kant, as for most of us living in the twenty-first century, charitable acts such as sending money to the International Red Cross for food relief in Sri Lanka are praiseworthy but strictly speaking optional. They cannot in the ordinary sense be morally required.

But is this really a fair description of charitable acts in the context of contemporary medical care? Yes and no. For while one may not require a physician in private practice in the United States, say, to donate his or her medical services to the needy poor, there are acknowledged limits to the exercise of such professional options. For example, it is a recognized medical and moral duty not to cause (or allow by acts of omission) someone who is penniless to die on the front door of one’s clinic just because they cannot afford emergency medical services. Again, if life-saving aid

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\(^{10}\) Webster’s Third New International Dictionary (1965), p. 378, hereafter WID. ‘Charity’ derives from the Late Latin word ‘caritas’, meaning Christian love. Webster’s defines the latter as: ‘the virtue or act of loving God with a love which transcends that for creatures; loving others for the sake of God’ (WID, 1965, p. 378, my emphasis).

The Public Funding of Health Care

that could have been rendered was in point of fact withheld, would this heartless inaction not be widely and justifiably condemned? Moreover, since for Kant charitable acts also conform to the moral law (what he called the ‘Categorical Imperative’) — according to which persons ought to be treated as ends in themselves, never as mere means — charitable acts are in any event exemplary and praiseworthy.

To summarise, we may observe in these persistent religious, scientific, and humanistic traditions — from Hippocratic precepts, to Judeo-Christian scriptures, to Enlightenment thinkers such as Kant — an implicit affirmation of the importance of the charitable impulse as a necessary condition for membership in the moral community. I dare say this humane tendency to consider the safety and welfare of the other is one of the enduring legacies of our ancient and modern past embodied at least in part in our own age by social workers and health care professionals, plus the government agencies and taxpayers who tacitly agree to fund and facilitate their good works.

In addition, within the ethos and norms of the public health movement as it arose from roughly the eighteenth century to our own day, charitable acts may include providing bandages, prescription medicines, crutches, inoculations, surgical procedures, pure drinking water, fresh linen, etc., at little or no direct cost to the recipient. Indeed, with the gradual acceptance of Louis Pasteur’s (1822–96) germ theory by about 1875, and the gradual adoption of Robert Koch’s (1843–1910) bacteriological model of disease about twenty-five years later, doctors, medical researchers, and public health officials were increasingly encouraged by the promising social and health implications of these stunning scientific breakthroughs. Hence, during the nineteenth century when it came to using public or private funds with the end in view of restoring or preserving the health of the masses, government officials began to push for a variety of preventive medicine measures. Perhaps chief among the more controversial of these measures was the deployment of public inoculation programmes. To be sure, inoculations were attempted, at various times, to thwart a variety of deadly diseases including cholera, smallpox, diphtheria, and malaria. (Inoculations were later called ‘vaccinations’, once specific vaccines were developed containing the immunising antigens or micro-organisms which were then injected). In fact, Rosen states that the method of inoculation was known to healers throughout the world at least since the early 1700s, and probably earlier in the East and Orient (Rosen, 1958, p. 184). As a technique, it became established in medical circles under the simple-sounding principle, ‘Like cures like.’

For example, it was known to some midwives and others that exposure of a non-infected person to a series of weakened (attenuated) doses of a pathogen, say, measles, somehow had the power to render that ‘in-
oculated’ person immune from the very disease to which she had been intentionally exposed (Rosen, 1958, p. 183). While inoculation was an extremely useful method, many in England and elsewhere during the seventeenth and eighteenth centuries were sceptical. They worried, not altogether without justification in the early days of the technique, that those exposed to excessive or corrupted doses of the allegedly life-saving pathogens might somehow grow ill and die. As we saw in our earlier account of the bubonic plague, these horrific epidemics were capable of wiping out whole generations: labourers, farmers, merchants, craftsman, sailors, the landed gentry — none were spared. Philosophically, most adults came to realize that all people were in some sense true equals before the onslaught of these unyielding scourges. Predictably, as the techniques of inoculation and vaccine development became more efficient and reliable — thanks to the early efforts against smallpox by researchers like Edward Jenner in 1796, and over a century-and-a-half later against polio by researchers like Jonas Salk in 1953 — the public’s scepticism and resistance against inoculation programs slowly gave way to guarded acceptance.

Of course, these inoculation programs were actually not free but were usually funded by governments or, in some cases, supported by the emerging health care professions, or by monies donated by pioneering medical researchers and their sponsoring labs and institutes. Such programs were initially, at least, cast as charitable programs for the improvement of the health and welfare of the poor. This preventive medicine trend gradually spread across Europe as the method of inoculation became perfected, and as the science and clinical evidence backing it up gradually won both scientific and popular acceptance by the middle of the nineteenth century.

In fact, it was in England, with the publication in 1798 of Edward Jenner’s paper, ‘An Inquiry into the Causes and Effects of the Variolae Vaccinae ... [Known as] Cow pox’, that the efficacy of using vaccines in the process of inoculation was established. Jenner, a country doctor and clergyman’s son who studied in London under John Hunter, was one of the first medical scientists to endorse the widespread use of inoculations in his fight against smallpox (Rosen, 1958, p. 188ff; Porter, 1999, p. 274ff.). To Jenner’s remarkable achievement we now turn.

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[12] Specifically, smallpox inoculation was known as ‘variolation’, although the term is now rarely used.

[13] Even now, this acceptance is somewhat fragile and wont to slip: witness the suspicion of the combined measles, mumps, and rubella inoculation in the UK in the late 1990s, that grew from a study linking the vaccine to serious side-effects. Despite the study being roundly and openly discredited at the time by the broader scientific community, these suspicions lingered for some time.
Rosen reminds us that, during Jenner’s lifetime (1749–1823), smallpox was one of the most feared diseases in Europe and America—a leading cause of death. ‘It smouldered endemically in city and town, flaring up recurrently into epidemic outbreaks … According to William Douglas, writing in 1760, smallpox was a chief cause of the high infant mortality in Europe’ (Rosen, 1958, p.184). Porter adds: ‘“The speckled monster” had become virulent throughout Europe, responsible in bad years for perhaps a tenth of all deaths; Queen Mary of England (1662–94) died of it, as did Louis XV (1710–74) of France’ (Porter, 1999, pp. 274–75). Thanks largely to Jenner’s experiments, inoculation caught on as a protective measure against smallpox in England, along with preventive medicine programs against other deadly diseases, by 1900. Even so, there were still those who held out. For example, some of the Calvinists in Scotland resisted inoculation on grounds that rendering a patient immune through human intervention interfered with Divine Providence. In contrast, the philosophes in France, including Voltaire (1694–1778), endorsed inoculations as a boon to mankind; the practice was officially endorsed by the French government in 1750.

Back in England, Lady Mary Wortley Montagu (1689–1762), the wife of a British consul in Constantinople, was a forceful early advocate. In fact, she decided to have her five-year-old daughter inoculated against smallpox in London, in 1721. This she did after having observed a few years earlier a somewhat cruder form of the technique used by peasant women in Turkey (Porter, 1999, p. 275; Rosen, 1958, p. 186). Across the seas, in Colonial America, the clergyman Cotton Mather (1663–1728) was also a strong advocate of inoculation. ‘[H]e knew about suffering, having had to watch as two wives and thirteen of his fifteen children succumbed to disease’ (Porter, 1999, p. 175).

To clarify, the immediate aim of smallpox inoculation was to induce a mild dose of the disease in a non-infected person, thereby conferring lifelong immunity without causing unsightly pock-marking or any other harmful consequence (Porter, 1999, p. 275). Before he began his experiments that led to the groundbreaking development of an effective smallpox vaccine, Jenner was familiar with traditional inoculations. In performing them, he aimed to infect his subjects with weakened doses of the smallpox material in order to confer immunity. In the process of performing traditional inoculation, Jenner noticed something odd: those subjects who had earlier contracted cowpox—a disease of cattle occasionally contracted by humans—had evidenced no reaction whatsoever to his traditional smallpox inoculation. That is, they appeared to be immune to smallpox.

But Jenner did not feel confident with his observation. So, remembering the challenging words of his professor, John Hunter, ‘Why not … experiment?’, Jenner decided to test his hypothesis. What if the cowpox
had properties that could be developed into a vaccine that would render subjects immune to smallpox?

In 1796, an opportunity to try out this idea presented itself. Jenner inoculated a boy, James Phipps, with cowpox matter taken from the hand of a milkmaid, Sarah Nelmes, who had acquired the infection naturally. Then after several weeks he inoculated the boy with smallpox, but it failed to take—James Phipps was immune to smallpox. (Rosen, 1958, p. 188).

Ironically, when Jenner first tried to present the result of his experiment to the Royal Society, he was refused. Soon thereafter, however, his results were accepted in 1798 under a more modest title. Within just three years, his 'Inquiry into the Causes and Effects of the Variolae Vaccinae' received widespread attention in Continental Europe and America. In fact, it was published in a third edition by 1801, and went into Latin, German, French, American, Dutch, Spanish, and Portuguese editions by 1803 (Porter, 1999, pp. 276-77).

To the layperson, the often missed epidemiological significance of Jenner’s contribution is that while smallpox was fatal to humans, cowpox was benign. Therefore, if Jenner were able to develop a vaccine from the cowpox material, the inoculation process would in this case be measurably safer. Moreover, if his hypothesis proved correct, a successful cowpox vaccine could then be developed in larger quantities, and dispensed to more subjects more cheaply and efficiently than the traditional inoculation. For the latter technique did not strictly speaking require vaccination at all; mere exposure, through whatever medium, would do. In addition, things could run amok using traditional inoculation. For one thing, the inoculated person could sometimes contract the full disease from the attenuated dosage if the quantities were too potent or the exposures were too frequent, and die. Second, if the aim was to inoculate large numbers of people there was a substantially greater risk that something could go wrong with the quantity and quality of the materia medica of the dosages themselves since the chemistries were not that well understood.

No doubt a lasting hallmark of the practical significance of Jenner’s discovery of the smallpox vaccine is the greater confidence it inspired toward the medical community itself among the people whose lives he and others helped to save through the deployment of massive and often charitable vaccination programs. At first, this was the case for smallpox but later for a long list of deadly diseases that were defeated or resisted via the vaccination process which Jenner helped develop and perfect. In so doing, Jenner may also be said to have laid the initial groundwork for the science of immunology. Indeed, once Jenner’s vaccination techniques gained currency, his discoveries were further confirmed in 1800 by Harvard Medical School’s first professor of physic, Benjamin Waterhouse (1754–1846). Waterhouse published his own confirmation under
the title, ‘A prospect of exterminating the smallpox’ (Rosen, 1958, p. 189). In addition, President Thomas Jefferson (1743–1826) became an active supporter of Waterhouse, arguing forcefully for public vaccination programs as a civic imperative (Rosen, 1958, p. 189). Connecting the motive of charity to Jenner’s scientific breakthrough, Rosen states that a benefactor by the name of Valentine Seaman was the first advocate of mass vaccination in America. In 1802, Seaman originated in New York the ‘Institute for Inoculation . .’ the main purpose of which was to furnish inoculations free of charge to the poor (Rosen, 1958, p. 189). In England, over 5000 individuals had been vaccinated by 1799 alone. The practice was deemed so important in Sweden that it was made compulsory. In contrast, compulsory vaccination was resisted for a time in England for fear the rights of individuals would be trampled by the state (Porter, 1999, p. 277; Rosen, 1958, pp. 189–90). The situation in Germany was arguably even more progressive.

The German government briefly explored the idea of ‘Medical Police’, a term meant to convey the need for a government administered program of health protection for all citizens. Its principal proponent was Johann Peter Frank (1748–1821) who wrote a six volume work on this topic which was published between 1779–1819. But the project never really reached fruition until after 1871 when a central department of public health came into being. By 1883, Chancellor Otto von Bismarck (1815–1898) introduced for the first time a system of medical social insurance. ‘Bismarck’s system became a model for other European countries, including Britain’ (Chave, 1986, pp. 8–9). In France, Napoleon (1761–1821) was so taken in by the seeming miracle of defeating smallpox by Jenner’s technique that he ordered his entire army vaccinated. He is further reported to have said: ‘Anything Jenner wants shall be granted’ (Porter, 1999, p. 277). Not to be outdone, in 1802, the English Parliament awarded Jenner a prize of £10,000. Just a year later, in 1803, the Royal Jennerian Society was founded. Its prime aim was to promote vaccination for the masses as part of a charitable and humane program. Indeed, by the beginning of the nineteenth century, rulers in Europe and elsewhere embraced the general dictum that the promotion of health was essential to a well functioning state (Porter, 1999, p. 277).

**Summary: Four Motives Supportive of Public Health**

I began this paper by conjecturing that any effort to pursue a unified psychological, sociological, or philosophical explanation for that most remarkable of human practices, namely, the decision of governments, institutions, or groups to use public or private funds in order to succour the sick or make whole the injured, would almost certainly face treacherous seas. Based on the evidence gathered here, I submit that this conjecture has so far been confirmed.
But while a unified, monolithic account of the public or private funding of health care has eluded our capture, what we have discovered during this voyage has in some ways proved more instructive. We have discovered a broad, multifaceted account that accommodates a wider range of historical periods and governing philosophies than any single explanatory principle would likely do. Why would a single explanatory principle not fly? Because, as should be evident from the present sketch drawn from 2500 years of social history, things are just not that tidy in the chronicles of Western governments and in the diaries of the common people over which they ruled. Hence, despite the fact that no unifying raison d’être has emerged to account for the seemingly altruistic behaviour that lead to the public or private funding of health care, this result is hardly cause for despair.

In point of fact, we have identified and characterised at least four critically important human motivations that are often involved in preserving, restoring, or enhancing the health and well-being of citizens. These action-guiding elements include the redemptive, utilitarian, prudential, and charitable motives. Furthermore, any one or more of these motives qualifies as sufficient conditions. That is, when present they tend to function as contributing causes psychologically and morally in almost any decision-making process that leads individuals, groups, institutions, or governments to actually fund health care for the masses (at whatever level of funding). Thus, by being made more aware of the necessary conditions involved in this decision-making process, we have come closer to a fuller understanding of the tableau of human impulses, volitions, and choices that encourage such other-directed, socially conscious projects as those associated with what is now widely called the public health movement.

Objection and Reply: Oversimplifying Choice and Action?
Nevertheless, some may object that the picture I have just painted commits the fallacy of oversimplification. This it allegedly does because the four motives which I have explicated as more or less discrete concepts in our four central illustrations—the funding of hospitals, military medicine, quarantines, and inoculations—may sometimes overlap with each other. But, as I will show, this objection is hardly fatal. In fact, properly understood, it reminds us that some apparent impediments from the logical point of view turn out to be little more than instructive mirages when viewed from the right angle, i.e., with a deeper understanding, in this instance, of how language and thought actually work together.

[14] An earlier version of this objection was suggested to me by Niall Maclean. The core fallacy is of course committed when one takes a complex thing and construes it to be much simpler than it really is.
So let us suppose, for the sake of discussion, that the preceding objection is correct: our four motives do sometimes overlap in their action-guiding capacities. Hence, suppose that what I have described as the ‘charitable motive’ to give aid to the needy by funding inoculations, may at times overlap with the ‘redemptive motive’. Thus, the redemptive motive, too, may impel an actor to accomplish the same end out of (in this case) a basic love of God. Does the fact that one or more of these motives may overlap undermine all that we have come to understand so far?

Not at all. If anything, the fact that these four motives may occasionally overlap invites us to ask a critical question, one with illuminating implications for how the human mind, choice, and volition shape individual or institutional conduct in what some call the phenomenology of action. Is it realistic to assume that the diverse impulses and motives at work as we experience ourselves and others in the world, and as we act on things in the world to accomplish desired ends, are in fact as rigidly distinct as we sometimes imagine them to be? In short, is the existential and psychological process of deliberation and decision-making messier than we imagine?

In my view, the only honest answer is yes. We often talk as if concepts and motives are more rigid and discrete than they really are. But why? We do so, I suggest, mainly as a short-hand technique by which we may more conveniently and efficiently negotiate the world. This technique includes, at the highest deliberative levels of government, the orchestration of the collective motives and agendas of diverse political constituents needed to build a consensus aimed at establishing sound health care policies within democratic societies. As a result of these practical insights, social habits, and collective capacities, we do not have to spell out everything that we are experiencing in tedious, time-consuming detail in order to get things done in our households, communities, or nation states.

In addition, I conjecture that neither the worlds we regularly mediate and describe through the multiple lens of language, nor the higher-order concepts that anchor our action-guiding motives and impulses within the common ethos of our natural languages, behave in the artificially rigid and inflexible ways we sometimes imagine. In fact, based on my own observations, I would argue that the discrete, action-guiding motives we have been exploring (the redemptive, utilitarian, prudential, and charitable motives) do, in fact ‘give’; that is, they do indeed ‘overlap’ and ‘interpenetrate’ in the mind of the actor. Again, this happens especially when they converge on common ends that are deemed worthy of execution by citizens, institutions, or governments. Furthermore, our four central motives behave in this flexible, overlapping manner precisely because, at bottom, they turn out to be conceptually related
in an interesting, suggestive way. That is, they bear what could be called a family resemblance to one another. If so, as members of the same loosely related conceptual family (to be named below), is it so surprising that our four leading motives may overlap in various contexts?

So again, to admit that there is this occasional overlapping of concepts hardly spills the wind from our sails. Instead, it usefully serves to remind us that as actors, whether legislators, kings, or citizens, our motives may sometimes work in concert but also manifest in ‘mixed’, creative, and even contradictory ways. It hardly follows from this that the four motives in question have no distinct characteristics, or no proper limits of usage. Indeed, as I have suggested, they may be flexible, overlapping, yet more or less discrete — without conceptual embarrassment or loss of explanatory power in any robust theory of human action. Hence, the objection from oversimplification need not foul the lines of our analysis any further.

**Conclusion: Philanthropy and Funding Public Health**

What, then, is the name of the parent concept to which the four central motives under investigation may be said to bear a family resemblance? One gets a bold hint, I suggest, by reflecting further on the now familiar passage of the Hippocratic author of *Precepts*.

And if there be an opportunity to serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man (*philanthropia*), there is also love of the art.

If my intuition is right, our four motives, properly speaking, are related to the higher-order concept of ‘philanthropy’; at its root, it literally means ‘loving mankind’ (derived from the Greek *philia* = love, and *anthropos* = mankind). In contemporary usage, philanthropy may be defined as: (1) ‘good will toward one’s fellow man, especially as expressed through active efforts to promote human welfare’; or (2) ‘an

[15] By using the phrase ‘family resemblance’, I am adapting Wittgenstein’s terminology. My simple point is that these four motives—the redemptive, utilitarian, prudential, and charitable—may, in fact, share no easily identifiable common characteristic. Yet, like members of a human family who may not look much like one another individually but are nevertheless recognisable as bearing a similar family resemblance or orientation, we likewise notice the shared relatedness of these four motives. This we do because they often appear in similar contexts and behave in similar ways (often moving us toward acts or programs that assist others). See Ludwig Wittgenstein (1953), section 67.

[16] A complete theory of action, while outside the scope of this paper, may be found in L. Davis’s *Theory of Action* (Davis, 1979).

[17] For a different take on the Hippocratic tradition of philanthropy, which construes occasional pro bono medical care as a clever way for doctors to improve their reputations, see Edelstein (1967).
act or instance of deliberate generosity: a contribution made in the spirit of humanitarianism’ (Webster’s Dictionary, 1965, p. 1697).

I submit that actions arising from the redemptive motive, which seek to benefit mankind out of a love of God and so lead quite naturally to the funding of hospitals, bear a family resemblance to this parent notion of philanthropy (as defined above). So, too, actions arising from the utilitarian motive, which seek to optimise the balance of well-being over misery and so lead quite naturally to the funding of military medicine for the better defence of the community, also bear a family resemblance to our notion of philanthropy. As for the prudential motive, was it not predicated on selecting appropriate means to desired ends? Can anyone doubt that, even today, the funding of medical quarantines is sometimes the desirable thing to do—in order to reduce human suffering and benefit those citizens not yet infected? This last consideration also links the prudential motive in a familial way to our core notion of philanthropy: however difficult to enact and enforce, quarantines can and do serve humanitarian purposes, too. Lastly, there is the charitable motive. This encourages actions aimed at aiding the needy or suffering and so lead quite naturally to the funding of inoculations designed to prevent the spread of communicable diseases like smallpox. It also bears an obvious family resemblance to our preceding notion of philanthropy.

My final conjecture is that our notion of philanthropy loosely unites and subsumes each of our four central motives in at least two interesting and parallel ways. First, it interfaces with the redemptive and charitable motives by helping us notice that these both aim to generate good will and promote human welfare—the former for the glory of God, and the later for the sake of the poor. Second, it interfaces with the utilitarian and prudential motives by helping us notice that these both aim to promote the health of citizens by restoring the national defence and by blocking the spread of epidemics—the former for the sake of balancing optimal outcomes, the later for the sake of finding appropriate means to wise ends. If so, ‘philanthropy’, as here defined, may be said to constitute a basic concept which both links and illuminates the fuller meanings and potential psychological powers of the redemptive, utilitarian, prudential, and charitable motivations as we experience the effects of these forces in our lives.

But if this is the case, then I must modify an earlier important claim. While it is still true that no monolithic philosophy or care-giving principle emerges from the historical record to account for why governments, religious institutions, or other groups may have decided, over the centuries, to support the funding of health care, it would now be false to conclude that there is no unity at all in the four leading motives we have identified. What unites them is precisely the humanitarian vision that good will toward one’s fellow man involves consideration of a
higher-order philanthropic imperative. The imperative in question asserts that we ought to work to reduce human suffering and promote, as generously as possible, the well-being of all citizens. I am calling this imperative the philanthropic imperative.

Consider further: If this philanthropic imperative were wholeheartedly endorsed by the international community of nations, what would happen? If these nations worked openly together to achieve humane medical care through cooperative arrangements with each other and with such groups such as the World Health Organization, would not the funding of sound public health programs tend to flourish on a more responsive and extensive global scale than they do today?¹⁸

In my judgment, the answer is yes. At bottom, the international endorsement of the philanthropic imperative—which I have here reinterpreted as a core value at the heart of any humane program of public medicine—would go a long way toward building and sustaining sound programs of global health for planet Earth and its many inhabitants well into the twenty-first century.¹⁹

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¹⁸ Consistent with at least part of my conclusion, it is interesting to observe that the world’s largest private philanthropic institution, the Bill and Melinda Gates Foundation, has christened their ‘Global Health Initiative’ as a current top priority. See www.gatesfoundation.org for details.

¹⁹ I owe a debt of gratitude to Professor Philip Wilson, a medical historian at Pennsylvania State University’s College of Medicine, Hershey, PA, for helpful criticisms of an earlier draft of this paper. Thanks, too, to Professor David Hufford, Chair, Department of Humanities, and the staff of the George T. Harrell Medical Library at Hershey, for arranging guest scholar privileges during the 2006 summer term.