consequences across a catalogue of occupations. With Thackrah, an eighteenth-century form entered a debate which was central to the nineteenth century. Its republication reminds us of the continuities as well as the changes and controversies that characterized a key turning-point in British medicine.

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DANIEL M. FOX, *Health policies: health politics. The British and American experience 1911–1965,* Princeton University Press, 1986, 8vo, pp. xi, 234, $25.00.

This book is a comparative study of the British and American health systems as they have developed since the end of the nineteenth century. It argues that the key to understanding them is the concept of "hierarchical regionalism". Hierarchy describes the process by which the specialized and exclusive knowledge of the medical profession is dispersed to the population at large via health care. Regionalism is the organizational principle on which both the British and American health care systems are based. It involves the dispersal of facilities on an area basis.

Daniel M. Fox makes rather large claims for the concept of "hierarchical regionalism". He says that in it lies the key to understanding how the health care systems of both countries have developed. He argues that "Debates about how to pay doctors, govern hospitals and apportion the costs of caring for working class and indigent patients seemed more important to contemporaries throughout the century than did the consensus about hierarchical regionalism"! (p. 208) and that this has led many historians of medicine to the mistaken conclusion that these controversies are more significant than they were. This has led to a neglect of the slow, unwinding, and silent motor of health care systems in America and Britain — hierarchical regionalism. Fox seems to be arguing that it was precisely because of its widespread and unspoken acceptance that it has failed to attract the historian's attention.

I would not disagree about one aspect of hierarchical regionalism. Underlying this rather unwieldy term is the idea that the professionalization of medicine and the emergence of a caste of doctors and health-care professionals offering specialist medical care are important influences on the way health-care systems function. Many health-care professionals see offering to the public parcels of medical care as the means of secure status and advancement and they see medical institutions as the vehicle for this process. This is an important part of the story of health care in the twentieth century. But, unfortunately, Fox does not carry his discussion very far. If he had, he might have been forced to make some conclusions that modify the force of the concept of hierarchical regionalism. For example, whilst, to put it crudely, the relationship of doctors to the health market in health care is very noticeable in the USA, the situation is far more complex in Britain because of the existence of the state-funded National Health Service. Second, the position of many "élite" medical men (and women) in Britain is also more complicated and cannot be analysed solely by the theory of professionalization. Gaining access to and influence among other social and political élites, becoming one of those who tender advice to the political class, has had a very notable effect on the careers of many of the great and good in British medicine. When they achieve the higher level, politics and adherence to the general social and educational values of the élite become rather more important than the demands of professionalization.

"Regionalism" seems to me to be an unexceptionable concept, though, perhaps because of that, not very illuminating. Where I do disagree with Fox is in his determination to disenthrone all other factors in the story in favour of hierarchical regionalism. This leads him to exaggerated and misleading statements. He says, for example, that by the twentieth century, "How services should be organised had become the starting question for health policy. Money — either to maintain the wages of members of the working class or to finance their access to services — had become a subordinate issue." (p. 30). If we believe this, what are we to make of the debates in Britain in the 1920s and 1930s on the relation between low wages and benefit levels and malnutrition and ill health? Many among the medical profession continued to be perfectly clear

that organization of medical services was, by itself insufficient to meet this problem. The food policy of the British government during the Second World War, as well as being economically and politically necessary, was also seen as a health policy based on the principles of need, access, and income, not on "hierarchical regionalism". Many of the medical investigations launched by the Medical Research Council and other medical organizations between the wars were based on studying the relationship that Fox claims had disappeared as a significant part of the medical psyche. Though Fox modifies his argument slightly in respect of the late 1930s, in fact it leads him into making some surprising statements such as "Because of this consensus, British debate about health policy in the 1930s was usually a struggle for territory rather than about priorities." (p. 56). A glance at the health debates in Hansard during this period would disabuse anyone of this view.

The principle of hierarchical regionalism may have been unduly neglected. It certainly is the case that one principle, "hierarchy", as defined by Fox, deserves closer historical attention. One of the best parts of his book is Fox's discussion of the emergence of market forces in American medicine in the 1950s with its accompanying fads and fashions. Nonetheless, it will not replace the significance of access and equality in the story of health care in both countries. Even from the point of view of consumers of health care — if not from the dispensers or administrators — when, where, who, for how long, and at what price remain the most important questions in the encounter between the population and the medical profession.

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OLIVE ANDERSON, *Suicide in Victorian and Edwardian England,* Oxford, Clarendon Press, 1987, 8vo, pp. viii, 475, illus., £40.00.

The history of suicide in England has been oddly neglected. Michael MacDonald is currently completing a major investigation of the incidence and interpretation of suicide in the pre-industrial period, and the literary and cultural stereotypes of self-slaughter in Georgian England — one facet of the "English malady" — have received some attention. But little work has hitherto been done on the nineteenth century, which is *prima facie* surprising, because it was then that suicide records became comprehensive and reliable.

Professor Anderson's magnificent study radically changes this situation, by examining nineteenth-century suicide from a multiplicity of different but complementary angles. She makes use of a wide range of sources, from coroners' inquests and official statistics to newspaper reports; she examines individual case histories as well as literary and moralistic clichés and medical diagnoses; and, not least, she is sensitive to regional variations and to changes — in suicide incidence and suicide culture — over time. Her monograph is a model instance of how a murky and often secret subject can be reliably analysed thanks to the sensitive integration of quantitative and qualitive evidence.

Professor Anderson argues, plausibly, that thanks to the heavy policing of Victorian society and the nature of the coroner's office, nineteenth-century suicide figures are accurate enough — not as guides to absolute numbers but as indices to relative incidence and changes over time. What then do these data show? Not surprisingly perhaps, they destroy the literary and moralistic stereotypes. For instance, the typical female suicide was emphatically not — despite all those ballads! — the starving seamstress or the seduced maid (she was more likely, in London at least, a drunken prostitute).

Moreover, historians may take a certain malicious pleasure that Victorian data and Professor Anderson's readings of them show Durkheim and the French school of suicidology were utterly and completely mistaken in their interpretation of what drove people to kill themselves in early industrial society. Durkheim and his school saw suicide in modern society consequent upon the *anomie* created by industrialization, urbanization, and competitive market individualism. But Professor Anderson demonstrates that the great industrial megalopolises were not the suicide centres; suicide incidence was far higher in many rural areas or in small backwater towns: it was safer to live in Salford or Sheffield than in Suffolk or Sussex, and skilled manual labourers or miners were most unlikely to kill themselves.