eradication, for shifts in rates of mortality and life expectancy. His samples in Massachusetts (1900) and England (1880s) suggest that rates of infant mortality and stillbirth were between 8 per cent and 25 per cent higher in cities using lead pipes than elsewhere; over 50 per cent higher where pipes were new or the water particularly soft. New pipes were more likely to leach into soft water; calcium and magnesium in hard water helped (though not invariably) to form a protective layer within pipes. Despite some high-profile outbreaks, Troesken shows that authorities frequently played down known, if ill-defined, risks: lead was more flexible and resilient than alternatives, and expensive to replace. Some cities saw no reported cases, but when Massachusetts discovered it had a problem, in 1900, many residents were habitually consuming over 100 times the current US safety limit. Until the 1930s, US and British legal systems held consumers responsible for their lead pipes, even where lead use was compulsory.

Troesken's chapter on mid-nineteenth-century Glasgow suggests the culpability of municipal politicians in subduing concerns over water-plumbism and the failure to undertake precautionary treatment by the addition of lime or chalk. While improved water systems are often closely related to declining mortality, he points out that the arrival in 1859 of the famously pure and soft municipal supply from Loch Katrine brought no break in trend: mortality rates in Glasgow had begun to decline in 1840. Troesken argues convincingly against a simple equation between public (municipal) provision and the public good. There is also an implication, here, that private suppliers may have been more responsive to the safety issues, but this is not explicitly stated. On the evidence presented, the relative merits of private and public suppliers remain open to question.

There are some important omissions in the British context: there is no Hamlin, Hassan, Luckin or Millward. Troesken's focus on drinking water, and on the role of epidemic disease in motivating reform, leaves under-examined the implications of industrial demand for plentiful soft water. A few errors include Snow's 1854 pump breakthrough set in 1848. These reservations aside, this is a ground-breaking study, placing lead pipes on the map for histories of water, public health and the environment, historical economics and demography. It calls persuasively for increased vigilance on the still unpredictable impacts of inorganic poisons.

Vanessa Taylor,
Birkbeck College, University of London

Marjaana Niemi, *Public health and municipal policy making: Britain and Sweden, 1900–1940*, Historical Urban Studies Series, Aldershot, Ashgate, 2007, pp. xiii, 228, £55.00 (hardback 978-0-7546-0334-4).

Marjaana Niemi examines the impact of political, social and economic interests on local public health policies in the early twentieth century by analysing and comparing infant welfare and tuberculosis prevention campaigns in the cities of Gothenburg, Sweden, and Birmingham, Britain. According to the author, these campaigns "served to depoliticize and 'naturalize' local economic arrangements, social structures and moral norms" (p. 22). Both cities were part of an international public health community and justified their public health policies by scientific knowledge, claiming to be value-free and politically neutral. Yet there were striking differences in their public health policies, partly due to national and local social, economic and cultural differences.

In chapter four Niemi presents the infant welfare campaigns in each city and looks at how they served to regulate working-class family life and gender roles, and also how they were used to promote the aspirations of medical professionals. Political ideals and norms were embedded in the campaigns, like the norms of the responsibility of families to be self-supporting, and of the men as breadwinners. Although there were clear links

https://doi.org/10.1017/S0025727300003793 Published online by Cambridge University Press

between poverty and infant mortality, in the case of Birmingham, it was claimed that there was no *direct* connection to poverty. Infant mortality was considered to be primarily the result of ignorance and bad behaviour among the poor. The focus of the campaign was mainly on improving the home environment and the promotion of breastfeeding through education. The campaign upheld existing gender roles by arguing in favour of male breadwinners and criticizing female employment.

In Gothenburg infant mortality was clearly lower than in Birmingham, and thus there was less pressure to make improvements. Nevertheless, medical practitioners lobbied the government for measures to improve child welfare, partly so as to enhance their own professional status. By contrast to the situation in Birmingham, most practitioners in Gothenburg worked in the public health sector and thus had a vested interest in its expansion. The Swedish campaign was to a large extent directed at reducing the relatively high infant mortality among illegitimate children, blaming single mothers and absent fathers. Nurseries and milk depots were supported, making it possible for single mothers to have employment. In the 1920s the campaign shifted to wider sections of society by starting infant welfare centres for all children.

Chapter five discusses how anti-tuberculosis campaigns regulated urban life and legitimized municipal intervention or non-intervention in the housing markets. Gothenburg had relatively high tuberculosis mortality compared with Birmingham. In Gothenburg the efforts were concentrated on isolating tubercular patients in hospitals and on housing inspections. In Birmingham, the poorer areas, characterized by overcrowding and defective housing conditions, experienced higher tuberculosis mortality than the more affluent ones. The dominant policy in combating tuberculosis was not to intervene in the housing market, but mainly to stress the unhealthy attitudes and lack of hygiene among the poor. As was the case in the infant welfare campaign, education was considered to be the most efficient way to combat the disease.

The author sometimes implies that the public health actors had a hidden political agenda for promoting the existing social and economic order. The arguments presented often seem plausible, but it is not always clear whether different elements of the public health campaigns were primarily a product of more or less conscious intentions to reinforce or maintain the social and economic order, or whether they reflected the best efforts to promote health within the given political circumstances. Maybe Niemi could have developed this issue more extensively or discussed possibilities of alternative interpretations.

I was somewhat surprised that eugenic ideas and theories that had a considerable impact on contemporary public health discourse, should have exercised relatively little influence on local public health policies in the early twentieth century. Niemi mentions that Swedish women who were believed to transmit serious hereditary defects were seen as grave threats to the health of the nation and the Nordic stock. Many were sterilized on these grounds, and pressure was put on mothers diagnosed with tuberculosis to place their children in foster care. This issue could also perhaps have been discussed at greater length.

Nevertheless, this book provides valuable insights into the local public health policies in early-twentieth-century Sweden and Britain, and their interplay with political interests, gender structures, science and professional aspirations.

Sam Willner,
Linköping University

Steven J Peitzman, *Dropsy, dialysis, transplant: a short history of failing kidneys*, Baltimore, Johns Hopkins University Press, 2007, pp. xxi, 213, £16.50, $24.95 (hardback 978-0-8018-8734-5).

The kidneys have often been the poor relations of other organs in the history of

https://doi.org/10.1017/S0025727300003793 Published online by Cambridge University Press