present and the very recent past, with those in nineteenth-century Europe. Such wide-ranging examples, both in terms of time period and geographic location, are commonplace throughout the book. They lead to Riley's main conclusion that no one nation's—or even sub-national region's—experience of improving life expectancy was or is replicated in another. National routes to low mortality inevitably vary due to choices made from the suite of six "tactics" (Riley's word, p. 56) available in relation to public health intervention, medical care and the emphases placed on wealth generation, education, nutrition and behaviours. But is an international comparative framework enough to make *Rising life expectancy* a truly global history? If Riley's panoptic use of evidential material were the criterion, then for those of us who scratch around in the dark warrens of local and micro-histories, his approach is a refreshing and necessary counterpoint. But this should not be the sole basis for judgement.

A more fundamental question would be to ask whether an account of improving global life expectancy that places the "health transition" at its intellectual core is any more or less satisfying as a world-view than demographic and epidemiologic transition theories, both of which are deeply Euro- and North American-centric in their basic assumptions and empirical grounding. As Riley explains, "the key factor in the health transition is not disease but the actions that diminish it, reducing mortality or morbidity. Those can be divided into four categories: avoidance, prevention, treatment, and management" (p. 26). Obvious though the advantages may seem that this definition holds over epidemiologic transition theory, the idea of health transition is fairly recent, achieving widespread acknowledgement only in the mid-1990s. But from a global historical perspective, surely it remains problematic as a unifying schema. At the risk of applying a different gloss on the "global" to that which Riley intended, two observations make this point. First, he notes that the gap in life expectancy between rich and poor countries has been shrinking, largely due to mortality reductions in countries that "came late to the health transition" (p. 40). "Late" compared to which countries, in what time period, and when? Second, in the chapter on the role of medicine, Riley sees the need to distinguish practices of traditional and modern healing from one another (p. 89). "Traditional" and "modern" for whom, when? And who decides what is "traditional" and what is "modern" anyway?

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William H Hubbard, Karl Pitkänen, Jürgen Schlumbohm, Sølvi Sogner, Gunnar Thorvaldsen, and **Frans van Poppel,** *Historical studies in mortality decline*, II. Hist.-Filos. Klasse Skrifter og avhandlinger Nr.3, Oslo, Novus Forlag in association with the Centre for Advanced Study, at the Norwegian Academy of Science and Letters, 2002, pp. 134, €22.70, Kr 182.00 (paperback ISBN 82-7099-360-3, ISSN 1502-9727).

This volume, which is published in faultlessly clear English, comes from a research group within the Centre for Advanced Study at the Norwegian Academy of Science and Letters. Its subject is the mortality decline—that is "the secular decline in mortality without an immediate significant fall in the birth rates"—between 1780 and 1920. If 1780 sounds surprisingly early it is because Norway had the lowest rate of infant mortality in Europe, and was one of the earliest countries for the onset of the mortality decline.

There are six chapters: three from Norway, one from Finland, one from Germany and one from the Netherlands. It is the fate of most multi-authorship books to consist of good chapters and some which are conspicuously weak. This is an exception. All six chapters are winners. All are clearly written. All consist of original contributions to our understanding of the nature and the determinants of the mortality decline and the value of international and inter-regional comparison.

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Pitkänen (from Finland) compares the mortality decline in Norway, Finland, Denmark, Sweden and France showing the many revealing differences. The history of infant mortality (to my mind a fiendishly difficult subject) is the central theme of many chapters. Thorvaldsen (from Norway) writes about rural infant mortality in nineteenth-century Norway and shows the wide differences in the infant mortality rate (IMR) between countries. In the nineteenth century Norway had the lowest rate, followed by Sweden, Denmark, Finland, Austria and Württemberg, in that order, but the differences had narrowed by the end of the nineteenth century. Hubbard (Norway) examines mortality in Norwegian towns, and the extent to which low mortality in Norway was linked to the low level of urbanization (in 1855 less than 14 per cent of the population of Norway lived in towns compared with 50 per cent in England and Wales). If you lived in a Norwegian town in the early or mid nineteenth century you were much more likely to die as an infant or young adult, than if you lived in the country. Sogner (from Norway) has written a case study of this "rural advantage" in infant mortality based on the records of a vast but sparsely populated parish in Eastern Norway named Renalden. In general, however, the rural advantage (or urban penalty) had all but disappeared by the end of the nineteenth century. Schlumbohm (from Germany) is one author who avoids infant mortality. Instead he contributes a brilliant chapter on whether the medicalization of childbirth led to a reduction in maternal mortality, underlining the dreadful results of the lying-in (maternity) hospitals before the end of the nineteenth century and asking why, when there was so much evidence that mortality in these hospitals was horrendous, they were allowed to exist.

All the chapters provide detailed statistical information and most discuss the factors which determined levels of mortality at different times and in different countries and regions. It may be my personal passion for maps, but the final chapter by van Poppel, based on mapping changes in infant mortality in the Netherlands, really caught my attention. He has taken three periods—1841–1860 1895–1903 and 1934–1939—and for each period he has calculated the IMR for each of the hundreds of different municipalities, grading them into five levels from the lowest to the highest. On the maps, the municipalities with the highest rates stand out as jet black, the lowest as faintly dotted white, and the intermediate three as increasingly dark cross-hatching. As the national level of infant mortality fell between 1840 and 1939, you can see how the darkest areas in each period, that is the worst areas, moved from being concentrated in the west around Rotterdam and Utrecht towards the centre of the country, and finally down to the southern and eastern regions. It is an outstandingly vivid presentation which you can visualize if you imagine three daily weather maps showing the passage of a band of heavy localized showers driven across the Netherlands by a north-west wind. The reasons for this migration of infant mortality are discussed in detail. As the author says, mapping shows that "even in a small, homogenous country like the Netherlands, large differences in the levels of infant mortality can be found between regions. This has implications for the study of mortality and for the study of social history in general".

It is my impression that historical demography and historical epidemiology (nearly but not quite the same) constitute one of the fastest growing areas in the history of medicine. To a large extent this can be attributed to computers and the internet and it is easy to forget how recent that is. Until about twenty years ago, as far as I am aware, no medical historian owned a computer (I think the first appeared around 1982–83). Without computerization I would guess that much of the phenomenal amount of work underlying most of the chapters (especially van Poppels') would have been so difficult, so time-consuming, that it would have seemed impossible. Now, historical demography, which tended at first to be parochial, is expanding fast in the direction of international comparisons.

I have not been able to do full justice to this collection of essays because they are so densely

packed and argued. Although it is immensely rewarding, the book is not light reading. I realize that historical demography is not every historian's choice, but provided you are not allergic to tables, graphs and statistics, this is a fascinating indicator of the way that historical demography is progressing.

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Paul Hackett, *"A very remarkable sickness": epidemics in the Petit Nord, 1670–1846*, Manitoba Studies in Native History 14, Winnipeg, University of Manitoba Press, 2002, pp. xvii, 315, Can$55.00 (hardback 0-88755-174-2), Can$24.95 (paperback 0-88755-659-0).

In *"A very remarkable sickness": epidemics in the Petit Nord, 1670–1846*, Paul Hackett broadens our understanding of the diffusion of disease in the fur trade era in the Canadian Northwest known as the Petit Nord (south of Hudson Bay and north of Lake Superior, west to Lake Winnipeg). Hackett argues that epidemic disease spread into the region primarily through Aboriginal contacts. The study proceeds chronologically from 1670 through to a rather arbitrary end date of 1846; a structure that reflects the nature of his sources, Hudson's Bay Company records, rather than any regional patterns. Hackett also makes clear that the impact of disease was not uniform across the region. At times some groups were severely affected while others escaped completely. His use of a continental perspective is especially helpful as he documents the steady loss of isolation as the region is pulled into the larger disease pools to the east, south and eventually to the west at Red River. Hackett's work is an important contribution to a field that is often based more on conjecture and supposition than on specific regional analysis.

Hackett shows that epidemic disease probably did not arrive in the Petit Nord until the first decades of the eighteenth century, despite the presence of Hudson's Bay Company (HBC) traders in the region. The length of the voyage from London to Hudson Bay and the small crews mitigated against the transmission of what Hackett variously calls Old World diseases, crowd diseases, or epidemics. It was instead the westward expansion of Montreal-based traders in their relatively swift trade canoes that eventually brought epidemic smallpox to the Petit Nord. This was the "very remarkable sickness" mentioned in the title. It was considered remarkable because of the general good health enjoyed by the Aboriginal people up to that time. In the last half of the century mention of epidemics, mostly respiratory diseases, increased in the region but, as Hackett admits, this may simply reflect better record keeping by the HBC. Smallpox broke out again in 1779–1783, this time spread from the south at Mexico City. In the late eighteenth and early nineteenth centuries the fur trade itself changed as competition between the HBC and Montreal-based traders led to a rush of post-building in the region. At the same time new disease pools emerged to the south as settlers and traders moved into the upper Missouri River region, and to the west at Red River. This increasing loss of isolation had predictable results for the Aboriginal people—increasing frequency of illness and the emergence of new diseases acting in concert such as whooping cough and measles.

Hackett argues that the period from 1821 to 1845 saw an epidemiological transition in the region as canal building in eastern North America and the introduction of steam technology brought families and their diseases more quickly to the margins of Petit Nord. Especially important was the increasing number of immigrant children to the south and west who brought childhood diseases such as mumps and chickenpox. The deadly transition was marked by repeated, often annual, epidemics. No longer would the people of Petit Nord have decades or even years to recover from epidemic disease. Compound epidemics of influenza, whooping cough, and scarlet fever also began to appear. But here Hackett makes two important points. First, even in this period of increased disease load, within the region disease continued to be carried from community to community by Aboriginal contacts. Second, within the region disease diffusion continued to