Accountability for Public Health: Regulating the Housing Market in Nineteenth-Century New York City

In the late 1850s, New Yorkers expressed alarm that their city's steadily rising mortality rate now exceeded that of Old World capitals and of all other American cities. The city's annual death rate had doubled between 1810 and 1856, a statistician reported to the state assembly, and "was greater than in any city and at any period where life was valuable enough to be numbered." That the nation's richest city should also have the poorest health seemed to contradict the utilitarian faith that progress—the realization of the greatest good for the greatest number—could be measured through rising aggregate wealth made possible by unfettered market relations.1

Faced with this contradiction, observers at the time offered a range of explanations for New Yorkers' abysmal health: the dramatic increase in city residents—from sixty thousand in 1800 to half a million by 1850—simply overwhelmed the city; immigrants who came through the port brought their intemperance and illnesses with them; efforts to supply clean water had been obstructed first by the corporate fraud of the Manhattan Company and then by party quarrels; indifferent, inept, or corrupt politicians failed to enforce the available health ordinances. Yet by the 1850s, public health and housing reformers had also begun to focus—in the phrase that Dr. John Griscom borrowed from the British health reformer Edwin Chadwick—on the "sanitary conditions of the laboring population" as the source of the city's poor health. In the city's wealthiest ward, one out of fifty-five people died in 1856, a mortality rate half that of the city as a whole; in the city's poorest working-class ward, the rate was one in twenty-three.2 In the minds of health reformers, such figures established public health as a social question, one that required coming to terms with the city's deepening housing crisis. That crisis—the inadequate supply of affordable, healthy housing for working people—resulted from the intersecting relations of the city's evolving labor and housing markets.

In the early nineteenth century, New Yorkers found themselves negotiating two concepts of health in relation to the market. On the one hand, health was considered a personal characteristic, the responsibility of individuals who lived within a "private" set of social relations—contractual relations—that were placed largely beyond legal regulation. On the other hand, due in large measure to epidemics, health, from the late eighteenth century on, was increasingly regarded as a social product, a feature of the city at large. Preserving public health entailed setting limits on how people could use their property within a shared landscape, expanding the legal precept that proprietors should not use their land in such a way as to injure the interests of their neighbors. Health and housing reformers developed programs to regulate health "nuisances" in alliance with the city's businessmen, and they shared with property-minded New Yorkers the confidence that they could transform the city's physical environment without transforming the underlying market relations that shaped it. Yet as "personal" household relations themselves became a matter of market exchange—contingent on the securing of wages and payment of rents—so too did conditions of health themselves come to be treated not simply as a household product or a social good but also as a commodity. That is to say, access to health depended primarily on the personal ability to pay for a healthy environment.

In defining public health as a social concern, reformers raised the question of who was accountable—who, as the legal scholar Arthur Miller has put it in another context, "had to answer in another place"—when thousands of people died young or lived poorly. Yet, the reasoning that supported the expansion of market relations in the nineteenth century also constrained reformers' ability to establish accountability by asking further what the improving healthiness of some New Yorkers had to do with the deteriorating health of others.

ACCOUNTABILITY: GOD, PROPERTY RIGHTS, AND PERSONAL OBLIGATION

Accountability is both a moral and a legal concept, a means of attributing blame and demanding retribution or restitution. It is a concept that assumes that bad occurrences have causes that can be explained and redressed. Of course, within religious traditions, God is both the cause of human experience and the agent of retribution. Most colonial New Yorkers regarded disease as one of God's providences over which people had little control. Sinners might answer in Hell for their violation of God's will, but divine power over human life remained unaccountable.

Even secular thinkers shared something of this fatalism. In his 1788 treatise on English common law, Sir William Blackstone identified health—alongside life, limb, bodily integrity, and security of reputation—as a natural right of free persons. No one in the eighteenth century thought government could promise good health as a blessing of liberty; however. At best, governments might prevent citizens from harming one another. Apparently Blackstone did not pay much attention to the new medical opinions of his era, for he could identify only two established fields of public law that defended people's right
to health: quarantine and rules against selling adulterated food.' By the time he wrote, however, medical investigators in ports like New York had begun to develop theories that linked disease to the environment—particularly to vitiated air—and thus suggested a new scope of public regulation.

When New York physicians investigated yellow fever epidemics from 1790 to 1825, they identified poor waterfront neighborhoods as the "ground center of the calamity." The wharf district was "thickly inhabited, its houses generally small and badly ventilated," Dr. Jonas Smith Addams typically observed in 1791. "Many of the inhabitants were in indigent circumstances," he added, "which is a frequent cause of the want of cleanliness." Since Addams and other early sanitarians subscribed to the theory that disease originated in the atmosphere, they especially decried the lack of ventilation in the close quarters of one- or two-story wood cottages built on landfill lots. Yellow fever festered, moreover, in the poorly drained yards of these houses. In 1796, Dr. Noah Webster traced the outbreak of the epidemic to Dover Street, "which [having] been raised several feet since the buildings . . . were erected," blocked the windows of the adjacent wood houses and formed a dike that flooded the yard with contaminated water. These early medical investigators had little trouble discerning why people would live in such quarters: they could not afford to live elsewhere. The "higher price of house rent in other parts of the city," Dr. Valentine Seaman explained in 1795, "concentrated a great proportion" of the town's poorest families in the epidemic neighborhood "and crowded them in very small confined apartments." Whereas "opulent" New Yorkers fled the city during epidemic months of August and September, the "less prudent and the more indigent remained exposed to the diseases."

The doctors who investigated the source of epidemics were moving away from a providential explanation for public health and ill health toward a social theory of prevention. In so doing, they directed attention not simply to the sanitary condition of the environment but also to the economic position of individual households within the city. Yet, as both Addams's and Seaman's observations suggest, their empirical studies left them caught between a belief that health rested on personal virtues—prudence and cleanliness—and a new recognition of its connection to a social condition—indigence.

At the time of these investigations, most New Yorkers continued to regard health not simply as a matter of providence but also as a measure of the personal character of individual householders. In the first instance, autonomous adults were expected to exercise prudence in taking care of themselves. Although sympathetic to the "constitutionally" weak or disabled, New Yorkers were quick to judge and condemn individuals whose behaviors—drinking alcohol, for example—placed them "at risk" of disease. Health was also thought to be the collective responsibility and property of households, a quality embedded in a set of prescribed or contractual obligations. In the eighteenth century, when houses sheltered the town's trade and domestic work, most workers lived with their employers. Masters had a duty as well as an interest in maintaining the health of apprentices, journeymen, servants, and slaves who, alongside family members, constituted the household. The labors of a mistress and her servants in maintaining a household's health were among the "in kind" goods exchanged when household workers contracted for room and board. What the medical investigators added to this assumption of householders' responsibility for the health of dependents was the recognition that indigent—and generally tenant—households could not control the quality of the houses they occupied. The epidemics, moreover, did not confine themselves to the quarters of the poor. They disrupted the rhythms of trade and threatened the lives and livelihoods of the entire port.

In response to the medical investigations of yellow fever epidemics, New Yorkers began to recast the common law against "nuisances" in order to assign accountability for the unsanitary conditions they believed bred disease. The Anglo-American legal system built its concepts of rights and wrongs on the institution of property, the cornerstone of a well-ordered society. Within this tradition, preserving every free man's right to enjoy the benefits of private property also required striking a balance of mutual restraint. Thus, a fundamental principle of common law held that proprietors should not use land in such a way as to injure the interests of neighbors. Even before doctors identified atmospheric sources of disease, common law had defined light and fresh air as essential features of a house, attributes necessary to its enjoyment. When householder's created a "nuisance"—letting a privy overflow or neglecting manure and garbage piles, for example—their neighbors could take the direct action of removing it.

In seeking to prevent or control epidemics, the early sanitary reformers appealed to city officials to expand the reach of the eighteenth-century legal concept of "common nuisances": uses of land that could be regulated by government because they impinged on everyone's well-being. With the support of merchants (who preferred a focus on the local environment to the theories of contagion, which, in advocating quarantine, also disrupted trade), health reformers proposed new ordinances to eliminate the physical conditions that fed disease: to regulate and regrade the streets, fill in sunken lots, clean out refuse that accumulated in slips and wharves, and introduce clean water and sewers. In addition to extending the boundaries of districts that required "fireproof" building materials, public health ordinances proscribed burial and such nuisance industries as tanning, bone-boiling, or butchering within the built-up areas of the city. Officials also tightened regulations governing the emptying of privies and disposal of waste and garbage. The creation of the city inspector's office in 1804 institutionalized city government's responsibility for health as a public concern. So too did the Common Council's hiring of street cleaners. These early ordinances represented the efforts of elected representatives to establish the conditions of a healthy environment for the city as a whole.
Early health reformers and government officials alike looked upon the physical environment as the manifestation of the city’s progress as well as the source of disease. Worrying about the impact of the city’s rapid, unregulated growth, they sought to make proprieters accountable for how they used their land. In this view, the sources of disease—overflowing privies, foul-smelling trades in proximity to dwellings, piles of manure, dead carcasses, stagnant water, polluted wells—were extrinsic to expanding market relations, not intrinsic aspects of the housing market. If nuisances were what economists later called the “externalities” of capitalist development, the unintended and unpleasant side effects, such bad “external” effects could be limited by drawing maps and establishing a set of ground rules. Proprietors could not use land in any way they wished, but since in theory landlords gained equally from the regulation of a shared landscape, neither did they sacrifice their more fundamental rights to control their own property.

The historian John Teaford observes that nuisance laws became the primary arena of local government action in the early nineteenth century. As such, he suggests, health concerns helped define a new republican concept of the public good. Yet the historian Hendrick Hartog emphasizes the private economic interest that underlay the invention of local government’s “police power” out of the common law of nuisances. In earlier generations, rules against common nuisances aimed to maintain stability and order by preventing new uses of property that disrupted “a fixed, customary order.” The new ordinances, by contrast, both accommodated and promoted the changes brought about by market relations, particularly the rise of a speculative housing market. Whatever the benefits to public health—and some historians think they were limited—laws banning cemeteries, wandering pigs, or ash heaps from the built-up town made some areas of the city more attractive for builders and thus encouraged higher levels of investment. The new ordinances, in effect, recast government’s traditional obligation to protect private property by redefining “protection”: securing property rights would entail government taking a new interest not simply in sanitary conditions but also in the “highest and best use” of land, thereby establishing the private right to the use and benefit of property as a right to profit within the capitalist economy.

The implications of the selective identification of the public good with land use regulation that enhanced property rights (and values) can be seen by comparing this development to the shifts in the doctrine of contract law, the other field of market relations that raised the question of accountability for the health of city residents. Whatever the new theories of environmental—and hence social—causes of disease in the city, most New Yorkers in the early republic still believed that health depended on the actions of individual householders. Yet the simultaneous development of wage labor and rental housing in the late eighteenth century was also altering customary definitions of the personal obligation of employers to workers and of proprietors to tenants.

A new generation of employers, who paid nonresident journeymen hourly wages, had no obligation for workers’ maintenance and well-being. Landlords who collected those wages as rents had no responsibility to guarantee the quality of the domestic quarters they rented out. These contractual relations were intrinsic to the market, and in contrast to the application of nuisance law to regulate the specific uses of city property, judges were moving the doctrine of contracts away from evaluating the substance, fairness, or consequences of such market exchanges.

In the eighteenth century, legal historian Morton Horwitz has argued, contractual relations were open to scrutiny on the grounds of fairness of exchange. But the emerging legal doctrine of contracts held that judges and juries should regard and enforce all contracts simply on the basis of the agreement struck between buyers and sellers. Employers were not liable to their workers or accountable to the public, for example, if they maintained unhealthy or dangerous working conditions; once a person had agreed to the terms of employment, he or she accepted any risks to health that arose on the job. Common law, moreover, had long held that responsibility for the maintenance of rented quarters fell not on the landlord but on the tenant. By the mid-nineteenth century, judges were reinforcing this doctrine by applying the contract rule of caveat emptor (“buyer beware”) to rental housing. “A bad smell in the pantry, a kitchen being too hot with the stove in it, bad smells from the front window, a stagnant pond of water near the place, bad smell from fish, vermin in the bedrooms were all matters that might have given some trouble to eradicating,” a judge ruled in a typical case, “but none of them can be held sufficient to relieve the tenant from liability” for rent or require the landlord to correct them. Accountability within contractual relations thus rested primarily with the parties’ obligation to look after their own interests before entering into an exchange. Whether as wage-workers or as tenants, individuals assumed the risks of their own relations with others.

The legal doctrines governing common nuisances on the one hand and contractual relations on the other set limits for how New Yorkers addressed the problems of public health in the first half of the nineteenth century. The market was said to operate through invisible and ostensibly neutral laws of supply and demand. If vaguely sanctioned market relations of the society as a whole rather than the actions of particular proprietors organized the life (and deaths) of the city, no one person could be held answerable for encroachments on what Blackstone had articulated as an individual’s rights to health. City officials could forbid certain land uses and require proprietors to perform certain duties. But government could not intervene in contractual relations that determined the conditions of work, the distribution of housing, or, indeed, the marketing of health itself as a commodity.

Even in the eighteenth century, the provision of health had assumed aspects of a commodity, a physical attribute of housing and a product of domestic
labor that could be assigned a cash value and exchanged. In boarding houses, for example, landladies generally charged extra for nursing a sick tenant. The late-eighteenth-century health reformers who mapped the correspondence of disease and poverty observed that health carried a price tag: yet they also regarded the poor families living in the city’s worst housing as exceptions within their society, not as harbinger of the future. And they believed that new city ordinances could eliminate the vitiated atmosphere and contaminated water that most directly endangered health. By the 1820s, however, far from being an isolated condition, poverty represented the permanent outcome of contractual relations between the city’s laboring families and their employers and landlords. And the value assigned to health, produced in a domestic setting, had become one of the selling points of domestic property as well as of domestic labor. Light and air could not be easily insured by defending a household from neighbors’ nuisances, but these features of housing could be purchased or leased. Thus, despite the flurry of ordinances, securing health was becoming a matter of individual households establishing priorities for spending their own money. If epidemics helped shape a consciousness of the city as a shared environment and the “public’s” right to health, fear of epidemics also propelled the organization of a bifurcated housing market. Government policy, viewing public health as coterminous with economic development, not only tolerated but promoted the formation of this class-divided housing market that would, in turn, push reformers to focus on the housing crisis as the source of the city’s health crisis.

HEALTH AND THE FORMATION OF THE BIFURCATED HOUSING MARKET

During the yellow fever and cholera epidemics of the late eighteenth and early nineteenth centuries, the most common means of defending the right to health was to look out for oneself. Those families who could afford to, got out of town. Those who could not remained behind to nurse the sick and bury the dead. City officials compensated for the failure of their preventive measures by evacuating pestilent neighborhoods and providing temporary housing north of the port. But such dramatic government initiatives during emergencies belied the prevailing belief that health was primarily a measure of an individual’s and a household’s virtue and habits—the qualities of disciplined character that, within republican thought, represented the means to self-protection. Those who properly valued health would take care to maintain a clean, well-ventilated dwelling.

In the early decades of the nineteenth century, then, Manhattan’s housing market developed above all else as a market in health. The concentration of yellow fever epidemics in the wharf district altered the way New Yorkers valued housing and particular locations. The recurrent epidemics must have come as a sore shock, for example, to the prominent merchant families who had in the late 1780s and 1790s invested their fortunes in new mansions in the heart of the port. Removing their offices and counting rooms from their houses to wharf-front stores, the proprietors of Bowling Green, State Street, and lower Broadway had nonetheless placed a premium on maintaining dwellings close to the centers of trade, as well as to one another’s households. However convenient for business, the prime location of these downtown dwellings rendered them all the more vulnerable to disease in August and September. In 1799, Elizabeth Bleeker, who lived on lower Broadway, was shocked that a black man who was dying of yellow fever “came up our alley and laid himself down on the ground”; in August four years later she noted in her diary that her brother had removed his family from Water Street because “several persons have died near him with the fever.” The wealthiest families annually left the city for country homes and resorts; during the 1805 epidemic, more than one-third of the city’s residents moved out of downtown in late summer.

The new demand for dwellings beyond the wharf district spurred speculative construction in the early decades of the century. In 1807, a “small genteel family” advertised its desire for domestic quarters and typically noted that “the neighborhood must be respectable and in a healthy part of the city where it would not be necessary to remove in the event of the fever.” Builders responded to these concerns by featuring “healthiness of situation” in their advertisements for new houses, and they found a ready market among merchant and professional families who sought to insulate themselves from the threat of fever. Although expensive, a new dwelling north of Chambers Street might save a family the cost of suspending business and paying for temporary domestic quarters two or three months a year.

In increasing the allocation of family income to new dwellings and housekeeping, property and middle-class New Yorkers elaborated their ideas about “the home” as the center for both morality and health, the two inextricably linked. Caring for the sick, of course, had long been a domestic labor. But domestic literature in the 1830s and 1840s, which promulgated new standards of housekeeping, underscored the association of health and housing and helped define the features of new dwellings—their sitting and their utilities—as necessities rather than luxuries. (Indeed, the nineteenth century’s spiraling costs of health care could be measured not in the costs of technology, science, or doctors but in the new levels of capital investment in housing.) By the 1840s, writers like Catharine Beecher were stressing the importance of well-designed houses in order for women to fulfill their domestic responsibilities in caring for family health and morals. In defining the values of home life in opposition to the market, writers like Beecher helped obscure the connection between the two.

The speculative production of healthy and respectable neighborhoods beyond the port, however, introduced a new dynamic to the housing market.
Artisan families had first moved to the port’s periphery to escape the high rents of prime commercial land in lower Manhattan. Often leasing land from a rentier, they initially built inexpensive two-story wood and brick-front houses and shops on the Lower East Side in the vicinity of the shipyards or on the West Side along Hudson Street and in Greenwich Village. As wealthier families devoted a substantial portion of their incomes to purchasing dwellings in neighborhoods north of Chambers Street, land and housing prices soared. So did rents. Through the building boom of the 1820s and early 1830s, builders and developers produced the largest number of new dwellings for the most lucrative and economically secure market: wealthy and middle-class families. Substantial brick or stone townhouses offered not only roomy, well-ventilated interiors but new utilities as well. Although frequently shared by two families and their servants, blocks of “single-family” row-houses formed the city’s respectable neighborhoods west of Broadway.13

By feeding the speculative land market between Chambers and Fourteenth streets and establishing builders’ and developers’ new expectations for the rate of profit from construction, propertied New Yorkers’ demands for new dwellings in the years 1800 to 1840 established the connection between one group’s pursuit of healthy living conditions and the deterioration of the living conditions of others. Although small builders also erected new brick-front and wood dwellings for artisan households east of Broadway, fewer and fewer wage-earning families could afford to pay rent for an entire house. While single journeymen and day laborers found domestic accommodations in the city’s proliferating boarding houses, working-class families went to housekeeping in former artisan houses subdivided for three or more families. Through subdivision, boarding houses and tenant houses emerged from within the city’s oldest housing stock; once a neighborhood had been socially “devalued” through the concentration of tenant and boarding houses, investors avoided building new dwellings that cost more than the neighborhood market could bear. The builders’ main concession to the city’s growing number of working-class families before 1830 was to anticipate further subdivision by introducing three-story rather than two-story rental houses east of Broadway, thereby increasing the space that could be subdivided into apartments when landlords sought more tenants.

By the late 1820s, the city’s new class geography was apparent in the contrasting density and quality of housing stock in wealthy and working-class districts. As Charles Rosenberg and others have noted, evangelical and temperance reformers who visited the poor to distribute religious tracts in the late 1820s and 1830s saw a danger to the city’s health and morals in old and closely built tenant neighborhoods. Yet they were ambivalent about where to place the blame for the deteriorating conditions. Moral reform, after all, required that individuals take personal responsibility for the habits of cleanliness that signaled piety and produced health, and many commentators blamed poor housing conditions on Irish immigrants who did not follow the codes of Protestant rectitude. Doctor Jonas Addams, however, was not the last health reformer to attribute poor housekeeping habits themselves to “indigent circumstances.” By the 1840s, John Griscom would judge inattention to cleanliness a symptom of poverty—“demoralization”—rather than its cause.15

Whatever the assessment of cause and effect with respect to poverty and cleanliness, the continuing identification of health with morality in housing circumscribed the vocabulary of reform when it came to explaining why working-class living conditions were growing worse. In the 1830s, as rents continued to soar with the economic boom that accompanied the opening of the Erie Canal, even middle-class New Yorkers complained that the provision of housing was governed by a “spirit of avarice.” They were reluctant, however, to condemn that same spirit in other arenas of the economy. In 1834, the city inspector, noting that “some cause should be assigned for the increase of deaths beyond the increase of population,” merged moral and market explanations. No cause “appears so prominent as that of intemperance, and the crowded and filthy state in which a great proportion of our population live, and apparently, without being sensible of their situation,” he observed. He then went on to echo a widespread complaint by adding, “We have serious cause to regret that there is [sic] in our city so many mercenary landlords, who contrive in what manner they can stow the greatest number of human beings in the smallest space.” There were two sides to the formation of the city’s housing market, and the quality of housing New Yorkers could afford to buy or rent was also determined by what they could earn in wages. Despite the mobilization of a citywide labor movement in the 1830s, “mercenary” employers—or the conditions of the wage relation itself—did not figure in the health reformers’ attribution of responsibility for rising poverty or early death.14

In any case, aldermen in the early 1830s were less worried about the growing poverty, immorality, or mortality of wage-earning families than about promoting new improvements that would enhance New York’s status as the nation’s economic capital. They enthusiastically supported the differentiation in housing standards by creating private residential squares like Gramercy Park and granting tax breaks to developers for landscaping public spaces like Union Square. In subsidizing elite residential development, officials paid lip service to the health benefits of these open spaces, but they seemed more impressed by the benefits to real estate values. Indeed, the republican concept of a public whose good lay in preventing proprietors from injuring the interests of their neighbors was rapidly giving way to a new abstract and utilitarian public whose greatest good could be measured by the aggregate figures of rising land values, population growth, and increasing capital investment in industry. Aldermen recognized that their policies led to the displacement of poorer tenants, but they saw no direct link between improvement and deterioration. “The exceeding rapid increase of our population, and the measures
which have been taken to lay out and form public squares," a typical report observed, "have so much enhanced the value of lots in their vicinity as to render it desirable for persons of lesser means to turn their attention to situations somewhat more removed . . . where lots can be purchased at such a moderate rate as to come within their means." Yet with the de-skilling of crafts and the expansion of the waged labor market, proprietorship was permanently giving way to tenancy for more and more people "of lesser means"; they had little choice but to move into the already crowded rental quarters of subdivided houses.

Given the utilitarian perspective in business and governmental circles, the growing problems of public health registered most strongly when the aggregate figures of rising mortality rates, exacerbated by the 1832 cholera epidemic, threatened the city's commercial reputation. Aldermen, debating the introduction of the Croton aqueduct, stressed that Philadelphia had gained a competitive edge by solving its water (and thus its health and fire) problems. It was the New York fire insurance companies that most aggressively campaigned for a new water system. The construction of the Croton aqueduct satisfied demands for a clean water source that health reformers had been making for nearly three decades. Yet in its first fifty years the new water system and the sewers that followed reached a selective public, for the rising costs of housing were not matched by increased income for the majority of the city's families.

Building owners had to pay for the introduction of water pipes and fixtures to their houses as well as a tax for use. Not surprisingly, many landords, calculating that they would not be able to pass this expense on to tenants, ignored the opportunity. Landlord William Gibbons, who owned both middle-class dwellings and multifamily tenant houses throughout the city, resisted the introduction of Croton water: "I will not contribute anything toward it or undertake to furnish water for any tenant," he informed his agent just after the new system opened. Finding he had no choice but to pay the general water tax, Gibbons nonetheless introduced pipes only to houses with middle-class tenants and then raised their rents. Far from regarding himself as acting from immoral or "mercenary" motives, Gibbons thought he followed the sound investment practice of any sensible capitalist.

Even landlords who might want to introduce running water or plumbing were constrained by the location of street pipes, and here city policy often ratified landowners' strategies for maintaining what they judged a satisfactory rate of return on their investments. Since landowners paid assessments for introducing sewers, for example, aldermen usually awaited their petitions before taking action. Sewers, Gibbons once again protested to his agent, "are an unhealthy arrangement and should be avoided at all times if possible. A street can be kept in better order by [washing] the accumulated matter on the surface of the ground—than by depositing it in a sewer." When neighboring propri-