PUBLIC HEALTH ADMINISTRATION IN ENGLAND AND SCOTLAND:

POINTS OF CONTRAST AND OF CONTACT.*

By A. CAMPBELL MUNRO, M.B., D.Sc.,
President of the Scottish Branch of the Incorporated Society of Medical Officers of Health.

The occasion of the first meeting of the Incorporated Society of Medical Officers of Health in Scotland appears to me to afford a fitting opportunity for a review and contrast of the systems of public health administration in operation in England and Scotland. We are accustomed to accept things as they are, without a too curious questioning as to how they have come about. It may not be uninteresting, once in a way, to inquire how the present methods of public health administration in England and Scotland respectively have been evolved; to inquire how far they are well-founded in the abstract, how far justified in concrete experience; how far the existing systems are natural evolutions; and how far their form and direction have been determined by accidental circumstances. Methods differ in England and Scotland—how far have these differences been rendered necessary by the varying circumstances of the case, and in what degree are they accidental?

A recent American writer has observed that English Local Government is a most conglomerate circumstance. "It reminds one," he says, "of the old manor-house which the traveller meets from time to time in England—a building which has quite lost its original identity, because of the modifications introduced to suit the fancies of succeeding generations. The most violent architectural contrasts strike the eye, for each owner, while adding something to gratify his own taste, has left intact as much as possible of the earlier work. So with local government incongruity is the rule. And the queer mingling of the archaic with the modern is explicable here, as in the manor-house, not on utilitarian, but on historical grounds."

It will be convenient to deal with the subject generally, under the heads of (1) The Central Authority; (2) Intermediate Authorities; and (3) Local Authorities.

The Central Authority.† — The time immediately before the Norman Conquest in England was characterized by extreme

* Read at the provincial meeting of the society, Edinburgh, July, 1898.

† In my narrative of the evolution of the Central Authority in England I have to express my indebtedness to Sir John Simon's classic work on "English Sanitary Institutions."

decentralization in matters of government, and there existed a tolerably complete system of local government. With the Conquest everything was changed: all power became centred in the King, and local government was carried on by his representatives—the Sheriffs. Again, in process of years, this system of extreme centralization passed, and gave place to a system of local administration, in which the Justices and the Church in their respective spheres—or outside of them—held sway; and this continued, more or less, into the third decade of the present century. About that time it came to be recognised that the old system was insufficient to deal with the new circumstances which had arisen. The increasing density of the population, with the evolution of industrial enterprises, had introduced new problems, with which the former methods were unable to cope. The failure of the older system of complete decentralization had been most complete in respect of the care of the poor, and the introduction of the Poor Law Amendment Act in 1834 brought about a complete revolution in the department of local administration which was then of most pressing importance—the relief of the poor. The pitiable condition of the labouring classes, and the apparent inadequacy of any other solution, induced the Legislature to place the most absolute powers in the hands of the new Poor Law Board. Little was left to local poor law authorities beyond the election of officers, and the distribution of relief in accordance with regulations minutely prescribed by the Board. The system of poor law administration then established has been but little modified since.

The appointment of the Poor Law Board paved the way for the introduction of reform in the domain of public health administration — naturally, in a certain sense, accidentally, in that the Secretary to the Board chanced to be Mr. Edwin Chadwick, who had already made an extensive study of social conditions beyond the domain of poor law administration. In 1838 the Poor Law Commissioners, in a letter to the Home Secretary, pointed out that the existing Act required amendment, particularly in respect of making provision for averting the charges on the poor-rates caused by "nuisances by which contagion is generated, and persons are reduced to destitution. . . . The amount of burthens thus produced is frequently so great as to render it good economy on the part of the administrators of the Poor Laws to incur the charges for *preventing* the evils where they are ascribable to physical causes, which there are no other means of removing." The letter was supplemented by reports from the Board's Medical Inspectors, Drs. Neil Arnot, Phillips Kay, and Southwood Smith, based upon

inspections of the poorer quarters of London. The Inspectors reported, absolutely, that nothing whatever had been done to improve the condition of the districts inhabited by the poor, which suffered from a total want of drainage, from accumulations of putrefying matter of indefinite age, and from gross overcrowding. In these pestilential places the poor were obliged to live in order to be near their work. By no prudence of their own could they avoid the dreadful evils to which they were exposed. Out of a given population, in one year (1838) one-fifth of the whole were attacked by fever, of whom nearly one-tenth died. The public suffered to a far greater extent than they were aware of from this appalling amount of wretchedness, sickness, and mortality. They had to pay not only for the support of the sick, but of families pauperized in consequence of the sicknesses and deaths of the wage-earners. It appeared that the *prevention* of the evil—rather than the mitigation of the consequences of it—was "not only the most beneficial, but the most economical course."

This letter and these reports inaugurated a new era of social reform. The Commissioners were instructed to extend their inquiry into the causes of disease prevailing among the labouring population in England, Scotland, and Wales. The further report of the Commissioners was presented in 1842. "The principles of amendment deduced from the inquiry," said the report, "will be found as applicable to Scotland as to England."

Another Commission, of which the late Lord Playfair was a member, was appointed in 1843, and reported in 1845, and in 1846 the first public health statute, the Nuisance Removal and Prevention of Epidemic Diseases Act, became law. Under this Act, which was of a temporary character, the Privy Council was constituted the central health authority for England and Scotland. This was superseded by the Public Health Act of 1848, which established a General Board of Health as the central authority for England and Scotland. Of this Board Mr. Chadwick was the heart and soul. The Act was to continue in operation for a limited period only. When Lord Palmerston moved the renewal Bill, involving the continuance of the Board, in 1854, a storm of opposition to the Board, which had been gathering for years, burst over the heads of the Government. In vain did Lord Palmerston endeavour to avert it, and to mitigate the opposition. The Bill was defeated, the General Board of Health ceased to be, and a new Public Health Act was passed, upon a footing of annual renewability, which created a new Board, henceforth a Board only in name, with a salaried President, eligible to sit in the House of Commons, who would in himself constitute the Board.

The defects of the General Board of Health, and the difficulties of the situation, are now very apparent. The Board had no parliamentary responsibility or check, and thus easily got out of touch with the Legislature. It had no permanent staff of skilled inspectors. It had no medical member—at first, at least; one was added, with a touch of irony, when the administration of the Interments Act was placed in the hands of the Board, "to bury the dead," as someone said. The Board had had, as Lord Palmerston euphemistically put it, "to manage arrangements which conflicted with the fair and legitimate interests of many very intelligent and very active men." In other words, the Board had had to deal with vested interests, hitherto left untouched. And in these days neither legislators nor administrators had learnt the happy mean between centralization and decentralization. The principal fault of the Board was over-eagerness.

The new Board minimized the show of command, and carried out its communications with local authorities chiefly through a number of medical inspectors, of whom two were attached to headquarters, as "medical superintendents." In 1855 an Act was passed empowering the appointment of a medical officer, in which office Sir John Simon was installed. In 1856 the Board ceased to be the central authority for Scotland. In 1857 it was enacted that the Vice-President of the Privy Council might be the President of the Board. In 1858 the existence of the reconstructed Board of Health terminated, and its more medical duties, with its Medical Officer, were transferred to the Privy Council. The functions of the Medical Department of the Privy Council, apart from vaccination and regulations with respect to epidemic disease, were essentially those of inquiry and report. The Department was to "inquire into any matters concerning the public health in any place or places."

The Lords in Council promoted and carried the Sanitary Act of 1866. In this statute, as Simon happily puts it, "the grammar of common sanitary legislation acquired the novel virtue of an imperative mood." It declared it to be "the duty" of local authorities to provide for the proper inspection of their districts, and to take proceedings for the suppression of nuisances. On complaint of default of duty, the Secretary of State was empowered to take action to enforce the neglected duty. As time went on, the public looked more and more to the central government to exercise a real supervision over sanitary administration. In 1869 Dr. George Buchanan and Mr. John Netten Radcliffe, from occasional were converted into permanent Medical Inspectors. The Department was authorized

to promote laboratory investigations in the branches of science collateral to its province of duty. In 1870 Dr. Thorne Thorne was added to the staff, and in 1871 three additional medical inspectors were appointed, with an indication that three more might be added in the following year. The Medical Department had now liberated itself from the clouds of prejudice and distrust which had gathered around the central authority in earlier times, and the omens appeared to foreshadow a period of still greater usefulness.

The present central authority in England had its origin in the report of a Royal Commission appointed in 1868 to inquire generally into the system of sanitary administration in operation in England. With respect to the constitution of the central authority, the Commission recommended "that the administration of the laws concerning the public health and the relief of the poor should be presided over by one minister . . . whose title should clearly signify that he has charge of both departments, an arrangement which would probably render necessary the appointment under him of permanent secretaries to represent the respective departments. . . . The new department will have to keep all local authorities and their officers in the active exercise of their own legally imposed and responsible functions; to make itself acquainted with any default, and to remedy it. It will also have to discharge, to a much greater extent, its present duties . . . namely, to direct inquiries, medical or otherwise, to give advice and new plans when required, to sanction some of the larger proceedings of the local authorities, to issue provisional orders subject to parliamentary confirmation, to receive complaints and appeals, to issue medical regulations on emergencies, and to collect medical reports."

The Royal Commission further proposed that the Central Authority should have transferred to it the Medical and Veterinary Departments of the Privy Council, the Local Government Act Office, with its engineering inspectors, the Registrar-General's Office, and all sanitary powers and duties exercised by the Privy Council, and the Home Office, and the Board of Trade, and that the several reports, till then prepared disconnectedly in those departments, should be issued by the new department as parts of one series. It further recommended that the office of Chief Medical Officer under the Privy Council should be continued in the new Central Department. There should be two classes of special inspectors, "some with engineering knowledge," and "some with medical knowledge, who would be the agents of the Chief Medical Officer in the Central Department, and would bring him into relation

with the 4,000 medical officers already attached to the local authorities throughout the kingdom." The recommendations of the Commission fell short of counsels of perfection only in that they did not propose at once the establishment of a separate Ministry of Public Health, but the defect was a fatal one.

The Government lacked capacity or courage to propose a thorough measure of consolidation. It contented itself with proposing the creation of a new department, to be styled the Local Government Board, which should be invested with the powers and duties of the existing Poor Law Board, certain powers of the Home Secretary relating to Local Government, and certain powers of the Privy Council relating to public health, but not as to diseases of cattle.

The failure of the Government to establish, at once, a Ministry of Health was misfortune the first. Its failure to consolidate in one central department all matters concerning the public health was misfortune the second. Misfortune the third was that the President of the Poor Law Board, Mr. Stansfeld, became head of the new Department, and that the Poor Law Department, which he brought with him, became the predominant partner of the new concern. Under Mr. Stansfeld the new office started virtually as a continuance of the old Poor Law Office. In relation to the interests of public health, it was as "if the Act had ordered that the old Poor Law Board, subject only to such conditions of consultation and reference as itself might impose upon itself, should be the central sanitary authority for England. . . . The engineering and medical staffs were, as it were, pigeonholed for reference." Mr. Stansfeld provided that the Board might delegate any of its functions to secretaries or *under*-secretaries, and the system of public health administration by under-secretaries, upon the lines of the poor law administration, which was established then, has lasted, with little modification, until the present time. The Board has discharged the functions of a Poor Law and Local Government Board most excellently, but, looking back over the quarter of a century since the creation of the Board, I do not think that it can be pronounced a success as a central health authority.

By-laws have been confirmed, or disallowed, with the precision—and something of the automatism—of clockwork. Its duties of financial and purely administrative control have been admirably discharged. But in the domain of public health administration its policy has, for the most part, been one of masterly inactivity. It has not been a terror to evildoers, or a praise to them that do well. The reports of the Cholera Survey of 1885-86, carried out twenty

years after the passing of the Public Health Act, reveal an almost incredible failure on the part of local authorities over the country to give effect, in their districts, to the most elementary principles of sanitation, and this failure carries with it a distinct reflection on the administration of the central controlling authority.

The Board had at its disposal an imperial subvention, out of which a contribution equal to half the salaries of health officers appointed under the sanction of the Board was made to sanitary authorities. I regard imperial subventions with no great favour. They constitute a sin against sound economic principles. They are frequently frittered away uselessly; and they tend to encourage extravagance on the part of local authorities. The first principle I would lay down, with respect to imperial subventions, is that they should only be made in respect of matters which are of imperial concern. The second is that the object for which they are bestowed should be one the importance of which local authorities are unlikely properly to appreciate. In no case should the grant be made indiscriminately; it should be bestowed only as a reward for efficiency; and, as the subvention comes from the Central Government, the Central Government should satisfy itself that it is given only for value received. In other words, I believe in "payment by results," using that much-contemned phrase in a broad sense. Now, in this power of the purse the Board has had in its hands a lever which might have been used to the immense advantage of the nation. The Board had the power of putting a very real pressure upon sanitary authorities who failed to discharge their most elementary duties. But this power the Board have been too timid to use to any effect, and the subvention has fallen, like the rain from heaven, alike upon the efficient and the inefficient local authority.

It has become a truism in health administration that the larger the administrative unit, within limits, the more efficient the administration. Now, Section 286 of the Public Health Act of 1875 contained the possibilities of an immense reform in the sanitary administration of England. That section provided that the Board could compulsorily establish combinations of districts, exclusive of districts with populations over 25,000, and boroughs having separate courts of quarter sessions. So far as I know, that provision has remained a dead letter. It certainly never was utilized to any appreciable extent. It would have been possible for the Board to have applied, in the first instance, the gentle *compulsitor* of withholding the grant in the case of local authorities who declined to enter into efficient combinations. With the knowledge

of the stronger power in reserve, rural local authorities would generally have taken the hint. When, however, they proved obdurate, Section 286 ought to have been put into operation. Through the *lâches* of the Board in this matter, the condition of a large proportion of the rural districts of England remained, what the Cholera Survey revealed it to be, lamentably defective in respect of sanitary conditions.

The central authority has not, however, entirely failed to move with the times. Dr. Buchanan, Medical Officer to the Board, was in a position in 1884 to acknowledge "the increased recognition which the Board has during recent years been pleased to accord to the advice of its medical staff." Amidst the cholera alarm of 1884, the Board appears to have awakened to a consciousness that it had certain supervisory functions to perform with relation to local sanitary authorities, and a systematic sanitary survey of England was undertaken, which has given an immense impulse to the cause of sanitary reform in the more backward sanitary districts. But the period of alarm passed, and the survey has never been completed. There is, however, evidence that circumstances have forced upon the Board an increasing recognition of the advice of the Medical Department, and the Board's administration is becoming more and more embued with the medical and scientific spirit. This, indeed, notwithstanding the original constitution of the Board, was inevitable, for the Board has been exceptionally privileged in its Medical Department. In its association with the *personnel* of the Medical Department, it was impossible that the Board should remain a mere piece of automatism. And the influence which the work of the Department has exercised upon the public mind, and the way in which it has been recognised in other countries, have undoubtedly reacted upon the mental constitution of the Board.

Still, the central administration of public health affairs in England remains a thing of shreds and patches. What is required is a Ministry of Public Health, detached from any relationship to Poor Law Administration. Under this Ministry would be grouped the ordinary public health administration of the country, the Factory and Workshop and the Burial Grounds Departments from the Home Office, the Veterinary Department from the Privy Council, and the Registrar-General's Department—in more intimate relation than it at present has with the Local Government Board. Then there would disappear the unedifying spectacle of two Government departments in hostile conflict, as in the case of the Veterinary Department of the Privy Council and the Medical

Department of the Local Government Board. Then, too, there would be hope of the resolution of the chaos existing in the health administration of the Factory Acts, and of a proper definition of the spheres of action of the officers of the central and of local authorities. In the codification of the Factory and Workshop Acts which is talked about, the draughtsman of the measure should certainly have in contemplation the detachment of the Factory Inspection Department from the Home Office, and its establishment as a Department of the Local Government Board.

The history of the evolution of Public Health Administration in Scotland may be dealt with more summarily.

The earliest public health law appears to have been one in the reign of James I., for the separation of leprous persons from the rest of the people. In the time of James II. Acts to prevent the importation of poisons, and to cause persons affected with the pestilence to be either confined to their own houses, or removed to the vicinity of towns, were passed. Under James VI. an Act was passed for protecting the purity of the water in "lochs and burns." A statute of the time of Queen Anne regulated the application of quarantine in England and Scotland.

The history of the central authority in Scotland up till 1856 is embraced in the history of the English central authority—they were one and the same. In 1856 the General Public Health Act was superseded in Scotland by the Nuisance Removal and Health of Towns Act, and the Board of Supervision for the Relief of the Poor, which had been established in 1845, had imposed upon them, in the words of the Board, "certain duties unconnected with the administration of the Poor Laws in every parish," in other words, the Act constituted the Board the Central Public Health Authority for Scotland.

This Board had a real and not a mere technical existence as a Board. Its constituent members were three Sheriffs-Principal, the Lord Provosts of Edinburgh and Glasgow, the Solicitor-General, with three members nominated by the Crown, one of whom received a salary as Chairman of the Board. Most of routine business, however, was transacted by the Chairman and Secretary.

The Local Government Act of 1889, the equivalent in Scotland of the 1888 Act in England, left the constitution of the Board of Supervision untouched, and textually, at least, did not affect its powers. It was evident, however, that the new statute was regarded with no great favour by the Board. The Secretary to the Board, in a semi-official manual, speaking of the transference of the administration of the laws relating to public health from the

parochial board to the county councils and district committees, significantly remarked: "Whether the change will be for the better remains to be proved, but that it was inevitable can hardly be doubted." This feeling of distrust is quite intelligible. While the Local Government Board in England had pursued a policy of masterly inactivity in relation to local authorities, the Scottish Board, inspired by the late Sir John Skelton, had exercised a very real supervision over the doings and defaults of the smaller local authorities. The Board was a strong Board. Its policy in public health affairs, as in matters of Poor Law administration, was one of centralization. It had a finger in the pie of every parochial local authority in Scotland. Everywhere its influence was stimulating. When repeated remonstrances failed to stir a laggard authority into action, the Board made no difficulty about applying its powers of coercion. The Secretary to the Board had some justification in observing, at the time of the passing of the Local Government Act, that—"It can hardly be questioned that the sanitary condition of the people, even in rural districts, has vastly improved since the passing of the [Public Health] Act. In the remoter counties this is mainly due to the steady pressure of the central Board." The English Board has declared that it is not within the province of the Board to offer legal opinions. The Scottish Board, when applied to for advice by local authorities, was not slow to advise on legal or any other matters brought before them, and its advice was customarily given in clear and unhesitating terms. As far back as 1867 the principle of security of tenure for sanitary officers had received a certain acceptance in Scotland. The sanitary inspector, save in the case of burghs having a local authority, or having a population of over ten thousand, was removable from office only by the Board. And sanitary inspectors over the country knew that, in the execution of their duty, they would be backed up by the Board.

As an illustration of the effective way in which the Board exercised its powers, I may mention that in its later days it had placed at its disposal an annual grant in aid of some fifteen thousand pounds for distribution amongst local authorities in counties. The Board immediately issued a circular laying down specific conditions without the fulfilment of which county authorities would not qualify for participation in the grant. I regret to have to record that later on a Secretary for Scotland, under local pressure, caused this circular to be withdrawn.

The weakness of the Board of Supervision as a central health authority—a weakness which was becoming increasingly appreciable

in its later days—was that it had no proper medical or scientific staff. Its methods were conceived in the legal spirit, its bias was, if not anti-medical and anti-scientific, at least a-medical and a-scientific. In respect of a slender annual allowance, it had a certain lien upon the services of a distinguished medical officer. But, as in the case of the English Board, the medical officer was simply pigeonholed for reference; and the bias of the Board was reflected in the case of the local authorities. The medical officer had no security of tenure, he had hardly any administrative functions; he received the slenderest of stipends, and he, too, was simply pigeonholed for reference. Despite the Public Health Act of 1897, it will be many a day before the laicizing influence of the Board of Supervision will have disappeared in Scotland. Under the Local Government Act of 1889, the appointment of county medical officers in Scotland became compulsory, and it was at once apparent that the control which the Board had exercised over rural local authorities would, with the advent of skilled advisers, become much more remote and shadowy.

The defects in the constitution of the Board had been generally recognised, and the Board was finally dissolved by the Local Government Act of 1894, and reconstructed under the style of the Local Government Board for Scotland. The effect of the Act was to transform the central public health authority for Scotland from a semi-independent body into a State Department, with the Secretary for Scotland at its head, the Board becoming, through him, like other State Departments, directly responsible to Parliament. There is, indeed, an *imperium in imperio*. The Board, for ordinary purposes of Poor Law and Public Health administration has its seat in Edinburgh, and consists of a chairman, a legal member, and a medical member. But there is a larger Board, of which the Secretary for Scotland is President, the Chairman of the Edinburgh Board Vice-President, and of which, in addition to the legal and medical members already referred to, the Under-Secretary for Scotland and the Solicitor-General are members. Continuity and uniformity of action between the Scottish Office in London and the Edinburgh Board is thus secured. A more symmetrical arrangement, or one better designed to meet the requirements of the case, it would be difficult to imagine. Theoretically, the Poor Law and Public Health Departments should be disjoined; but in a country so small as Scotland a central Board of double function is perfectly justifiable on practical grounds, and, with a medical member, there is security that the Poor Law Department will not be permitted to overshadow the Public Health Department.

The new Board has but put on its armour; its career is before it.

But while, as a Board, its constitution seems to leave nothing to be desired, its equipment as a central public health authority is of the most meagre character. I find from the recent Civil Service Estimates that the expenditure of the English Board, exclusive of the cost of district audits, and of the inspection of alkali works, amounted to £136,535. I do not think anyone will suggest that that expenditure is excessive. Indeed, it is acknowledged that in some departments of work the Board is unduly restricted. The estimated expenditure of the Scottish Board is only £11,698, being a *decrease* of £253 as compared with the year before. I find that, taking the income of the English Board and the populations of the two countries as a basis, the Scottish Board ought to have an income of about £19,000. In other words, the Scottish Board is starved to the extent of 60 per cent. I dare say the Scottish Board could get on with less than its due proportion, but it is undoubtedly, at the present time, starved in respect of staffing and office accommodation. There is nothing in connection with the Scottish Board to represent the Medical and Engineering Department of the English Board. When local inquiries of any importance in relation to public health are required to be held, the Board has to rely upon casual assistance, an arrangement which adds nothing to the dignity of the Board, nor to its efficiency as the supervising authority. As an irreducible minimum, the Board, as the central authority, ought to have a couple of engineering, and a couple of medical, inspectors. The Board ought, also, to be provided with funds to enable it to employ special expert assistance to carry out those bacteriological and chemical investigations which are so important a function of a central health authority, and which are from time to time urgently demanded by the exigencies of the public service. The impotence of the Board in respect of this matter is pathetic.

Intermediate Authorities.—In England, the Local Government Act of 1888 established county councils over the country. The original intention was that the Bill itself should, in express terms, devolve upon county councils powers exercised by various State Departments. The matter, however, proved to be one of intricacy and difficulty beyond expectation, and the original specific proposals were withdrawn in favour of a general authorization, which took shape in Section 10 of the Act, whereby the Local Government Board is empowered at any time, by provisional order, to transfer any of these powers.

Control over the smaller local authorities was rather suggested

than bestowed. The county council was empowered to appoint a medical officer of health, and medical officers of health of all sanitary districts having populations under 50,000—boroughs with populations over 50,000 were constituted under the Act administrative counties, under the designation of "county boroughs"—were required to send copies of their annual reports to the county council. In this way county councils were enabled to exercise a certain supervision over the doings of the smaller authorities, although they were able to exert no directly controlling power. They were authorized, however, if it appeared to them, from any of the reports just referred to, that the Public Health Act was not being properly enforced in any district, or that any matter affecting the public health of a district required to be remedied, to make a representation to the Local Government Board.

In order to galvanize into action that inanimate statute, the Rivers Pollution Act, it was provided that the county council should have power, *in addition to any other authority*, to enforce the provisions of the Act in relation to any streams which passed through or by their county.

The control of the County Councils over the smaller local authorities was most advantageously extended by the Isolation Hospitals Act of 1893.

The Scottish Local Government Act of 1889 was based, generally, upon the English Local Government Act, but it was in its essence a measure for the reform of local administration in counties, and was not specially designed, like the English Act, to be a measure of decentralization. Indeed, decentralization was not so urgently called for in Scotland as in England. The central authority had not so evidently failed in respect of the supervision of the smaller local authorities as in England. Furthermore, a comparison of the two measures brings out, I think, certain differences of national temperament.

The Scottish, like the English Act, constitutes the county council an authority for the purposes of the Rivers Pollution Act. It provides for the appointment of county medical officers; but where the English Act says "may," the Scottish Act says "shall." And it gives security of tenure to all public health officers in the country, a matter upon which the English Act is silent. So much for Scottish thoroughness. Independence is supposed to be a national characteristic of Scotland. But nationalities, like individuals, have "the defects of their qualities," and the defects associated with this quality of independence are most unfortunately evinced in this measure. While in England the annual reports of the health

officers of all districts having populations under 50,000 are required to be sent to the county council, and the county council is empowered to make representations to the Local Government Board as to the defects in the Public Health administration of these districts, in Scotland the only reference to reports is contained in a section which provides that medical officers for counties and districts of counties (exclusive of burghs) shall present annual reports. In other words, reports are to be made with reference to districts for whose sanitary administration the direct supervision of the county council furnishes a reasonable guarantee of efficiency,* while the small burghal districts, which are under no such supervision, are not required to furnish any reports.

The "independence" of the small burghs was duly conserved. Ancient "centres of civic life," it was remarked on the occasion of the introduction of the measure, cannot lightly be obliterated or merged in the surrounding counties. The result was unfortunate. In small local government areas the public interest is a matter little considered in comparison with private interests. There is a lack of a large and well-informed public opinion. A small local authority has small resources: without combination it is unable to obtain the best skill in any department of its work, or to secure the most efficient appliances. The Scottish Act follows the English Act to the extent that the burghs are represented on the county councils; but that representation is an empty form, as the burghal representatives may not act or vote in respect of any matters involving expenditure to which the burghs do not contribute. The small burghal districts are thus in the position that while they are admittedly, on the average, behind the rural districts in public health administration, they are, unlike the rural districts, exempt from the supervision of the county council; unlike the rural districts, their officers are not required to report annually upon the health and sanitary condition of the districts. The consequence is, that while the rural districts have shot ahead since the passing of the Local Government Act, there has been but little advance in the smaller burghs. But the independence of these "centres of civic life" has been preserved.

A great opportunity was missed when the Act of 1889 was passed in this emasculated form, and it appears as if the only way in which a tolerably uniform standard of sanitation over the country can be attained is that which I have already suggested—the provision of a

* In county districts the local authority is the district committee, composed of the county councillors for the electoral divisions of the district, with a representative from each parish council within the district.

sufficient inspectorate in connection with the Local Government Board to maintain the necessary supervision, and to report cases of neglect and inefficient administration to the central authority.

Local Authorities and their Powers.—In England the local authority for public health purposes is the town council in boroughs, the urban district council (the urban sanitary authority under a new name) in urban districts, and the rural district councils in rural districts. The rural district council is a new body, constituted under the Local Government Act of 1894, and it takes over the duties and powers which were executed, or more frequently neglected, by the former rural local authorities, which were composed of what we, in Scotland, would term the "landward" members of the board of guardians. The rural district councillors are specially chosen by the parish electorate, and are *ex-officio* members of the boards of guardians for the unions in which their districts are situated. Rural districts had been in the past notorious for lax sanitary administration, and the Legislature, in its determination to get rid of the scandal, has so hedged the new rural authorities about with checks, that it is difficult to believe that men of capacity or station will be got to act upon them. The Act virtually assumes that they will prove inefficient, and provides that the parish council—a body which has very little work of its own to perform, and may consequently be expected to concern itself a good deal with other people's work—shall act as a check on the one hand, and the county council on the other. It may complain to the county council that the rural district council have failed to provide sewerage or water-supply, or to enforce the provisions of the Public Health Act, and the county council may make an order transferring the powers of the rural district council to itself, or may issue an order limiting a time for the performance of the duty with respect to which complaint is made; and if the duty is not fulfilled within the time so limited, the county council may appoint a person to perform such duty. Again, when a rural district council have determined to adopt plans for the water-supply or sewerage of any place within their district, they must give notice thereof to the parish council of any parish concerned before entering into any contract for the execution of the works. Now, questions of water-supply and drainage in rural districts are not unfrequently matters of great difficulty and complexity. There are, in the first case, for instance, apart from engineering and financial difficulties and questions of combination, questions of water rights and compensation to be faced. I have known capable district authorities, with every desire to facilitate

the provision of village water-supplies, detained for three or four years over these preliminary matters. In the case of sewerage works, intricate and tedious negotiations for the establishment of desirable combinations with other local authorities may have to be settled preliminarily, and the matter of outfall is often one of serious difficulty. Only persons intimately acquainted with all the circumstances of the case are in a position to say whether the local authority has been dilatory, or has only proceeded with judicious deliberation. The parish council is not in a position to form a competent opinion on the subject, nor is the county council so constituted as to be fully informed. If the English Act of 1888 has been more fortunate than the Scottish Act of 1889 in its method of dealing with small urban districts, the English Act of 1894 has been distinctly less successful in respect of the rural local authorities which it established.

In Scotland there has been ingeniously wrought out a chain of continuity from the county council to the parish council. The district committee, which is the rural sanitary authority,* is not directly elected, but is constituted, in part, of members of the county council, in part of members of the parish council, the proportion of county councillors being greater in populous districts. By reason of this representation of the county councils on district committees, these latter bodies stand upon a distinctly higher platform than the rural district councils; and they have this further advantage, that when any question affecting the sanitary condition of the district comes up either in the county council or the parish council, the rural local authority is represented. The Scottish system is also more satisfactory than the English in that the parish council in Scotland has no executive functions under the Public Health Act. The parish council in England is empowered to utilize any well, spring, or stream within the parish for water-supply, so long as they do not interfere with the rights of any corporation or person. They are also empowered to deal with any pool, pond, ditch, drain, or place containing or used for the collection of drainage or other matter prejudicial to health. A rural district council may delegate its powers to the parish council *quoad* the particular parish which it represents. Surely a case of too many cooks!

To complete this summary review of public health administration in England and Scotland, it will suffice to refer very briefly to certain points in which the new Scottish Public Health Act differs

* The district committee is not entirely the homologue of the rural district council in respect that burghal districts are represented upon it.

from the English Act. The provisions of the Act of 1897 are very unequal. As a sanitary code, the Act presents a good many gaps. But, on the whole, it represents a distinct advance on previous public health legislation. Its provisions with relation to public health officers are distinctly in advance of those of the English Act. It re-enacts the security of tenure which was granted in the Local Government Act. It expands the requirements of the Local Government Act, and no medical officer of health may hereafter be appointed in Scotland unless he is possessed of a statutory public health qualification. This requirement will, no doubt, give rise to cases of difficulty and hardship at first, but its final effect will be to improve the status of medical officers, and its tendency will be towards the combination of sanitary districts—a consummation most devoutly to be hoped for. The definition of offensive trades has been usefully extended, and slaughter-houses now require to have their licenses renewed annually, as under the Public Health Acts Amendment Act. While, under the English Acts, unsound articles of food may be seized only if sold, or exposed, or deposited for sale, under the Scottish Act unsound articles may be seized in course of transmission for sale or preparation for sale; and further, the onus of proving that the article was not intended for food is thrown upon the defendant. Under the same section live animals may be seized, and power to search carts, vehicles, etc., is given to the sanitary officers and to the police. The owner or person in whose possession, or upon whose premises, the article is found, is liable, at the discretion of the court, to imprisonment with hard labour for a term of not more than three months. In the event of a second conviction within twelve months, the court may order a notice of the facts to be affixed to the premises of the convict for a period not exceeding twenty-one days. A person obstructing officers in the execution of the section is liable to imprisonment for a term not exceeding one month.

But it is in respect of infectious disease that the new Act is most conspicuously in advance of prior legislation. The Infectious Disease Notification Act is extended to every district in Scotland. The medical officer of health may enter any house in which he has reason to believe that infectious disease exists, or has recently existed, and examine any person upon the premises. In contradistinction to the methods of the Infectious Disease Prevention Act, and immensely simplifying matters, the term infectious disease includes *every* infectious disease, whether notifiable or not, and all the "prevention" sections apply to *every* infectious disease. Compared with this, the Infectious Disease Prevention Act is cumbrous-

ness itself. In England the local authority *may* provide hospitals, apparatus for disinfection, and ambulances. Under the Scottish Act every local authority, "if required by the Board, *shall*" provide hospitals, reception-houses for the quarantine of persons who have been exposed to infection, disinfecting apparatus, and ambulances. This is excellent, but, without a medical inspectorate, the Board has no proper means of determining the cases in which it may judiciously exercise its *compulsitor*. Until such an inspectorate is established, it may safely be said that the Board will rarely put these powers in operation. The clause dealing with compulsory removal to hospital has been strengthened, in respect that not only persons "without proper lodging and accommodation" may be compulsorily removed, but also "persons so lodged that proper precautions cannot be taken for preventing the spread of the disease." The same clause provides for the compulsory removal to a reception-house of persons who have been in contact with infected persons where deemed necessary. The Act further provides that dairymen, when called upon by the local authority, shall furnish lists of the persons from whom they obtain their milk-supply, and of the names and addresses of their customers. Under another section any person or company deriving gain from the washing or mangling of clothes is required, when desired, to furnish a full and complete list of their customers. It is forbidden, under a penalty, that any child shall be sent to school, or received at school, from any house in which there has been infectious disease within the preceding three months. The local authority is specially authorized to "defray the cost of vaccinating or re-vaccinating such person as to them may appear expedient"—it would appear to be a short step from that to the logical position of constituting the sanitary authority the vaccination authority. Finally, county, or rural, local authorities are for the first time entrusted with powers—more efficient powers, indeed, than exist in the case of burghs—for regulating the erection of new buildings.

This address, I fear, has had what, in quarters in which sermons are not popular, are regarded as some of the chief characteristics of a sermon. Let me at least be consistent, and end with a "practical application"—a practical application which, as is frequently the case, does not arise directly out of the text, but remotely and inferentially.

Seven years ago the public health law of Scotland, and its application, especially in relation to rural districts, lagged sadly behind that of England. To-day the law and, I think I may add, with reference to rural districts, its application is distinctly in advance

of that of England. I do not hesitate to say that this advance is in a considerable degree due to the action of the Society of Medical Officers of Health for Scotland. From its inception the Society agitated systematically and ceaselessly for a new Public Health Act. In 1892 there was thrown in the path of this agitation what promised to be a very serious obstacle, in the shape of a ponderous measure—the Burgh Police Bill. This Bill of many clauses was intended to form a complete police and sanitary code for Burghs in Scotland. If it had passed into law in its original form, the enactment of a general and comprehensive Public Health Act would have been postponed — to the Greek Kalends — the burghal populations would have been provided with a Public Health Code, and the demand for a general statute would have been reduced to a whisper. Many of the sanitary clauses were of a crude character, and very open to criticism, and the Society took advantage of this and of other circumstances, and secured the dropping of the part of the Bill which was entitled "Sanitary Provisions." The demand for a general Public Health Statute thus retained its full original force. In 1894 a Local Government Act was introduced which, among other things, proposed the establishment of a new central health authority—a Local Government Board. The composition of this Board was hotly debated in Committee. It seemed as if the opposition to the inclusion of a medical member would certainly triumph, and we should be reduced to the old expedient of a medical officer—"pigeonholed for reference." But the Society struck in with energy at the critical moment. The official leader of the critics of the Bill happened, luckily enough, to be member for the University of Edinburgh, a largely medical constituency; the medical members of the House rendered yeoman service, and the medical member was securely seated on the Board. Largely through the exertions of the Society, powers for the scavenging of rural districts, which had formerly been withheld, were granted, in the same statute. Finally, after further agitation, in which other bodies took part, a Public Health Bill for Scotland was introduced. In its original form the Bill was largely suggestive of a skeleton. But, again, as the result in a considerable degree of the action of the Society, the bones were clothed with flesh. This Bill was finally withdrawn. On its re-introduction, in 1897, a strong, and, in some degree, organized effort was made to laicize the measure, to eliminate, as far as possible, the medical and scientific element from public health administration. Again the Society buckled on its armour, and organized every available force to counteract this tendency. To the Council of the Incorporated Society the warmest

acknowledgments of the Scottish Society are due for their unstinted aid at this crisis. Once more the tide of battle was turned, and the Public Health Act of 1897 left the hands of the Legislature in a form with which the Society has every reason to feel satisfied.

The objects for which the Society was constituted have now been tolerably completely secured. Its members believe that it is no longer necessary for the Society to maintain its militant attitude. Its constitution has been so altered as simply to secure its formal continuance, the activities of its Members being directed into another channel of usefulness—the Scottish Branch of the Incorporated Society.

Has the Incorporated Society nothing to learn from this recital? The Scottish Society has been a body small in number and of slender resources. The Incorporated Society is a body great in numbers and in resources. It has done much in the way of scientific discussion, in which the Scottish Society has done little. But have the numbers, resources, and forces of the Society been organized in such a way as to influence outside opinion, to influence the Legislature? I am afraid the question must be answered in the negative. Is not the time ripe for a new departure? The introduction of a new Public Health Act for England cannot much longer be delayed. The compulsory notification of infectious disease requires to be made general. The clauses of the adoptive Acts require to be made of general application. In short, the Public Health Laws will have to be amended and codified. The Society has a right to be heard in respect of such matters. Will it allow the opportunity to pass? Will it allow itself, as has happened before, to be shouldered aside when the time for action arrives? Or will it assume an attitude of preparedness betimes, and organize its forces for the fray?

Spread of Throat Illness by Milk.—During 1897 there was a well-marked outbreak of follicular sore throat, and as the result of personal inquiry it was very soon found that a milk-supply was the apparent factor in distribution. A visit to the premises was made with no result, and a close inspection of the cowsheds and of the employés was also made. A sewer was being laid in the road outside the farm, and for a limited period there was a smell to be noticed; but it was unlikely that this could have so far affected the milk (since it was not kept stored on the premises near this road) as to render it in any way dangerous to health. A man whose business it was to milk the cows was examined and found to be out of health, and suffering from well-marked tonsillitis and gastrodynia, and further with suppurating whitlows on the hands. He was, of course, immediately discontinued from any employment with the cows, and no further cases occurred. There were considerably over thirty cases of illness—some very severe—under my notice, and probably many more.—Dr. O. Coleman, Surbiton.—*A.R.*, 1897.