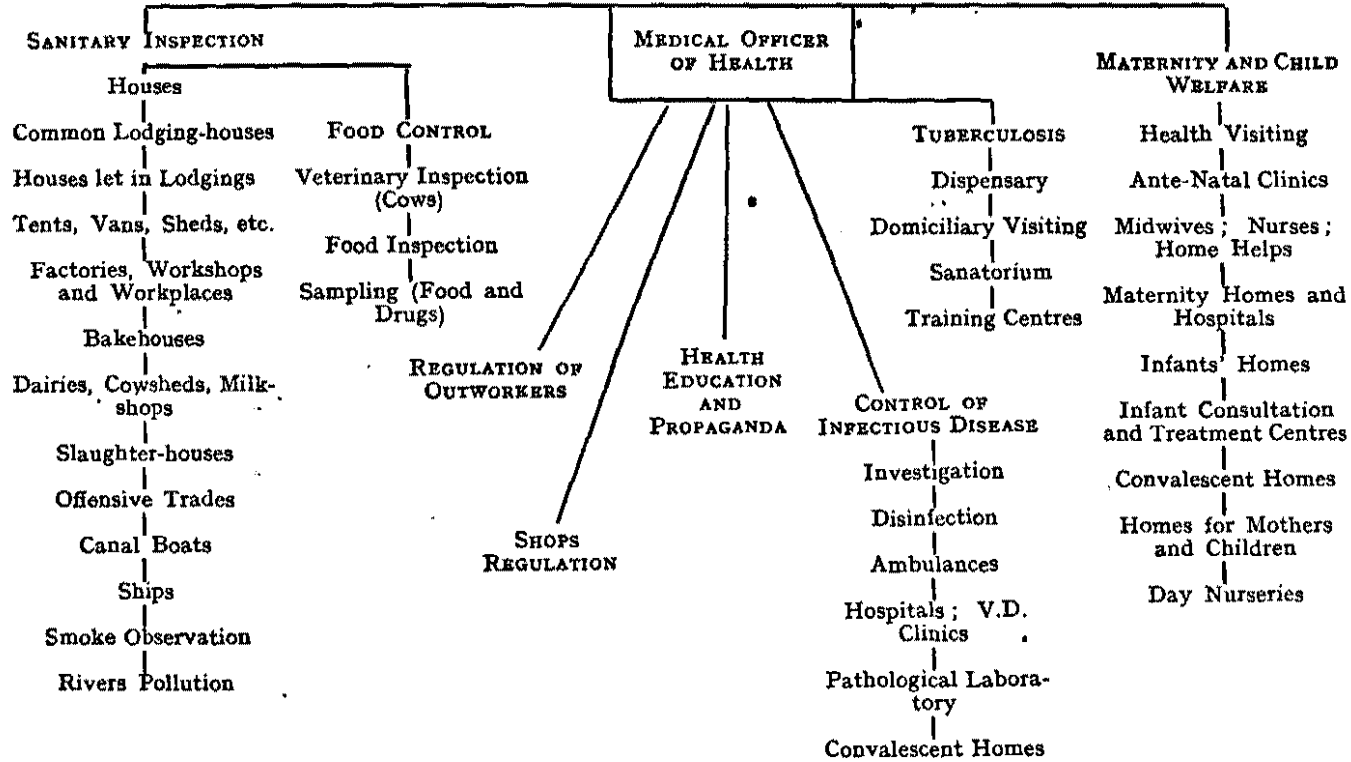


STUDIES IN ECONOMICS AND POLITICAL SCIENCE

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School of Economics and Political Science.

**ENGLISH PUBLIC HEALTH
ADMINISTRATION**

DIAGRAMMATIC REPRESENTATION OF THE ACTIVITIES OF A PUBLIC HEALTH DEPARTMENT



ENGLISH PUBLIC HEALTH ADMINISTRATION

BY

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PREFACE TO THE FIRST EDITION.

THERE are many good books dealing with sanitary administration. They are, however, as a rule, divisible into two classes; they are either purely formal legal works giving the text of various Acts of Parliament annotated by comments and references to judicial decisions, or they are practical hand-books for sanitary officers, and contain, mixed with many administrative matters, information about methods of laying and testing drains, distinctions between sound and unsound food, hints upon the cultivation and recognition of pathogenic bacteria, etc. None of them treat the public health department as an administrative unit of the system of local government. This book is an attempt to rectify this omission by providing a survey of the administrative technique of the public health department.

In so doing I hope to meet a double need: that of persons interested in the public health service as students or as electors or elected persons; and that of officials, especially the younger ones, of the public health department who are preparing for some of the examinations now held for clerks by the National Association of Local Government Officers, and for sanitary inspectors by the Sanitary Inspectors' Association, the Sanitary Inspector' Examination Board and the Royal Sanitary Institute.

It is a pleasant and necessary duty to acknowledge the debt I owe to various gentlemen for

inspection and information, without which this work could never have been undertaken or completed. To Mr. Graham Wallas I owe the original suggestion that I should make such a survey of public health administration, and throughout its preparation I have received from him that constant aid and encouragement which his friends and students know so well and appreciate so highly; my obligation to him has been greatly increased by his consenting to write an introduction to this effort of mine. For information and suggestions in various sections I am deeply indebted to Professor E. J. Urwick, J. Biernacki, Esq., M.D., Superintendent of the West Ham Isolation Hospitals, E. T. Rhymer, Esq., Barrister-at-Law, and Messrs. O. Bentley and S. F. Mann, of the Town Clerk's Department, West Ham, and C. A. J. Hunter, of the Treasurer's Department, West Ham.

To C. Sanders, Esq., M.B., the Medical Officer of Health for West Ham, and my superior officer for nearly seventeen years, my debt for his constant kindness and willingness to give or to allow me access to information is too great to be adequately expressed in words; many administrative difficulties dissolve easily when the relations of subordinate and superior officials are so uniformly friendly and harmonious as they are in the West Ham Public Health Department. To my other colleagues in the service of the West Ham Corporation I have to pay a tribute for information at all times ungrudgingly given, and specially must I mention Mr. G. W. F. Ellis, of the Public Health Clerical Staff, for his unremitting efforts in collecting information, verifying references, and making suggestions without which, I fear, my labours would have become prolonged and tedious.

For responsibility for errors which, despite great care, may possibly have crept in, and for expressions

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of opinion which may not be palatable or appear justified to all my readers, I exonerate everyone and accept all blame. Of instances of the former I shall be glad to hear for future correction, and of contrary opinions I shall be pleased to have information, since it is only by a free and frank interchange of opinions and ideas that we can hope to arrive at the truth and keep the administrative machine working with ease, economy and efficiency.

B. G. BANNINGTON

WEST HAM,
July, 1915.

PREFACE TO THE SECOND EDITION.

THE first edition of this book was received by both the Press and the public in a very friendly way ; serious adverse criticism or correction was singularly lacking. This fact has been a great encouragement in the preparation of a new edition which the growth of public health legislation has made necessary. The promise of a consolidation of the Public Health Acts has delayed for several years a task which might have been rendered nugatory if the promise had been fulfilled. That has not happened ; nor does the prospect appear either close or clear. And so one takes the risk always present when surveying a phase of social activity which is in a constant state of flux and growth.

The significant feature of the development of public health administration during the decade following the war has been the increasing recognition of the importance to the community of the health of the mother and her children. The tendency, commented upon in the former edition, to attach a growing importance to persons is exhibited in legislation and organization concerned with maternity and child welfare and venereal diseases. The former is so new and extensive as to need a new chapter for adequate treatment. That in order to make space for this the chapter dealing with voluntary agencies and efforts has had to be omitted is not belittling voluntary effort. Far from it. Maternity and child welfare work of a public character has grown out of, and largely utilizes, the or-

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ganizations and services initiated in an experimental way by voluntary effort. And more and more voluntary efforts in various directions are being linked up and co-ordinated with public activities so that clear lines of demarcation are difficult to find. It will be a bad sign, and one which might be fatal to progress, when the services of enthusiastic amateurs are lost to public health.

I have again to thank my many helpers for services the value of which it is hard to estimate. Some of those who gave their aid before have passed away and left the public service poorer; others have retired to enjoy a well-earned rest from labours for the commonweal. To those who remain, together with new-comers between whom it would be invidious to distinguish, is due a gratitude which can be felt better than expressed.

The preparation has again been a labour of love; that it is free from errors is my hope, and the same kindly appreciation as it before received I trust will be my reward.

B. G. BANNINGTON.

“PEARLSCOT,” FRONT LANE,
CRANHAM, ESSEX.

INTRODUCTION TO THE FIRST EDITION.

MR. BANNINGTON and I have known each other for a dozen years, ever since he was my best student at a West Ham University Extension Course. I recognize indeed a quotation on page 3 which dates from that course. But I have a better reason than personal friendship for recommending his book. It is, as far as I know, the first general treatise (since Sir J. Simon's *English Sanitary Institutions*, now obsolete) on modern English public health administration which is likely to be equally useful to students and to officials. So far the student has had to content himself in the main either with popular handbooks on the subject or with the rather superficial chapters on public health in books dealing with local government generally. The official has used the successive editions of Lumley's *Public Health Acts*, admirable for working reference, but impossible to read or remember as a whole. Mr. Bannington aims at covering the whole ground, with perhaps a certain amount of repetition due to his desire to make each chapter complete in itself. But his book is a treatise and not a dictionary. Both the official and the student who uses it will be impelled to think for himself under the guidance of a man who for the last seventeen years has earned his livelihood not as a lecturer or writer of textbooks, but as a sanitary inspector visiting every day the homes of a great industrial district.

My own first thought as I read the book was that the administrative machinery which deals with English public health is extraordinarily new. Since

Disraeli's great Public Health Act of 1875 the current expenditure of sanitary authorities in English urban areas has been more than quadrupled. In the larger areas the single medical officer of health with perhaps a single inspector of nuisances and one assistant inspector has developed into a great specialized service of medical men and women, analysts, bacteriologists, veterinarians, clerks, lecturers, nurses, visitors and trained inspectors of food and drugs, drains, ships and canal boats, shop hours, and open-air schools.

The body of accumulated science which these men and women administer has grown even more rapidly, and Mr. Bannington would perhaps be the first to admit that the willingness of the ordinary householder to be guided by scientific authority in the management of his home, insufficient as it still is, has grown more rapidly than anything else.

Statistics show that the actual success of sanitary science in overcoming the dangers arising from the increasing density of population is also new. The death-rate per thousand of the English population only fell from 19.9 in 1850 to 19.3 in 1890, but was 15 in 1907 and 13.7 in 1913. The infantile mortality actually rose from 146 per thousand births in 1850 to 151 in 1890 and was reduced to 109 in 1913.

A service so new, in a nation so unwilling as are the English to look forward in matters of organization, is almost certain to be out of date in much of its machinery and traditions. Mr. Bannington, as a result of his daily experience, constantly urges the reconsideration of both. Sanitary law should be codified and simplified. The financial and administrative relations between central and local government in sanitary matters should be reconstructed. Some order should be introduced into the overlapping relations between the local authorities, sanitary, Poor Law, educational and "insurance." It should be no

longer true that (as Mr Bannington points out on page 314) "we have members of the same household undergoing treatment in the institutions or at the hands of the officers of the sanitary authority, the guardians of the poor, the education committee, the insurance committee, and some one or more of the voluntary hospitals or nursing associations."

We should understand that the "inspector of nuisances" is no longer a humble sort of parish constable watching to see that people do not, from carelessness or selfishness, commit acts which they and every one else know to be wrong, but the administrator and exponent of a changing and growing applied science. The training of the sanitary inspectors, the examinations which they pass, their opportunities of promotion, should no longer be left to chance. The increasing importance of women in the service should be recognized and provided for. If the necessity of maintaining the sharp distinction between the medical and non-medical officials is felt to prevent even the best of the non-medical officials from reaching the most important administrative posts, opportunities of advancement should still be offered to all who show themselves possessed of the too-rare power of administrative initiative. I have myself, for instance, often thought that the officials and inspectors of the Local Government Board should be recruited to a much larger extent than at present from the best of the local officials. In every Government department local experience should be present to give life and meaning to the accumulating bundles of paper reports and returns, and, as we are now learning under the sharp discipline of war, every Government office should be a place where men are trained to be on their guard against the first symptoms of the "official mind" and to welcome instead of shrinking from the effort to realize the effect of new know-

ledge. Anyone, for instance, who reads the paragraphs of Mr. Bannington's book dealing with milk and slaughter-houses will see that we have as yet done almost nothing to apply the lessons of modern bacteriology to the problems arising from our use in the towns of animal food produced in the country.

As I write I find myself wondering how far I myself am still living in the traditions of that distant epoch which came to an end in August, 1914. When the War is over shall we not have to face the most important of all new facts, that we are a poor and no longer a rich country? Will not the problem before our statesmen be that of cutting down instead of extending our sanitary service? But I remember that in that distant epoch I was teaching a class of His Majesty's military officers the nature of local public finance. I quoted to them a sentence of the late Lord Avebury's: "It is evident that the more we spend in rates and taxes the less remains to be spent in other ways." They unanimously agreed with Lord Avebury, until I asked whether we should have more to spend in London if we saved by disbanding the London police, ceasing to pump London sewage, or selling the London schools. I argued that the cutting down of local expenditure could be so arranged as to reduce the earning capacity of the average Londoner to that of the average inhabitant of a Hindoo village, and they unanimously agreed with me.

Even if, after the War, the recovery of our financial position is to be the sole end of English life, that recovery will require wise expenditure as well as wise economy. And hard thinking, which is the most profitable of all national possessions, does not always cost money.

GRAHAM WALLAS.

LONDON UNIVERSITY,
1915.

ENGLISH PUBLIC HEALTH ADMINISTRATION

CHAPTER I

HISTORICAL DEVELOPMENT

THE essentials for healthy existence are the same to-day as they were at the dawn of history ; but as numbers have increased and society has become more complex, so have these essentials become increasingly difficult of attainment. Mankind has gradually recognized and understood the importance of air, water, food, shelter, clothing and exercise, sufficient in quantity and pure in quality, and, in various ways, has made collective efforts to ensure them. Out of these efforts have grown the mass of legislation, network of authorities, army of officials, and the numerous and costly institutions and engineering works which to-day exist in all civilized States for the purpose of securing and maintaining the public health.

Many of the customs and taboos of primitive races probably had an element of hygienic prevision in their origin or survival, and the tribes best protected in this way would be those who would multiply and survive the ravages of disease or warfare. The Israelites have handed down in Leviticus and Deuteronomy fairly complete sanitary codes, whilst of later civilizations, notably the Roman, we have historical knowledge of health laws and officials, and the visible remains of great sanitary works of water supply and sewage removal. The contagious character of certain diseases was recognized in the Middle Ages, and

gave rise to the enforcement of quarantine regulations and the building of leper-houses for persons suffering from leprosy. Contemporaneously municipal and private enterprise was providing water for some of our towns. Later, the modern laws as to building, town-planning and overcrowding are to be found faintly foreshadowed in Tudor legislation, about which time the Fishmongers Company in London was endowed with the power of inspection of fish and the seizure of any found unsound, a function still performed by this body.

Mediæval governments were not, as is generally supposed, quite indifferent to questions of public health. As early as 1388 a law was passed providing a penalty for casting animal filth and refuse into rivers and ditches, town officers being ordered "to clean their towns of all that would corrupt and infect the air and bring disease." A century later the slaughtering of cattle in cities and boroughs was prohibited. Nor were such laws altogether neglected; manorial and borough bye-laws were enforced more or less generally in the effort to secure a moderate degree of cleanliness in the streets and the soundness and purity of food. It is on record that Shakespeare's father was fined in 1552 for violating the bye-laws of the Manor of Stratford-on-Avon by depositing refuse in the street, and again in 1558 for not keeping his gutters clean; and in 1512 a Mayor of Nottingham was presented at the Leet Court for sundry misdemeanours such as selling herrings that were unfit for food and for beginning a muck hill.¹ The organization of the Gilds was to some extent a police system; ² "in their political aspect they formed the subordinate mechanism of local government and the organs of local administration. In their economic aspect they were the instruments by which the town carried out that policy of supervision which the opinion of the time deemed necessary."³ "Neither government, municipal or sanitary inspectors, nor a clerk of the works

¹ M. Dormer Harris, *Life in an Old English Town*, p. 118.

² Cunningham, *Growth of English Industry and Commerce (Early and Middle Ages)*, p. 344.

³ Ashley, *Economic History and Theory*, Vol. I, Book II, p. 25.

was needed. The searchers of the craft saw to all that." ¹

That in many places such regulations were quite ineffective is amply shown by the graphic description of the state of Hythe as presented by a jury at the beginning of the fifteenth century : ²

" Streets were choked with the refuse of the stable, made impassable by the ' skaldynge de hogges ', and flooded by the overflow of a house, drowned by the turning of a watercourse out of its way or the putting up of a dam by some private citizen heedless of all consequences to the public way. Timber dealers cast trunks of trees right across the street, dyers poured their waste waters over it till it became a mere swamp, builders blocked it up utterly with the framework of their new houses, and traders made their wharves upon it. Not only the most thriving and respectable merchants, but the butcher and swine-keeper as well, threw the waste of house and shambles and swinecote into the open street till there was scarcely any passage left for the wayfarer ; or established a ' hoggestok ' which smells very badly and is abominable to all men coming to market as well as to all dwelling in the town ' say the jury. There was hardly a street or lane which was not described as ' almost stinking and a nuisance '. The ' cherche weye ' was occupied by the pits of a skinner . . . gates, streets, ditches and hedges in disrepair. . . . Worse still, the Holy Well was choked with refuse and so was the well in West Hythe, and ' the water in the cart of Geoffry Waterleader, by which the whole community is refreshed ' was equally obstructed and spoiled by the refuse of the butchers' shambles."

It is not to be wondered at that pestilence when introduced decimated the population of such places.

Public health law and administration is based upon sanitary science, which in its turn depends upon the laws of health derived from the study of physiology and kindred sciences. In Tudor times the science was lacking ; " the apothecary was still a variety of grocer, the surgeon still a variety of barber, and the physician but just ceasing to be an ecclesiastic." ³ In the seventeenth century, how-

¹ Lambert, *Two Thousand Years of Gild Life*, p. 367.

² Mrs. A. S. Green, *Town Life in the Fifteenth Century*, pp. 29-30.

³ Simon, *English Sanitary Institutions*, p. 70.

ever, differentiation of function and specialization in research resulted in tentative suggestions as to the causation of disease and ushered in the dawn of preventive medical science, whilst towards the end of the eighteenth century the industrial revolution changed the whole structure of social England, and created new problems in every domain of life, not the least important being those concerned with the health of the growing population.

The industrial revolution consisted in the invention and utilization of machinery driven first by water and later by steam power, and resulted in the employment of many workers in factories and workshops and the destruction of the domestic industries which were spread throughout the length and breadth of the land. The textile industry, which after agriculture was the most important in the country, was the industry chiefly affected before 1830. The manufacture of textiles was transferred to the sources of power, towns grew up without plan, houses were built without regulation or supervision, great masses of people gathered together without regard to health, decency or comfort, and soil, air and water were polluted without restriction. The movement from rural to urban conditions was rapid and continuous; the population of England and Wales increased by 47 per cent. between 1801 and 1831, and the rural labourers, who numbered two to every town workman in 1790, only numbered one to every two of the latter in 1831.¹ Everything was sacrificed to the production of wealth and the belief in the prevailing philosophy of individualism—let things alone and all will be well.

But the resultant evils caused a reaction; the humanitarian movement gained impetus and, amongst other things, attacked the conditions that caused ill-health to be the common lot, and resulted in one out of every thirty of the population of towns dying every year. In 1774 an Act of Parliament was passed for the purpose of securing the health of prisoners. "Prisons were to be whitewashed yearly, regularly washed and ventilated; rooms were to

¹ Report of the Select Committee on the Health of Towns, 1840.

be set apart for the sick, hot and cold water baths provided, and in cases of necessity clothes were to be lent to prisoners; surgeons and apothecaries were to be appointed. Finally, the prisoners were to be kept above ground if it could be managed conveniently."¹ Ten years later Dr. Percival and others commenced the investigations which resulted in the passing of the "Act for the Preservation of the Health and Morals of Parish Apprentices and others employed in Cotton and other Mills" in 1802, the forerunner of a long series of Factory Acts.² It is typical of English legislation that it moves from precedent to precedent, dealing with many particular evils or special classes before the general character of a problem is realized and grappled with.

Fear, however, was more potent than philanthropy. Disease is no respecter of persons; even the well-to-do were endangered by the diseases of the poor. The repeated visitations of cholera and other diseases were valuable auxiliaries on the side of reform. As the Royal Sanitary Commissioners stated in 1871 in their *résumé* of sanitary legislation, "the recent sanitary legislation in this country has been remarkably drawn out by and connected with three outbreaks of cholera which led to investigations of the means of preventing and mitigating infectious diseases, and so drew attention to the fact that the seats of endemic diseases are generally where the air or water is polluted."

By the time of the first Reform Act the problems were being recognized and the remedies were fairly well understood, but the will to apply them and the machinery of government through which action could be taken were lacking. "The dense mass of working people brought together by the rapid growth of manufacturing, mining and commercial industry, presented sanitary difficulties of such unprecedented magnitude as to be at once novelties and puzzles for legislative treatment."³ Much advice,

¹ B. Kirkman Gray, *History of English Philanthropy*, p. 184.

² Cunningham, *English Industry and Commerce (Modern Times)*, pp. 628-9; Hutchins and Harrison, *Factory Legislation*, p. 7.

³ For some idea of the problems resulting from the industrialization of South Wales, see *Wales*, Chap. XI (by L. B. Cundall and T. Landman).

medicine and regulation resulted from the temporary establishment of a Board of Health consequent upon a cholera epidemic in 1831. Before 1837, outside a futile Quarantine Act and an annual vote of £2,000 for vaccination, "the central Government had nothing to say in regard to public health, and local authorities had but the most indefinite relations to it."¹ But the Poor Law and municipal government and factory legislation had come under the hands of the reformers, whilst the new system of registration of births and deaths and the reports of the Poor Law medical officers soon began to furnish accurate knowledge of the state of the public health. The inquiries of the Poor Law Commissioners in 1839 showed that individuals were helpless and that collective action was necessary but non-existent, whilst collective institutions were in a state of chaos. In the same year a Select Committee reported in favour of the organization of local sanitary authorities to enforce building and drainage legislation, but, despite Chadwick's energy, nothing resulted.

Chadwick, asserting that "by no prudence on their part can the poor avoid the dreadful evils of their surroundings," advocated with all his great ability and persistence his scheme of *ad hoc* local authorities for dealing with public health. At last the Report of the Royal Commission on the Health of Towns and Populous Places, issued in 1844-5, made further delay impossible. The sanitary conditions disclosed in this Report and in those of the Select Committee and the Poor Law Commissioners were too terrible and menacing to be neglected. It was shown that houses, courts and alleys were without privies or covered drains, but that fluids lay stagnant in open surface gutters; houses were dirty beyond description and extremely overcrowded, a large proportion of the working population being housed in "dark, damp, confined, ill-ventilated and dirty" cellars, whilst "heaps of rubbish and refuse, vegetable and animal remains, lay at the bottom of close courts and in corners." This evidence applied with more or less force to most great

¹ Simon, *Sanitary Institutions*, p. 167.

towns, in which mortality rates of over 30 per 1,000 were frequent. The Select Committee on the Health of Towns roundly asserted that "to require the workers to be clean, sober, cheerful and contented under such conditions would be a vain and unreasonable expectation," and declared it to be "the duty of the Legislature to take effective steps to protect so numerous and valuable a portion of the community." Two attempts at legislation failed before the Nuisance Removal and Diseases Prevention Act was passed in 1846. In the following year the Towns Improvement and the Police Clauses Acts consolidated certain provisions generally required in local Acts for various public purposes, and in 1848 the first Public Health Act, "the groundwork of our sanitary legislation," created a General Board of Health with power to create local sanitary districts with local boards of health either on petition by the ratepayers or compulsorily when the death-rate reached 23 per 1,000. The local boards were required to appoint surveyors and inspectors of nuisances, and were given wide but optional powers, among which was the right to appoint a medical officer of health.

The General Board of Health, without a representative in Parliament, created many enemies by its vigorous activity under the influence of Chadwick, and in 1854, after six years of stormy existence, it was deposed in favour of a new Board with a paid President. Four years later this Board was abolished and its duties handed over to the Privy Council, assisted by a paid medical officer. This year also brought an important departure in sanitary legislation, Local Boards being given powers under the Local Government Act to "compulsorily interfere with private property by purchase through the means of provisional orders," a power which the Royal Commissioners of 1871 noted as marking "an important and new step in legislation." In the same year (1858) the Medical Act, the charter of the medical profession, was passed. Before this date "the legal titles of medical practitioners were as various as the names of snuffs or sauces," and were guaran-

tees neither of the knowledge nor the ability of their holders, nor against the competition of anyone who chose to assume the title of doctor or surgeon. This Act "instituted for the first time a legal definition of the British medical profession; it directed the establishment and maintenance of a Medical Register," and created a superintending council, with power to remove from the Register the persons convicted of crime or guilty of infamous professional conduct. Although not going as far as desired by Mr. Cowper (afterwards Baron Mount Temple), the late President of the General Board of Health, it constituted a substantial advance upon the previous conditions and a useful starting-point for further progress.

Statistics were being piled up, research was being pursued, and the increasing staff of the central health department slowly developed "a scientific basis for the progress of sanitary law and administration."¹ Exact knowledge must precede effective legislation; this was fast being accumulated and progress quickened accordingly.

The Sanitary Act of 1866, placing the duty of providing for the proper inspection of their districts upon local authorities, was saved, like the Act of 1848, by a visit of Asiatic cholera. And again in 1869-71 cholera, aided by fever and small-pox, helped the reformers to success in pushing the proposals of the Royal Commission which reported in 1871.

The Report of this Commission disclosed an amazing complexity, lopsidedness and inefficiency of both sanitary legislation and administration. The progressive and experimental character of sanitary legislation resulted in the constant enlargement and extension of existing Acts without any attempt at reconstruction or any regard to arrangement, and the consequence was that "the law was frequently unknown, or at best, difficult to understand." No less than six departments of the Central Government acted in respect of public health, and it was "quite possible that on the same day inspectors from the different offices might

¹ Simon, *Sanitary Institutions*, p. 287.

visit a town for sanitary purposes without any cognizance of the presence of each other." The confusion in the Central Government had its parallel among the local authorities ; " in all country districts there is one authority for every privy and another for every pigstye ; but with regards to the privy, one authority is expected to prevent it being a nuisance and the other to require it to be put to rights if it be a nuisance." Three different authorities were functioning in some districts, and it was shown that " the sewer authority might provide hospitals, but it had no staff of medical officers to carry its powers into execution," whilst " the nuisance authority had a staff quite ready and daily at work, but it was not empowered to provide the accommodation." Despite the difficulties much progress had been made, and such places as Bristol, Croydon and Merthyr Tydfil had achieved great reductions in their death-rates by an effective use of their powers. On the other hand, the complexity of legislation and the overlapping of authorities, aided by ineffective central control, rendered the Sanitary Acts a dead letter in many places. At Epping, the sanitary condition of which was very bad and the mortality greater than in any other part of Essex, a special drainage district was formed, but in order to defeat action the members of the Board resigned, " since which there has been neither committee nor inspector nor any sanitary officer in the whole district." And in other districts the adoption or enforcement of sanitary legislation was prevented by the efforts of the ratepayers. The wholesale evidence of the difficulty of the adoption of adoptive Acts and the exercise of powers when adopted led one witness to assert that the " consent of the people being necessary for the adoption of these Acts is a most flagrant fault in them," and that Parliament made a great mistake when it " receded from the general principle of the Act of 1848 that people should have no prescriptive right to be dirty." The Commission strongly recommended that sanitary legislation be revised and recast, that the law should be strengthened, the system of sanitary authorities simplified,

and that every local authority should have a medical officer of health and an inspector of nuisances, towards whose salaries a grant-in-aid should be made by the Central Government, and that the control of local authorities by the central department should be made more effective. The establishment of the Local Government Board resulted, and was rapidly followed by the Public Health Acts of 1872 and 1874 and the great consolidating Act of 1875. These Acts, together with those which consolidated the Food and Drugs Acts in 1875 and the Factory and Workshops Acts in 1878, laid the foundation of the present system of sanitary legislation and administration.

Since that decade few years have passed without legislation affecting public health. The Factory and Workshops Acts were again consolidated in 1901; in 1925 a long series of Acts dealing with Housing and Town Planning disappeared and their effective parts consolidated; and such things as rag flock and rats and mice have been the subject of legislation. The twentieth century brought a change in the orientation of public health effort. Previously its main concern had been the material environment, now the tendency is to pay increasing attention to the human being. The school child is medically inspected and treated, and, where necessitous, fed; the welfare of mothers and their children is provided for by ante- and post-natal guidance and aid; and medical treatment and financial assistance during ill-health is secured for a large section of the working-class population by means of the National Health Insurance scheme. Meanwhile by the Local Government Acts of 1888 and 1894 and the London Government Act of 1899 sanitary areas have been simplified, authorities defined and reduced in number, and their powers have been to some extent co-ordinated, whilst at the same time the increasingly intimate relation between the local authority and the Ministry of Health, which after over half a century replaced the Local Government Board, resulting from the Ministry's powers of inspection, supervision, control and advice, has made for more efficient and equable administration; and

HISTORICAL DEVELOPMENT.

II

the effects are to be found in the gradual decline of the death-rates—the negative sign of an improved public health.¹

¹ The Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1925 gives the following figures (p. 7) :

Period (Annual Averages except for 1924).	General Death-rate per 1,000.	Infant Mortality (Deaths of Children under 1 year per 1,000 births).
1871-1880	21·4	149
1881-1890	19·1	142
1891-1900	18·2	153
1901-1910	15·4	128
1911-1920	14·3	100
1924	12·2	75

CHAPTER II

AREAS AND AUTHORITIES

THE existing sanitary authorities and the areas over which they exercise jurisdiction are, with one exception, the creation of legislation during the last quarter of the nineteenth century. Borough councils form the exception, but even they exercise their sanitary powers as urban district councils. For the purposes of local government, apart from those relating to the relief of the poor, the country is mapped out into sixty-two administrative counties,¹ containing county boroughs² wherein the county councils exercise no powers, and urban and rural districts;³ within the latter areas are the subordinate districts of the parishes, the council or meeting of which has some slight sanitary powers.⁴ In addition there are various special and joint authorities, such as port sanitary authorities and joint hospital or water boards. All these authorities are subject to a certain amount of control and supervision by departments of the Central Government—chiefly by the Ministry of Health—and their actions or inaction may become matters for review and decision by the various courts of law. Occupying an anomalous position are the boards of guardians, established by the Poor Law of 1834; they administer the Vaccination Acts and appoint vaccination officers and the registrars of births, marriages and deaths, who, subject to the control of the Registrar-General, collect and provide the statistics by which the efficacy of sanitary administration is indicated and judged.

¹ Local Government Act, 1888.

² *Ibid.*, ss. 31 *et seq.*

³ Local Government Act, 1894, ss. 21 *et seq.*

⁴ *Ibid.*, ss. 1 *et seq.*

There are sixty-two county councils; the discrepancy between the number of geographical and that of administrative counties being accounted for by the inclusion in the latter of the Ridings of Yorkshire (three), the Parts of Lincolnshire (three), the Divisions of Sussex and Suffolk (two each), the Isles of Ely and Wight, the Soke of Peterborough and London. Each council consists of councillors elected for three years and one-third as many aldermen, half of whom are elected every third year for six years. Its sanitary powers are limited and do not extend into the areas of county boroughs; they include the prevention of the pollution of rivers,¹ the making of bye-laws as if it were a borough council,² but which do not have effect within any borough, the appointment of analysts under the Food and Drugs and Fertilizers Acts, the administration of the Contagious Diseases (Animals) Acts, and orders made thereunder,³ and the establishment of isolation hospitals for infectious diseases under the Isolation Hospitals Act, 1893. Every county council must appoint a medical officer of health⁴ to whom the medical officer of health of each county district must forward a copy of his annual report upon the health of his district, and the county council may make representations to the Ministry of Health where it appears that any local authority has neglected its duties under the Public Health and Housing Acts.⁵ The council must pay to every urban and rural sanitary authority in its district a moiety of the salary of every medical officer of health and sanitary inspector, whose qualifications, appointment, salary and tenure of office are approved by the Ministry of Health; such payments are charged to the Exchequer Contribution Account. Many county councils now appoint sanitary inspectors through whom they gain information enabling them to exert pressure upon the local

¹ Local Government Act, 1884, s. 14.

² *Ibid.*, s. 16.

³ There are some exceptions to these powers in the case of boroughs with a population exceeding 10,000.

⁴ Housing and Town Planning Act, 1909, s. 68.

⁵ Similar powers are given by s. 7 of Public Health (Smoke Abatement) Act, 1926.

authorities to secure a more efficient enforcement of the sanitary laws.

The councils of county boroughs exercise their sanitary powers in the dual capacity of county councils and urban district councils. Their constitution, determined by the Municipal Corporations Acts of 1835 and 1882, is similar to that of a county council and consists of councillors and aldermen, but their presiding officer has the title and dignity of mayor, whilst that of a county council is termed a chairman. There are eighty-three¹ of these councils, but their number is constantly increasing, the additional dignity and powers of a county being obtainable, since the Act of 1888, by boroughs having a population in excess of 50,000,² by means of either a provisional order granted by the Ministry of Health or a private Act of Parliament.

The constitution of the councils of municipal boroughs, of which there are 255,³ is identical with that of the county borough councils. The distinction, for the purpose of sanitary administration, is to be found in the fact that whilst the latter are quite outside the jurisdiction of the county council, the former invariably where the population is less than 10,000 and sometimes when it is more, does not administer the Acts dealing with contagious diseases of animals and the sale of food and drugs. As sanitary authorities, these councils, like those of the county boroughs, act as and have all the powers of an urban district council, and they may, by means of private Acts, extend such powers as far as they desire and Parliament will permit.

Outside the boroughs the county is divided into urban and rural districts, differing generally, but not always, in density of population, the former being the denser. In 1927 there were 785⁴ urban districts with councils all the members of which are directly elected and presided

¹ Memorandum submitted by Ministry of Health to the Royal Commission on Local Government.

² It is proposed to raise this figure to 75,000.—Royal Commission on Local Government, First Report, August 7, 1925.

³ Memorandum as above.

⁴ *Ibid.*

over by a chairman. As is the case with all these authorities, the numbers of members of urban district councils varies, but they are elected for three years, and, as a rule, one-third retire each year.¹ Except the powers reserved to the county council, an urban district council possesses, or may obtain, all the powers conferred by the Public Health and kindred Acts and must appoint a medical officer of health and one or more sanitary inspectors for the purpose of their administration. In common with rural district councils, they have powers and duties which may be roughly enumerated under the following heads :

(1) Inspection and abatement of nuisances.

(2) Drainage, sewerage and sewage treatment and refuse removal and disposal.

(3) Regulation and inspection of common lodging-houses, dairies, cowsheds and milkshops, cellar dwellings, work-shops and workplaces, laundries, bakehouses and slaughter-houses.

(4) Inspection of food.

(5) Provision of water supply.

(6) Isolation of cases of infectious diseases, disinfection, and provision of hospitals, mortuaries, cemeteries and crematoria.

(7) Regulation of new buildings, town planning, and provision of houses for the working classes.

(8) Provision of open spaces.

Beyond these, urban sanitary authorities have powers in regard to :

(9) Regulation of offensive trades.

(10) Street cleansing and scavenging.

(11) Provision of baths and washhouses.

The members of rural district councils are elected for the parishes composing the district, and are also Poor Law guardians for the union in which the parish is situated ;² otherwise the councils resemble those of urban districts, but their powers are not so great since it is assumed that

¹ Local Government Act, 1894, s. 23.

² *Ibid.*, s. 24.

their sanitary problems are less urgent. These councils, of which there were 646 in 1927,¹ must appoint a medical officer of health and one or more sanitary inspectors, and may obtain by application to the Ministry of Health all or any of the powers of an urban district council.²

The parish, which is "a place for which a separate rate is or can be made, or a separate overseer is or can be appointed," is the unit of local government, but only rural parishes are organized for the purpose. For each rural parish having over three hundred inhabitants a council is elected at the parish meeting or by a poll if such is demanded. This power, if applied for, must be given by the county council to parishes having less than three hundred but more than one hundred inhabitants, and may be given to parishes with a population less than one hundred. The county councils and Ministry of Health have wide powers for uniting, dividing or altering parishes if such action is deemed desirable. Parishes without councils have a meeting at least twice a year, the chairman carrying out whatever administrative business is necessary; otherwise the meeting is usually held once a year, when a council of from five to fifteen members (the number is fixed by the county council) is elected. The parish council, which must meet at least four times every year, may utilize wells, springs or streams within the parish and provide facilities for obtaining water therefrom, and may deal with any pond, pool, open ditch or place containing, or used for the collection of, any matter likely to be prejudicial to health, by draining, cleansing, covering or otherwise.³ It may complain or make representation to the medical officer of health of the rural district council as to unhealthy dwellings or obstructive buildings;⁴ and, in common with the parish meeting, it may also complain to the Ministry of Health of any failure of the rural district council to exercise their powers under Part I or III

¹ Memorandum submitted by Ministry of Health to the Royal Commission on Local Government.

² Local Government Act, 1894, s. 25.

³ *Ibid.*, s. 8.

⁴ *Ibid.*, s. 6. See also Housing Act, 1925, s. 25.

of the Housing Act, 1925,¹ or to the county council of any similar neglect under the latter part of this Act.² Continued neglect of these powers may result in their transfer to the county council, which is also empowered to provide or maintain sewers or water supply for the parish if satisfied that the complaint of the parish council that the rural district council is defaulting is justified.³ The parish council may also have delegated to it by the rural district council any powers which may be delegated to a parochial committee under the powers conferred by the Public Health Acts.⁴ The parish meeting has exclusive powers of adopting the Baths and Washhouses Acts, 1846 to 1882, the Burial Acts, 1852 to 1885, and the Public Improvements Act, 1860, but as a rule the execution of the provisions of these Acts is left to the parish council.⁵ The accounts of both the parish meetings and councils are audited by the district auditors of the Ministry of Health. There were in 1927 approximately 7,166 parish councils and 5,646 parish meetings within the purview of the Ministry of Health.⁶

The Metropolitan Sanitary Authorities, with the exception of the unreformed Corporation of the central square mile known as the City, were created by the Local Government Act, 1888, which defined the County and established the county council, and the London Government Act, 1899, which divided the county area into twenty-eight boroughs. The nucleus of their powers is derived from the Public Health (London) Act, 1891.

The County Council controls an area of 121 square miles, with a population of four and a half millions, and is organized on the same lines as other county councils. The borough councils are constituted in a similar way to those of other boroughs, but their powers are not so extensive, and they are subject to considerable control by both the County

¹ Housing Act, 1925, ss. 23 and 73.

² *Ibid.*, s. 76.

³ Local Government Act, 1894, s. 16.

⁴ *Ibid.*, s. 15 and Public Health Act, 1875, s. 202.

⁵ Local Government Act, 1894, s. 7.

⁶ Memorandum submitted by the Ministry of Health to the Royal Commission on Local Government.

Council and the Ministry of Health. The County Council is the main drainage authority ; it regulates buildings, new and old ; it has extensive powers under the Town Planning and Housing Acts of 1925 ;¹ administers the Contagious Diseases (Animals) Acts ; regulates and enforces the law in respect of slaughter-houses, common lodging-houses, cowsheds and offensive trades ; makes various bye-laws for sanitary purposes including those under Section 6 of the Housing Act of 1925 ;² and appoints medical officers and sanitary inspectors to enforce and carry out the law. It is the appellate authority in various matters of dispute between the local sanitary authority (the borough councils) and private persons, and has powers of compelling the borough councils to carry out various duties placed upon them by the Public Health (London) Act, 1891. Outside the powers thus specially reserved to the County Council the borough councils have sanitary powers which approximate closely to those of a provincial urban district council. They must appoint medical officers of health and sanitary inspectors, and may appoint health visitors for the purpose of carrying out the duties placed upon them. Their administrative powers and methods differ little from those of the larger municipal authorities, with the notable exception that the water supply of the county together with a large extra-metropolitan area is provided by the Metropolitan Water Board, created in 1902, and that the Metropolitan Asylums Board provides hospital accommodation and treatment for cases of infectious disease.

Port sanitary authorities are constituted by the Ministry of Health either by an order which does not require the sanction of Parliament,³ or, in cases where objection is made by a riparian authority required to contribute to the expenses of the port, by a provisional order.⁴ The order

¹ Town Planning Act, 1925, s. 20. It is sole authority within metropolitan area. Housing Act, 1925, ss. 56 and 80.

² These Bye-laws are enforced by borough councils except those " for securing stability and prevention of fire."

³ Public Health (Ships, etc.) Act, 1885, s. 3.

⁴ Public Health Act, 1875, ss. 287 to 292.

may assign " any powers, rights, duties, capacities, liabilities, and obligations under the Act and under the Infectious Diseases Prevention Act, 1890, to such authority,¹ which may be either a riparian authority or a combination of such. For administrative purposes the coast-line of England and Wales is divided into port and riparian sanitary districts and in all the larger seaports port sanitary districts have been constituted under orders of the Ministry of Health. There are sixty-two port sanitary authorities,² including the Corporation of the City of London, which is the authority for the Port of London. These exercise over shipping within the area of their jurisdiction the same functions as sanitary authorities exercise on land, their chief objects being to exclude infectious disease, the supervision of the sanitary condition of the mercantile marine, and the inspection of imported meat and other foods. They may, with the sanction of the Ministry of Health, delegate to any riparian authority within or adjacent to their district the exercise of any of their powers.

In addition to the sanitary authorities already dealt with, there are various joint authorities constituted for the special purpose of exercising powers or providing services of benefit to the inhabitants of two or more contiguous districts.³ Two of the most important of these are the Metropolitan Asylums Board and the Metropolitan Water Board above mentioned. The former is composed of representatives of the London boards of guardians and of persons nominated by the Ministry of Health ; the latter of representatives of the local authorities in the various areas served by it. Similar authorities have been formed in various parts of the country for like purposes, for the provision of isolation hospitals under the Isolation Hospitals Acts of 1893 and 1901, as well as for the enforcement of the Rivers Pollution and Contagious Diseases (Animals) Acts. One of the most noteworthy of these joint boards is the Derwent Valley

¹ Public Health (Ports) Act, 1896.

² For list, see *Municipal Year Book*, 1926, p. 463.

³ About half of the port sanitary authorities are joint boards.

Water Board, constituted under an Act of 1899, of representatives from the corporations of Derby, Leicester, Nottingham and Sheffield and the Derbyshire County Council. Recent legislation enables local authorities to combine for the purposes of Part IV of the Public Health Act, 1925, dealing with verminous persons, places and things,¹ and for the exercise of their powers for dealing with smoke nuisances, in which case a joint committee may be appointed.²

¹ Section 49.

² Public Health (Smoke Abatement) Act, 1926.

CHAPTER III

SOURCES OF POWERS

FOR nearly a century Parliament has been engaged in the task of putting limitations to and restrictions upon that liberty of the individual which at the end of the eighteenth century was generally held to be the keystone of national greatness. Hard facts have proved too much for theories which assumed man to be merely a money-making machine ; material wealth is now realized to be of less primary importance than public health, and so to conserve and increase the latter the State has had, perforce, to curtail individual opportunities of amassing the former. The process has been slow, necessarily ; statesmen had neither precedents nor experience of the problems that the industrial revolution suddenly made urgent. Reformers had to feel their way, inquiring, legislating in a tentative, temporary fashion, creating and re-creating authorities and extending powers—too often permissive—to deal with special conditions as they presented themselves in pressing fashion. But they have succeeded in framing a body of laws, evolving a system of sanitary institutions through and by which the laws are administered and enforced, training an army of advisory and executive officials, and developing a technique for the purpose of “ securing that the fit are born, and preventing the fit from becoming unfit.”

Sanitary authorities owe their existence and their powers to Parliament ; and they may be destroyed or dispossessed of their powers in the same way. They are subordinate authorities. “ The sovereignty of Parliament is (from a legal point of view) the dominant characteristic of our

political institutions." ¹ In a lesser degree, as will be seen later, they are also subject to the superior power of various departments of the Central Government, i.e. the Ministry of Health, Home Office, and Ministry of Agriculture; and finally their activities and, in certain cases, inaction are always liable to review by the ordinary law courts of the land and subject to their decisions as to law, but not always as to fact.

The functions of local authorities are threefold :

- (1) Administrative—enforcing the law ;
- (2) Executive—doing things as required or permitted by the law ; and
- (3) Legislative—making laws such as bye-laws, regulations, and orders as required or allowed by the law.

It must, however, be noted that, whilst ultimately the source of their powers to perform these functions is statute law, it frequently happens that they are directly derived from subordinate authorities or even, as in the case of bye-laws, regulations and orders, from their own action. A peculiar example of this indirect method was to be found in the Contagious Diseases (Animals) Acts of 1878 and 1886, by which the Local Government Board was empowered to make orders for, among other things, authorizing a local authority to make regulations enabling and empowering them and their officers to do certain things—i.e. inspect the cattle and premises and prescribe conditions for the health of the cattle and the cleanliness of the premises and utensils. ²

Statute law may be classified in at least two ways which are of importance. In the first place, an Act may be a public or a private Act, one difference being that while the former is, or may become, of general application, the latter has effect only within the area of the authority which promoted it. The distinction was thus described by Sir Courtenay Ilbert :

¹ See Dicey, *Law and Custom of the Constitution*.

² This power is no longer delegated to the local authorities. See Milk and Dairies (Consolidation) Act, 1915, sec. 1.

" A public Bill is introduced as a measure of public policy in which the whole community is interested, and originates on the motion of some member of the House in which the Bill is introduced. A private Bill is a measure for the interest of some person or class of persons, whether an individual, a corporation, or the inhabitants of a county, town, parish or other locality, and originates on the petition of the person or persons interested. The object of a private Bill is, in fact, to obtain a privilegium—that is to say, an exception from the general law or a provision for something which cannot be obtained by means of the general law, whether that general law is contained in a statute or is common law."¹

But a very important difference is to be found in the methods by which they are passed through the Legislature, methods which the local health administrator must thoroughly realize if he would successfully influence the provisions of the one or secure the passing of the other. Secondly, the Act, if public, may be either general or adoptive; a resolution of the authority, passed in the prescribed way, being necessary before one of the latter class becomes applicable within its area. Instances of the former are the Public Health Act, 1875; the Factory and Workshop Act, 1901, and the Housing and Town Planning Acts of 1925; of the latter, the Baths and Washhouses Act, and Public Health Acts Amendment Acts, 1890 and 1907. The Infectious Diseases (Notification) Act, 1889 was adoptive until 1899, when it was made general, whilst the Notification of Births Act, 1907 became general in 1915.² The Public Health Act of 1925 offers examples of each. Part I is general; Parts II, III, IV and V are adoptive except as regards such sections of Part II as confer powers on county councils where no adoption is necessary. And even powers of adoption are not general.³ Powers which may be obtained by "adoption" must not be confused with those which are "permissive," of which there are far too many contained in the mass of legislation with which sanitary authorities have

¹ Ilbert, *Legislative Methods and Forms*, p. 28.

² Notification of Births (Extension) Act, 1915.

³ See next chapter.

to deal. The latter are to be found scattered plentifully among the clauses of sanitary statutes—general and adoptive—and are characterized by the use of the phrase “the local authority may,” etc., instead of “the local authority shall,” etc. In some cases the Ministry of Health has the power to issue orders converting permissive into mandatory powers, the case of Section 42 of the Public Health Act, 1875, relating to the removal of house refuse and the cleansing of certain sanitary conveniences, being one of the most important instances.

As indicated above, both authorities and officials are deeply concerned with legislative proposals affecting the public health. They may be, and many of them undoubtedly are, consulted before such a Bill is framed, but during its course through Parliament all have opportunities of bringing their views before individual statesmen and often, by means of the local member, before Parliament itself; this occurs when the Bill has been printed after the first reading, which, unless the Bill is very controversial, is agreed to with little debate. If, after debate, the second reading is carried, the Bill goes to a select committee if it appears desirable that its details should be closely examined, in which case evidence may be taken thereon, or it is referred to one of the grand committees or to a committee of the whole House, a similar course being pursued by a Bill after report by a select committee. It is next reported to the House, and, if any amendment has been made in committee, it is considered in detail; otherwise the third reading is taken and the Bill goes to the House of Lords. In the Upper House it at once enters upon the second reading, and after passing through the committee of the whole House is usually referred to a standing committee and on through a report stage to the third reading, finally going to the Crown for consent. Of course, the procedure varies somewhat when the Bill originates in the House of Lords, and in case of insoluble differences between the two Houses the Parliament Act may now be utilized to secure the will of the House of Commons.

It is thus seen that sanitary authorities have every opportunity of bringing the wisdom gained by experience to the help of the Legislature. That this opportunity is taken full advantage of is amply proved by a glance at the journals and periodicals dealing with local government and the professional interests of its officials. Immediately the provisions of a Bill affecting local government are made known they are at once discussed and criticized by experts—professional and lay—at general and special conferences of associations of authorities and officers. From them a stream of resolutions, often emphasized and supported by deputations, flow into the Minister in charge of the Bill, who cannot, if he wishes the Bill to work, afford to neglect the weighty criticism and advice thus gratuitously offered.

The procedure as regards private Bills is more complicated, and, together with "the growing complexity of the English administrative system and the number and importance of legal or semi-legal questions which arise in the course of central and local administrations by public authorities," has developed "a class of lawyers who devote themselves specially to this branch of learning or to some one or more of its ramifications . . . ; among these are to be found first-rate authorities on such topics as municipal, sanitary or highway law."¹ Private Bill legislation has been of the greatest value in the past,² but local authorities desirous of extending their powers as experience shows to be necessary complain very bitterly that it is costly, clumsy and slow. The fees payable under the Standing Orders of each House are high, the fees of Parliamentary counsel and agents and, often, expert witnesses are still higher, and local witnesses must be brought up to Westminster and frequently kept there for a considerable time.³ Fortunately the passing of public general and adoptive Acts

¹ Ilbert, *Legislative Methods and Forms*, p. 238.

² See Clifford, *History of Private Bill Legislation*.

³ Ilbert, *Parliament*, p. 87; Ashley, *Local Government*, pp. 175-6. Sir Park Goff, Chairman of the Select Committee of the House of Commons on the Mersey Tunnel Scheme, expressed the opinion that the expenses attending "that stage in legislation frequently amounted to a scandalous waste of public money."—*Municipal Journal*, July 31, 1925.

and the extension of the device of provisional orders have superseded much of the necessity for local private legislation, the tendency of which is to decrease in volume and importance.¹ The Standing Orders of both Houses define very precisely the manner and time of making application for new powers by local authorities. The Bills are introduced and read a second time and then usually go on to the Local Legislation Committee, before whom applicants and opponents are heard, counsel engaged, and witnesses called.

The Local Legislation Committee was first appointed in 1909, when it replaced the Committee on Police and Sanitary Regulations, which originated in 1882. It consists of fifteen members appointed at the beginning of each Session by a special order of the House of Commons. It sits throughout the Session and deals with all Bills of the type implied by its title, whether opposed or not, hearing counsel and witnesses on behalf of the promoters and any opponents, and receiving the assistance of experienced officials of the Ministry of Health and the Home Office who attend its proceedings. In its deliberation and decisions it adheres to the principles laid down by its predecessor in 1884, "that no local powers should be given which are in excess of the general law unless strong local reasons exist for such powers, and that no statutory enactments should be permitted for purposes which can be effected by bye-laws."

The report of this committee, if adverse, declares that "the preamble is not proved"; in any case it is usually final. The procedure in the House of Lords is practically the same. In this way many of the largest authorities have secured powers far wider than those given by general statute law, and have thus been enabled to maintain their administration at a high standard of efficiency and abreast of the increasing demands of modern sanitary science. By this means Bradford obtained power to remove to hospital or other institution any aged or infirm persons living under insanitary conditions or suffering from any

¹ Ilbert, *Parliament*, p. 87.

grave chronic disease, and so introduced a new principle in public health legislation, "applying compulsion mainly in interests of the persons compelled rather than in those of the general public." The same progressive borough also secured the application of the Infectious Disease (Notification) Act, 1889 to certain cases of venereal disease.¹ During the year 1926-7 the Minister of Health reported to Parliament on thirty-seven private Bills deposited by local authorities.²

Another way by which local authorities may obtain powers which used to require private Acts is by provisional orders, for which application must be made in the prescribed way to the appropriate department of the Central Government. Before granting the order the department sends down an inspector to hold a public local inquiry into the matter of the application and to report thereon. If the report is favourable, the provisional order conferring the desired powers is drawn up by the Ministry of Health and submitted, singly or with others, to Parliament in the next Session in a Provisional Orders (Confirmation) Bill, which usually passes without opposition, but which may be opposed like other private Bills.

The Ministry of Health has many powers which it may exercise by provisional order. One of these, which has been widely used, is the power to create port sanitary authorities ;³ whilst a second, of which practically no use has been made, is the power to transfer, subject to approval by the department and authorities affected and to confirmation by Parliament, certain powers, duties and liabilities of departments of the Central Government to the councils of counties or county boroughs.⁴

Statesmen and officials engaged in drafting Bills to bring before Parliament endeavour to keep them as simple and clear as possible. This is an extremely difficult matter ; Parliament cannot be expected to legislate for every detail

¹ Seventh Annual Report of the Ministry of Health, pp. 81-2.

² Eighth Annual Report of the Ministry of Health, p. 85.

³ Public Health Act, 1875, ss. 287 *et seq.* ; see also Chapter II.

⁴ Local Government Act, 1888, s. 10.

of administration with which the responsible authorities and officials will be faced.

"The increasing vigilance and intelligence of members [of Parliament] and their constituents, which has increased the difficulty of passing legislative measures through Parliament, has rendered necessary the adoption of various expedients for shortening and simplifying their form, expedients of which the delegation of legislative powers is among the most legitimate."¹

"The tendency of modern legislation is to place in the body of an Act merely a few broad, general rules or statements of principles, and to relegate all details either to schedules or statutory orders."²

Consequently the general provisions of many Acts are supplemented by the delegation of powers, under safeguards,³ to executive authorities, central or local, to frame and issue orders and regulations which amplify the statute law and make it applicable to the facts of social life. The high-water mark of this tendency was reached in the National Insurance Act of 1911 and the absence of any signs of an ebb has given rise to much keen criticism and the assertion that departments of the Central Government are usurping functions of Parliament.⁴

In this way the central departments are frequently enabled to bring pressure to bear upon reluctant authorities, especially when, as in the case of urban and rural districts appointing medical officers of health, sanitary inspectors and health visitors, and of education authorities carrying out medical inspection of school children, they have the power of sanctioning or making "grants in aid." By such orders the provisions of Section 5 of the Infectious Diseases (Notification) Act, 1890 were substituted for those of Section 120 of the Public Health Act, 1875, as applying to ships,⁵ the qualifications, appointment and tenure of

¹ Ilbert *Legislative Methods and Forms*, p. 40.

² *Ibid.* 266.

³ *Regulation Act*, 1893, and special rules in particular Acts, e.g. *Public Health (Regulations as to Food) Act*, 1907, s. 2.

⁴ See *Statistical* discussion at the Conference of the Institute of Public Administration at Cambridge, July, 1927, and comments thereon in *Local Government* press.

⁵ *Port Sanitary Authorities (Assignment of Powers) Order*, 1912.

office of medical officers of health and sanitary inspectors¹ are regulated, and powers were conferred upon rural district councils to make bye-laws in respect to slaughter-houses.² Similar powers are given to the Ministry of Agriculture under the Destructive Insects and Pests Acts, 1877 and 1907 and the Diseases of Animals Acts, 1894-1911, and have been used under the latter to provide for the examination of cattle and compensation for their owners in certain cases when, upon being slaughtered, the animal is found to be suffering from tuberculosis.³ And the Home Secretary is enabled to make orders defining, among other things, the classes of home work to which the provisions of the Factory and Workshops Act, 1901, regarding the conditions under which work is done, apply,⁴ and for requiring the provision of washing accommodation for employees in bakehouses.⁵

In a similar way extended powers are given to local authorities, or their activities are defined, by regulations issued by the central departments of Government. Cases of this class of departmental legislation are the inclusion of tuberculosis as a notifiable disease,⁶ the determination of the objects and records of inspection of dwelling-houses,⁷ the definition of standards of purity for milk and cream⁸ and of rag flock,⁹ for securing the inspection of all animals slaughtered for food¹⁰ and the inspection of imported food.¹¹ These were made by the Ministry of Health and its fore-

¹ Sanitary Officers Order, 1922.

² Rural District Councils (Slaughter Houses) Order, 1924.

³ Tuberculosis Order, 1925.

⁴ Section 107.

⁵ Bakehouse Welfare Order, 1927.

⁶ Tuberculosis Regulations, 1912, made under the Public Health Act, 1875, s. 130.

⁷ Housing (Inspection of Dwellings) Regulations, 1910, consolidated in 1925.

⁸ Public Health (Milk and Cream) Regulations, 1912. Section 7 of the Food and Drugs (Adulteration) Act, 1928, gives the Minister of Agriculture power to make regulations as to constituents of milk, cream, butter or cheese, and to the Ministry of Health to make regulations prohibiting the use of any specified preservatives in the manufacture of butter, margarine or milk-blended butter.

⁹ Rag Flock Act and Regulations, 1912, and Rag Flock Amendment Act, 1928.

¹⁰ Public Health (Meat) Regulations, 1924.

¹¹ Public Health (Imported Food) Regulations, 1925.

runner, the Local Government Board; other regulations prescribing procedure in the making of "closing orders" under the Shops Act, 1912 being made by the Home Secretary.

The distinction between orders and regulations of a department of the Central Government is difficult to determine, and appears to be only verbal—a matter of title—since regulations are prescribed "by this order," and they were included in the list of "orders issued" by the Local Government Board in its annual reports.¹

The sources of a sanitary authority's powers are not, however, exhausted by those already enumerated. In certain cases the authority is empowered, subject to limitations, to define its own powers and prescribe its own requirements by means of bye-laws, regulations and orders which differ rather in the procedure by which they are enacted than in their force. Urban sanitary authorities are invested with more extensive powers for the making of bye-laws than rural authorities, but the latter may usually secure them by applying to the Ministry of Health. By a general Order which came into force at the beginning of 1925 the powers to make bye-laws with respect to slaughter-houses was conferred upon rural district councils, sixty-one of which early took advantage of the power.²

Regulations, unlike bye-laws, do not, unless enforceable by a penalty, require the sanction of the Ministry of Health, and may be made for prescribing the mode of connecting drains and sewers,³ and for removing any person suffering from an infectious disease from a ship to a hospital and keeping him therein,⁴ among other purposes. The consent of the Ministry of Health is required, however, for orders to extend the application of the Infectious Diseases (Notification) Act, 1889 to other diseases,⁵ and the sanction of

¹ See Forty-second Annual Report of the Local Government Board, Part III, p. 218.

² Seventh Annual Report of the Ministry of Health, p. 84.

³ Public Health Act, 1875, s. 21.

⁴ *Ibid.*, s. 125.

⁵ Section 7.

the Home Secretary is required for certain orders made by a local authority under the Shops Act, 1912.¹

The legislation, statutory and derivative, which creates the sanitary authorities and endows them with duties, responsibility and powers is formidable in amount and complex in character. Act after Act is passed, orders and regulations are issued in bewildering profusion,² and still the basis of the whole is an Act passed over half a century ago. A consolidation and codification of sanitary law is urgently needed; at present the public are helplessly ignorant, authorities are bewildered, and lawyers reap their harvest accordingly.

THE CHIEF ORDERS AND REGULATIONS AFFECTING PUBLIC HEALTH ISSUED DURING RECENT YEARS

1921

The Ministry of Health (Factory and Workshops, Transfer of Powers) Order . . . Privy Council

1922

The Ministry of Health (Rats and Mice, Transfer of Powers) Order . . . " "

1923

Canal Boats Order Ministry of Health
 The Milk (Special Designations) Order " "
 Public Health (Condensed Milk) Regulations " "
 Public Health (Dried Milk) Regulations " "

1924

Rural District Councils (Slaughter Houses) Order " "
 Public Health (Meat) Regulations " "

¹ Section 5.

² " He often thought they were getting to the stage when they were more governed by Orders than by Acts of Parliament."—W. G. Kershaw, O.B.E., Chairman of the Sanitary Inspectors Association, *Sanitary Journal*, June, 1927, p. 279.

32 PUBLIC HEALTH ADMINISTRATION.

1925

Tuberculosis Order	Ministry of Agriculture
Public Health (Imported Food) Regulations	Ministry of Health
Public Health (Preservatives, etc., in Food) Regulations	" "
Housing Consolidated Regulations	" "

1926

Sanitary Officers Order	" "
Milk and Dairies Consolidation Act, 1915 (Commencement of Operations), Order	" "
Milk and Dairies Order	" "
Public Health (Preservatives, etc., in Food) Amendment Regulations	" "
Public Health (Notification of Puerperal Fever and Puerperal Pyrexia) Regulations	" "

1927

Public Health (Preservatives, etc., in Food) Amendment Regulations	" "
Public Health (Infectious Diseases) Regulations	" "
Public Health (Condensed Milk) Amendment Regulations	" "
Public Health (Dried Milk) Amendment Regulations	" "

1928

Alkali etc., Works Order	" "
Public Health (Notification of Puerperal Fever and Puerperal Pyrexia) Amendment Regulations	" "
Public Health (Ophthalmia Neonatorum) Amendment Regulations	" "

HEALTH PROBLEMS IN ORGANIZED SOCIETY

STUDIES IN THE SOCIAL ASPECTS OF
PUBLIC HEALTH

BY

Sir ARTHUR NEWSHOLME, K.C.B., M.D.,

*Formerly Chief Medical Officer of the Local Government
Board.*

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CHAPTER IV

LOCAL LEGISLATIVE PROCEDURE

THE ever-increasing volume of public sanitary law endows sanitary authorities with wide powers for dealing with conditions inimical to public health. Some of these powers are given to urban authorities only, others are of general application, but many of both (too many in the opinion of most sanitarians) are permissive—the local authority may or may not exercise them ; it has an option which is a direct incentive to jerry-builders, slum landlords and others with interests opposed to the public weal to obtain control of or influence upon the various councils. These powers, together with those conferred by orders and regulations of the Central Government, are the irreducible minimum of the legislative equipment of sanitary authorities ; they exist without effort on their part.

Sanitary authorities have, however, the right and opportunity of adding to or adapting these powers to suit the varying needs of their localities by means of adoptive and private Acts, provisional orders, bye-laws, regulations and orders. Of these the last three are the most general and imperative forms of local legislation ; adaptability and the little effort required on the part of the authority to secure their powers are their greatest merits. On the other hand, by private Acts and provisional orders extended powers may be obtained ; but procedure is made more cumbersome and expensive, so putting a premium on progress, since it is only those authorities who desire to move with the advance of sanitary science who will thus seek to increase their powers. Adoptive Acts, by leaving sanitary authorities free to accept or decline the powers

given therein, have the advantage of silencing the voices of opponents in and out of Parliament, since no authority need adopt them, although the best will do so. After experience has demonstrated their utility and time has lulled opposition they are frequently made compulsory.

In the exercise of these functions, consciously and voluntarily clothing themselves with increased powers and duties, local authorities act with varying degrees of legislative capacity, ranging from the simple resolution needed to adopt the whole or part of an "adoptive" Act to the difficult and technical task of framing and promoting a private Bill. The part played by the officers of the local authority in this work is an onerous and important one. Upon them devolves the duty of advising their authority as to the need for and direction of such action; they must be prepared to support their advice by facts and figures, and, when it is accepted, they keenly scrutinize, where they do not draft, the provisions to make certain that they fulfil the desired purpose. And from beginning to end they will find their authority bound down to certain forms of procedure, a breach of which may entail administrative difficulties, legal failures and, perhaps, financial loss.

The reason for and the justification of the elaborate procedure and nice precision of method and form of subordinate legislation has been well expressed by an eminent and experienced lawyer and legislator. He states that—

"Englishmen have a deep-seated distrust of official discretion, a deep-seated scepticism about bureaucratic wisdom. The ordinary Englishman, as represented by the average member of Parliament, would find much difficulty in assenting to the proposition of an eminent author that 'the substance, no less than the form of the law would, it is probable, be a good deal improved if the executive Government of England could, like that of France, by means of decrees, ordinances or proclamations having the force of law, work out the detailed application of the general principles embodied in the Acts of the Legislature.' If his liberty of action is to be subjected to restraint, he prefers that the restraint should be imposed by laws which have been made after public discussion in a representative assembly."¹

¹Ilibert, *Legislative Methods and Forms*, p. 39.

Parliament does, as a matter of fact, leave much matter for other authorities to legislate upon, but it defines the subject, prescribes the procedure, and keeps in its own hands the ultimate power of limiting or cancelling such efforts.

The adoptive Acts affecting public health are not numerous, but the procedure to be followed varies in practically every case. The Baths and Washhouses Acts, 1846 to 1896 may be adopted by borough councils,¹ urban district councils² and parish councils,³ the only restriction being the necessity of a two-thirds' majority of the parish meeting or of voters at a parochial poll.⁴ The Infectious Diseases (Prevention) Act, 1890, and the Public Health Acts Amendment Act, 1890, require special notice of the meeting of the authority and intention to apply for an order to be given to each member, but the former requires fourteen days' notice,⁵ whilst the latter specifies one calendar month;⁶ on the other hand, the Public Health Acts Amendment Act, 1907, does not require such notice,⁷ but one month's special notice is required by the Public Health Act of 1925.⁸ The notice must be given in the usual way or otherwise signed by the clerk and forwarded by hand or post to the member's usual or last known place of abode. In each case the resolution of the council must be published by advertisement in newspapers circulating in the district, but the Infectious Diseases (Prevention) Act also requires publication by handbills, whilst the Public Health Acts Amendment Act, 1890, leaves out handbills but specifies that notices must be fixed on the principal doors of every church and chapel in the district. This procedure complied with, application may be made, where required,⁹ to the Ministry of Health for an order directing that the

¹ Municipal Corporations Act, 1882, s. 242.

² Public Health Act, 1875, s. 10.

³ Local Government Act, 1894, s. 7.

⁴ Baths and Washhouses Act, 1846, s. 5.

⁵ Infectious Diseases (Prevention) Act, 1890, s. 3.

⁶ Public Health Acts Amendment Act, 1890, s. 3.

⁷ *Ibid.*, 1907, s. 3.

⁸ Public Health Act, 1925, s. 5 and Schedule.

⁹ Public Health Acts Amendment Act, 1907, s. 3.

Act or parts adopted are in force, but this does not come into effect until a month has elapsed from the publication of the council's resolution, a period reduced to a fortnight by the Public Health Acts Amendment Act, 1907. The Public Health Act, 1925, is interesting as illustrating the variety of ways in which powers may be distributed. Part I is of general application. Parts II, III, IV and V are adoptive except that no adoption is necessary in the cases where Part II confers powers on a county council, whilst Part VI may be extended by Order of the Minister of Health to any area where Part VI of the Public Health Acts Amendment Act of 1907 is in operation.¹ Urban authorities may adopt all or any of Parts II, III, IV or V unless the population is below 20,000, when the adoption of parts of Part II and III or any of Part V requires the consent by Order of the Minister of Health.² Rural authorities may adopt all or any of Parts II, III and IV except such sections in II and III as are reserved in Schedule II, and permission to adopt various provisions applying to urban districts may be obtained by Order of the Ministry of Health, notice of which application must be published in each of two successive weeks.³

“The object of a private Bill is, not to alter the general law of the country, but to alter the law relating to some particular locality or to confer rights on or relieve from liability some particular person or persons.”⁴ Such powers are in excess and extension of the powers given directly or indirectly by public Act—general or adoptive—or which may be obtained by bye-laws, regulations or orders. The possession and exercise of such powers by the larger sanitary authorities is of great value to the whole community. These districts are the laboratories where the efficacy of fresh ideas and proposals is put to the test of experience⁵;

¹ Public Health Act, 1925, s. 2.

² *Ibid.*, s. 3.

³ *Ibid.*, s. 4.

⁴ Ilbert, *Parliament*, p. 85.

⁵ For new proposals during 1926-7, see Eighth Annual Report of the Ministry of Health, pp. 85 *et seq.*

and if successful they are afterwards secured in like way by other authorities or placed at the disposal of all by a public Act.¹ Their origin and utility was clearly stated by a member of the Local Legislative Committee of the House of Commons, who wrote :

" Some councillor, town clerk, borough surveyor or medical officer of health is impressed with the recurrence of a practical difficulty which he meets with in the administrative work of his authority, or with the existence of some danger to the community which he has not sufficient power to control. He evolves an idea for amending the law so as to meet the difficulty or give him the required power. He could not influence Parliament to adopt this idea for the whole country by alteration of the general law, but he can and does persuade the councillors of his own town that the idea is good and ought to be put into operation for that town. Thus it becomes the subject of a clause in the next private Bill the council are promoting, and Parliament is persuaded to allow the new power to be tried within these narrow limits, although a general public Bill for a similar purpose might have no chance of passing. . . . Many important provisions of our general sanitary and local government law have found their origin in a clause tentatively allowed in a private improvement Bill promoted by the corporation of some provincial town." ²

County councils ³ and borough and urban district councils ⁴ are the authorities permitted to indulge in the expensive luxury of promoting private Bills, the purposes of which are largely determined by the recommendations and advice of the chief officers. So extensive has been the advantage taken of such opportunities by some of the larger towns that the resultant confusion has necessitated consolidation, Liverpool, for instance, replacing as many as ninety-six local Acts by a Consolidation Act in 1921.⁵

The procedure is lengthy and complicated. The council,

¹ The Public Health Act, 1925, is a good recent instance.

² Sir C. N. Nicholson, Bart., M.P., in introduction (p. ix) to *Local Legislation, 1900-1911*, by F. Noel Keen.

³ County Councils (Bills in Parliament) Act, 1903.

⁴ Borough Funds Acts, 1872 and 1903.

⁵ See an interesting paper on "Local Legislation," read by I. G. Gibbon, C.B.E., D.Sc., read at the Institute of Public Administration and published in *The Local Government Service*, October and November, 1925.

at a meeting called by ordinary notice and special advertisement ten days beforehand, must pass a resolution, by an absolute majority, affirming the desirability of promoting the Bill. The resolution must be published within seven days of the deposit of the Bill in either House of Parliament, and the approval of the Ministry of Health, who may direct a local inquiry, obtained. The Bill is then deposited in the Private Bill Office in form and manner, at time and with documents and data, as specified by the Standing Orders of the House. Not earlier than fourteen days afterwards a special meeting of the council must confirm, by an absolute majority, the propriety of promotion, and then a public meeting of electors, called by two weekly advertisements not later than twenty-eight days from the date of the deposit of the Bill, may approve or disapprove of the whole or part of it. At this meeting the Bill must be explained by the chairman or by a member or officer of the promoting council, and a single or a series of separate resolutions covering the Bill must be voted upon, the decision being final unless a poll is demanded by the prescribed number of electors or, in case of defeat at the meeting, by the council itself. Upon a written requisition for a poll by 100 or one-twentieth of the electors, whichever is least, the council must authorize a poll, and the defeated parts, or perhaps the whole, are withdrawn by the council upon receiving a report of the result. The town's meeting and poll of the electors is an antiquated and somewhat ridiculous relic of the time when communities were small and councils were not democratically elected authorities; they tend to be exploited by threatened interests or short-sighted economists, and often render nugatory much time and labour of the members and officers of the authorities promoting Bills which are sacrificed, because they contain one or two clauses to which opposition is raised.

As may be seen from the directions issued by the Local Legislative Committee to Parliamentary Agents, the information which must be sent, together with copies of the

Bill, to every department of the Government concerned, as well as to the Clerk of the Parliaments and the Private Bill Office, not later than November 30, is very comprehensive, and includes :

(1) Statistics.

- (a) Population at last two censuses and an estimate of the present population.
- (b) Area.
- (c) Rateable and assessable values for last three years.
- (d) All rates made in district during the last three years, giving rate in the £ in each case.
- (e) Amount produced by 1*d.* rate in the £.
- (f) Full particulars of existing loans ; amounts borrowed, repaid and outstanding ; periods allowed for repayment ; margin of borrowing powers under the Public Health Acts ; and date of authorization and actual borrowing.
- (g) Particulars as to permissive Acts adopted by the local authority, and a statement whether any powers have been sought under the Public Health Acts Amendment Act, 1907, and the Public Health Act, 1925, and, if so, with what result.

(2) In case of a municipal corporation, the last published abstract of accounts.

(3) Staffs of various departments of the local authority, showing—

- (a) Each officer, with his title, duties, salary, and stating whether engaged for whole or part time and whether certificated or not.
- (b) Particulars of any post, paid or unpaid, held by an officer, whether under the local authority or otherwise.

The Committee also desire to be furnished with a " Precedent Bill " showing in red ink the authority (if any) for the particular clauses in the Bill, and they state that

with regard to sanitary clauses the medical officer of health of the authority should always be in attendance and prepared to give information as to the sanitary condition and administration of the district, and should supply a copy of his last annual report.

The proceedings in Parliament have already been described ;¹ it is before the Local Legislation Committee that the great struggle, in cases of opposition, usually takes place. The council's officers, who have advised the insertion of various provisions or recommended application for various powers, and have commented upon and criticized the draft scheme prepared by the parliamentary agents, are now called upon to support by statistics and other data the proposals for which they are responsible, and to provide evidence rebutting the considerations urged against the Bill by the opponents of the measure. When the Bill is passed the powers are added within their sphere of application to those already possessed through public and private legislation, and give encouragement to and a precedent for other local authorities seeking similar advantages. During the year 1925-6 the Ministry of Health reported to Parliament on forty-five private Bills, of which thirty-eight were promoted by local authorities, two by companies, one by commissioners, three by joint boards and one to establish a joint board.²

For reasons already indicated the tendency of private Bill legislation is to decrease in quantity and importance. Provisions obtained by particular authorities are inserted in public Acts and so made available to all; the Public Health Act, 1925, is an excellent instance. But many things can now be obtained expeditiously and cheaply by means of provisional orders. These are orders containing provisions similar to those inserted in a private Bill, made by some department of the Government, the responsible Minister of which afterwards introduces into Parliament a Bill to confirm the order or a group of such orders. They

¹ See Chapter III.

² Seventh Annual Report of the Ministry of Health, p. 80.

are seldom opposed, but if opposition takes place the procedure from the second reading follows that prescribed for a private Bill and entails similar expense during the committee stage.

Provisional orders may be made by the Ministry of Health, without petition from or consent by the sanitary authorities affected, for the devolution of powers, duties, and liabilities of departments of the Central Government upon county councils,¹ and upon the petition of local authorities for, amongst other things, the purpose of the compulsory acquisition of land,² the alteration of powers conferred by previous provisional orders,³ and for the alteration or repeal of local Acts.⁴ During the year 1926-7 the Ministry of Health issued and obtained confirmation of twenty-two Provisional Orders repealing, altering or amending local Acts and dealing with such diverse subjects as markets and ash-bins.⁵

The local procedure is laid down in Sections 297 and 298 of the Public Health Act, 1875, whilst the parliamentary procedure is regulated by the standing orders of both Houses. Public notice of the purport of the provisional order must be given by advertisement in two successive weeks⁶ in the same local paper in September, October or November, following which the petition, accompanied by any necessary maps, plans, documents and statistical and financial data, as well as proof in the required form that the proper procedure has been complied with, is sent to the Ministry of Health, not later than October 31, November 30 or December 18. Duplicates must also be sent to the Clerk of the Parliaments and the Private Bill Office. The Ministry of Health then considers objections and, after holding a local inquiry, will, if satisfied of the desirability of granting the powers asked for, make the Order

¹ Local Government Act, 1888, s. 10.

² Public Health Act, 1875, s. 176. Isolation Hospitals Act, 1893, s. 11.

³ Public Health Act, 1875, s. 297.

⁴ *Ibid.*, s. 303; *Ibid.*, 1925, s. 6.

⁵ Eighth Annual Report, p. 88.

⁶ Three successive weeks under Section 170 of the Public Health Act, 1875, dealing with compulsory purchase of land.

and submit it to Parliament for the confirmation, without which it has no validity. Petitions may be made against such an Order within seven days after the second reading of the confirmation Bill in either House, in which case the Order is treated as an opposed private Bill and goes to the Local Legislative Committee for consideration. It is important that private Bills and petitions should be deposited before Parliament meets or early in the Session, since both Houses refuse to consider such Bills after dates specified by annual resolutions of the House of Lords and by the Standing Orders of the House of Commons.

CHAPTER V

SUBORDINATE LEGISLATION

IN the making of bye-laws—laws for the regulation of a "by" or township—a local authority is functioning in a purely legislative although subordinate capacity. A bye-law has been defined as "an ordinance affecting the public or some portion of the public, imposed by some authority clothed with statutory powers, ordering something to be done or not to be done, and accompanied by some sanction or penalty for its non-observance,"¹ or as "a local law made with due legal obligation by some authority less than the Sovereign and Parliament in respect of a matter specially referred to that authority." The main point about bye-laws, as of all subordinate legislation, is that they must be within the powers conferred upon the local authority, and consequently the powers are to be found in the general public law of the land; any bye-law made outside these powers would be held by the courts to be *ultra vires*. A bye-law may also be invalid for other reasons, as a long series of judicial decisions shows; and its confirmation or acceptance by the prescribed authority does not render valid a bye-law which by its nature is invalid. It is therefore important that the conditions to which bye-laws must conform should be kept steadily in mind when drafting them, since omission to do so may, at the best, result in disallowance and delay, and, at the worst, involve the local authority in the vexation and expense of a series of judicial defeats. In general the conditions are: (1) they must be reasonable; (2) they must be certain in their terms, plainly and definitely commanding or forbidding;

¹ Lord Russell, C.J., in *Krusa v. JOHNSON*, [1898], 2 Q.B. 91.

(3) they must be general and not particular in their application ; (4) they must not be repugnant to the general law ; and (5) they must not be in restraint of trade—e.g. they may be regulative, but not prohibitive. With these reservations, bye-laws, if validly made, have the same force within the sphere of their legitimate operation as an Act of Parliament, and a local authority is not, as a rule, permitted to dispense with their provisions, since they “are not for the authority’s benefit, but for that of the general public.”¹

The powers to make bye-laws are, as a rule, optional, those for common lodging-houses² being one of the exceptions ; in a recent Act power has been given to the Minister of Health to make bye-laws respecting houses divided into separate tenements if in his opinion such bye-laws are necessary, and either have not been made or are insufficient.³ This legislative power is in cases restricted to urban authorities, but may, with good cause shown, be extended by the Ministry of Health to rural districts, such extension being made general in the case of slaughter-houses by the Rural District Council (Slaughter Houses) Order of 1924. As will be seen from the appended list (p. 49) these powers are scattered about the Public Health and other Acts, but borough councils⁴ and county councils⁵ are empowered to make bye-laws for the prevention and suppression of nuisances not otherwise punishable in a summary manner under any Act in force.

The procedure for the making of bye-laws under the Public Health Acts is laid down in the Act of 1875,⁶ and this also applies to those made by borough and county councils for the prevention and suppression of nuisances. Notice of

¹ It is contrary to the practice of the Local Government Board to give local authorities a dispensing or discretionary power. *Vide* note, p. 443, Lumley’s *Public Health Acts*, 7th edition. See, however, Sections 99 and 101, Housing Act, 1925.

² Public Health Act, 1875, s. 80.

³ Housing Act, 1925, s. 6.

⁴ Municipal Corporations Act, 1882, s. 23.

⁵ Local Government Act, 1888, s. 16.

⁶ Section 184.

the intention to apply for confirmation of the bye-laws must be given in a local newspaper at least one month before the application, during which time a copy of the proposed bye-laws must be kept at the office of the authority available for inspection by the ratepayers, who must be supplied with copies if willing to pay for them. The bye-laws must be made under the common seal of the local authority, and before coming into force must be submitted to and confirmed by the Ministry of Health, who must be satisfied that the prescribed procedure has been complied with. For the purposes of evidence it is important to note that a written or printed copy of the bye-laws under the corporate seal of a borough council or signed and certified by the clerk of other authorities is evidence of the making, confirmation and existence of such bye-laws until the contrary is proved.¹ As a rule, local authorities when drafting bye-laws follow very closely the lines laid down in the series of model bye-laws which the Ministry of Health has drawn up and issued for their guidance. One of the most discussed model bye-laws is that requiring the use in slaughter-houses of a mechanical instrument for stunning animals, and only twenty-three out of sixty-one rural district councils, taking advantage during the year 1925-6 of their new power to make bye-laws for slaughter-houses, adopted this much disputed clause.²

A minor legislative function of sanitary authorities is the making of regulations which are expressly exempted from the procedure applying to bye-laws.³ In general they do not require the approval of the Ministry of Health, but if enforceable by a penalty such approval is necessary.⁴ The chief purposes affecting public health for which regulations may be made are for prescribing the mode in which connections between drains and sewers are to be made,⁵ for

¹ Public Health Act, 1875, s. 186.

² Seventh Annual Report of the Ministry of Health, p. 84. The total number of districts which had adopted this bye-law was 196.

³ Public Health Act, 1875, s. 188.

⁴ *Ibid.*, s. 125 is a special exception to this rule.

⁵ *Ibid.*, s. 21.

removing to and keeping in a hospital persons found suffering from a dangerous infectious disorder on board a ship,¹ for the management of mortuaries provided by the local authority,² with respect to the duties and conduct of its officers and servants,³ and for prescribing the conditions under which cellar dwellings of a certain class may be occupied.⁴

In connection with the regulation of retail trade a subordinate legislative function—the making of orders, of which comparatively little use had been made—was greatly extended by the Shops Act of 1912, which is administered by the councils of counties, boroughs and urban districts with a population exceeding 20,000. The law allows great diversity of action to shopkeepers in respect of closing, but with the consent of prescribed majorities of the retailers concerned the local authority may make orders fixing definite days and time which are applicable to all in the particular trade and area dealt with. The orders are of two kinds: for fixing the weekly half-holiday required, with certain exceptions, for all shops, or for exempting shops of a particular class from the statutory requirement of a weekly half-holiday,⁵ and secondly, for fixing a weekly half-holiday for the exempted trades or fixing the hours of closing for any class of shops upon days other than the weekly half-holiday.⁶ The procedure differs. In the first case the local authority must prepare a register of the shops of the class to be dealt with and notify their intention to make an order by advertisement (twice) or by posting notices in the district. A vote, by voting papers delivered to and collected from the occupiers concerned, is taken, or, if they have made a written application, the signatures must be verified, and if there is a majority in favour of the proposed day, the order fixing that day is made by the local authority, and all to whom it applies are bound by it. Before making an order for the weekly half-holiday for

¹ Public Health Act, 1875, s. 125.

² *Ibid.*, s. 143.

³ *Ibid.*, s. 189.

⁴ Housing Act, 1925, s. 18.

⁵ Shops Act, 1912, s. 4.

⁶ *Ibid.*, s. 5.

the exempted trades,¹ or for fixing the hours of closing on days other than the half-holiday ("closing order"), the local authority must be satisfied that there is a *prima facie* case for making such an order, a petition from the shopkeepers concerned being the usual form of satisfaction. The local authority must then prepare a register of the occupiers and advertise their intention to make an order by two notices, in a local newspaper, and by notices posted up in the streets, and information must be given to rate-payers applying for it. After a lapse of four weeks, during which objections may be received, a vote is taken or the signatures to the petition are verified, when, if there is a two-thirds' majority of the affected shopkeepers in favour, the council may proceed to make the order. This order, however, requires the sanction of the Home Secretary, to whom it must be submitted with proof that the prescribed procedure has been followed. Before sanctioning the order he may and will, if strongly petitioned against it, appoint a commissioner to hold a public inquiry, of which three weeks' notice must be given. At the inquiry persons affected may appear themselves or by counsel or agent. If confirmed by the Home Secretary, the order has the effect of an Act of Parliament, but it must be laid before each House of Parliament for forty days, and may be annulled by His Majesty in Council on an address for that purpose from either House.* Orders and closing orders may be revoked or amended in a way similar to that in which they are made.

The Shops Acts have thrown very onerous duties upon the health departments of the local authorities concerned. The mixture of trades in many shops and the variety of half-holiday days and closing times has created more administrative difficulty and public dissatisfaction than any other recent regulative Act. The ideal, from an administrative point of view, is to have one general early closing day and general closing times for the sale of all commodities. The former is not possible owing to the

¹ See Schedule II of the Act.

* Shops Act, 1912, s. 6.

alternative offered to the shopkeepers of choosing Saturday for closing; and from the point of view of small shopkeepers, who are frequently women, the general early-closing day has the disadvantage of preventing them doing their own shopping on the only day convenient for the purpose. The alternative of Saturday early closing is, naturally enough, little favoured outside the Jewish community, for whose benefit it was inserted; and small shopkeepers in poor districts complain, with some reason, that whilst Sunday trading is not stopped, they who are most affected are not given the alternative of closing on that day.

Orders for the closing and demolition of dwelling-houses that are unfit for human habitation may be made by sanitary authorities,¹ but these are judicial rather than legislative acts, and as such are dealt with elsewhere.² Sanitary authorities may extend the provisions of the Infectious Disease (Notification) Act 1889, to any disease not enumerated therein, by an order made at a meeting of which special notice has been given. The order requires the sanction of the Ministry of Health, and may be either temporary or permanent, but it does not come into force until at least a week has elapsed from the publication of the first advertisement notifying the making of such order.³ Similar powers are conferred by the Public Health Acts Amendment Act, 1907,⁴ in reference to offensive trades. Where this section has been adopted the sanitary authority may make an order, subject to confirmation by the Ministry of Health, declaring any trade, business, or manufacture, not designated as an offensive trade in Section 112 of the Act of 1875, to be an offensive trade subject to the provisions of that and the succeeding section as regards its establishment and regulation by bye-laws.⁵ In this way such trades as glue-making, dealing in rags and bones, fish-frying and parchment-making have been brought within the sphere of regulation.

¹ Housing Act, 1925, ss. 11, 14, 18 and 19.

² See Chapter XX.

³ Infectious Disease (Notification) Act, 1889, s. 7.

⁴ Section 51. ⁵ See Public Health Act, 1925, s. 44.

BYE-LAWS

- Cleansing of footways, &c. ; removal of house refuse ; cleansing of earth closets, privies, ashpits and cess-pools belonging to any premises (Urban and Rural). Public Health Act, 1875, s. 44.
- Prevention of nuisances arising from snow, filth, &c. ; improper keeping of animals (Urban and Rural). *Ibid.*
- Common Lodging Houses (Urban and Rural). *Ibid.*, s. 80.
- Houses let in lodgings (Urban and Rural). *Ibid.*, s. 90 ; amended by Housing Act, 1925, s. 6.
- Offensive trades (Urban). Public Health Act, 1875, s. 113 ; amended by Public Health Acts Amendment Act, 1907, s. 51, and Public Health Act, 1925, s. 44.
- Public Mortuaries (Urban and Rural). Public Health Act, 1875, s. 141.
- New streets and buildings (Urban). Public Health Act, 1875, s. 157, and Public Health Acts Amendment Act, 1890, s. 23.
- Slaughter-houses (Urban and Rural). Public Health Act, 1875, s. 169, and Rural District Council (Slaughter Houses) Order, 1924.
- Hop-pickers (Urban and Rural). Public Health Act, 1875, s. 314.
- Fruit-pickers (Urban and Rural). Fruit Pickers Act, 1882.
- Removal of offensive or fæcal matter or liquid through streets (Urban). Public Health Acts Amendment Act, 1890, s. 26.
- Tents, vans, sheds, or similar structures used for human habitation (Urban and Rural). Housing of the Working Classes Act, 1885, s. 9 (2).
- Requiring provision in new buildings other than private dwelling-houses of such arrangements for heating or cooking as are calculated to prevent or reduce the emission of smoke (Urban). Public Health (Smoke Abatement) Act, 1926, s. 5.

• Model bye-laws made.

REGULATIONS

- Removal to hospital of infected persons brought by ships (consent of Ministry of Health necessary) (Urban and Rural). Public Health Act, 1875, s. 125; as amended by Public Health Act, 1904, s. 1.
- Places for *post-mortem* examinations (Urban and Rural). Public Health Act, 1875, s. 143.
- Rooms habitually used as a sleeping place three feet below surface of street, &c. (Urban and Rural). Housing Act, 1925, s. 18.

CHAPTER VI

ADMINISTRATIVE ORGANIZATION

WE have seen that for the purposes of the administration of public health law England is mapped out into a number of districts the councils of which are endowed with various powers and functions and given the opportunity, where it is desired, to increase such powers and functions in certain directions by complying with a prescribed procedure. The result has been the creation of a system that an American observer has likened to

“ a large number of concentric circles ; the outermost, having the biggest powers, being the urban districts with all the functions of the Public Health Acts, adoptive Acts and kindred others ; the innermost being the rural districts of the most limited competence. Between the two are numberless other districts having various powers and functions, and hardly any two coincide.”¹

It is now necessary to inquire by what mechanism, administrative and executive, these authorities work. It is an established axiom of public administration that whilst it is possible and sometimes desirable to have large bodies to deliberate upon and decide matters of general principle, the practical application of principles to the details of administrative work is best left to smaller and more select bodies of men.² This is the basis of the committee system ; and Parliament, in framing the constitutions of local authorities and clothing them with their varied powers, has also empowered and, in certain cases, required them to appoint committees for the purposes of their work.

¹ Maltbie, *English Local Government of To-day*, pp. 88-9.

² Compare J. S. Mill, *Representative Government*, Chaps. V, XIV and XV.

For the purposes of the Public Health Act, 1875, every urban authority was empowered to appoint committees out of its own number where such authority was of opinion that any matter would be better regulated and managed by means of a committee; but such committees were prohibited from borrowing money, making rates or entering into any contract, and were subject to any regulations or restrictions made by the local authority.¹ This power, except as applied to municipal boroughs, was repealed by the Local Government Act of 1894,² which empowered urban (except borough), rural, and parish councils to appoint committees, wholly or partly of members of the council, and to delegate any powers to them, subject to the condition that the acts of the committee are to be submitted to the council for approval. The council may, however, authorize committees appointed for the purposes of the Public Health or Highway Acts; to institute proceedings or do any act which the council might have instituted or done except raising a loan, making a rate, or entering into a contract.³

The power given by this section to properly constituted committees to institute legal proceedings is an important one in public health administration, especially where long intervals elapse between meetings of the council. It is much easier to get a committee together should occasion arise than to await the regular council meeting, and consequently the abatement of nuisances and the carrying out of urgent works is secured more expeditiously than would otherwise be the case, since the initiative of officials is severely limited.⁴ In view of the requirement of the Municipal Corporations Act of 1882 that the acts of committees appointed by a borough council shall be submitted to the council for approval,⁵ it appears to be doubtful whether such approval is required for the acts of such a committee appointed for the purposes of the Public Health

¹ Public Health Act, 1875, s. 200.

² Schedule II.

³ Local Government Act, 1894, s. 26.

⁴ See Chap. XIV.

⁵ Section 22.

Act, 1875, but eminent authorities think that "probably it is not necessary."¹

The utility of such a power where dispatch of business is desirable has been recognized by some towns which have obtained the power, by private Acts, to absolutely delegate specified matters to committees. And Parliament, apparently unable to follow Bentham's dictum, "always do the same thing in the same way, that way being the best," or unable to determine which is the best way, has empowered local authorities to appoint committees for the purposes of the Housing Act, 1925, and to delegate to them any of their powers under the Act, no confirmation being required unless the local authority impose such a condition.² Similar powers are given to county councils by the Local Government Act, 1888,³ and to local authorities (county and county borough councils) by the Midwives Act, 1902.⁴ In the latter case the committee may be wholly or partly members of the authority—women being eligible—unless the authority is a county council, in which case it may, as an alternative, delegate its powers to the district councils, who may redelegate them to the committees, wholly or partly, of members of the council.

For the purpose of securing efficient administration in rural districts, which frequently consist of small centres of population scattered over large areas, the Public Health Act, 1875,⁵ empowered rural authorities to form parochial committees, wholly or partly, of members of the authority, with powers, subject to any regulations or restrictions imposed, to act as agents of the council. The non-members of the rural authority must now be members of the parish council of the parish for which the committee is appointed.⁶ The functions of such a committee are mainly supervisory, the opinion of the Local Government Board being that

¹ Lumley's *Public Health Acts* (7th ed.), note on p. 473.

² Section 111. The powers of borrowing or levying a rate are expressly excepted.

³ Sections 28 and 81.

⁴ Sections 8 and 9. Cp. Milk and Dairies (Consolidation) Act, 1915, s. 15.

⁵ Section 202.

⁶ Local Government Act, 1894, s. 15.

among the powers which may properly be delegated to such committees are :

“(1) The inspection of the parish to ascertain whether any works of construction are necessary or any nuisances exist which should be abated ; (2) to superintend the execution and maintenance of any works required or provided for the use of the parish ; (3) to consider complaints of any nuisances and the action of the medical officer of health or inspector of nuisances (now sanitary inspectors) thereon, and to inform these officers of any nuisances requiring their attention, and to give such directions for the abatement of the same in cases of urgency as the circumstances may seem to require ; (4) to report to the sanitary authority the several matters requiring their attention and the manner in which their officers and servants have discharged their duties.”¹

The Housing and Town Planning Act, 1909, which introduced innovations in several directions, had the distinction of creating the first statutory public health and housing committees, which, however, are only required of county councils. The section (71) is worth quoting *in extenso* :

“Every county council shall establish a public health and housing committee, and all matters relating to the exercise and performance by the council of their powers and duties as respects public health and housing of the working classes (except the power of raising a rate or borrowing money) shall stand referred to such committee, and the council, before exercising any such powers shall, unless in their opinion the matter is urgent, receive and consider the report of the public health and housing committee with respect to the matter in question, and the council may delegate to the public health and housing committee, with or without restrictions or conditions as they think fit, any of their powers as respects public health and housing of the working classes except the power of raising a rate or borrowing money, and except any power of resolving that the powers of a district council in default should be transferred to the council.”

It will be seen that every county council must establish a public health and housing committee, that, unless urgent, matters affecting public health must be referred to the committee, and that, with certain limitations, all powers

¹ Second Report of the Local Government Board, p. xlii.

of the county council under the Public Health and Housing Acts may be delegated to it without restrictions or conditions. The large areas of the counties and the infrequency of the meetings of the councils make such a provision essential if the large powers possessed by the councils of supervision over the district sanitary authorities are to be made effective. The same circumstances justified the compulsory character of the Isolation Hospitals Act, 1893, which requires the county council to constitute a hospital committee with wide powers, corporate capacity, perpetual succession and a common seal, for the management and maintenance of a district hospital provided under the Act.¹ If the county council make no contribution to the funds of the hospital so established, the committee must consist, unless the constituent local authorities otherwise desire, wholly of representatives of the local area or areas comprising the hospital district, but if the county council do contribute, they may constitute the committee either wholly of members of the county council, or partly of such members and partly of local representatives, or wholly of such local representatives.²

The compulsory inclusion of women upon a committee was introduced into public health administration by the Notification of Births Act, 1915,³ the necessary corollary being provided by the power to appoint non-members of the council. The Maternity and Child Welfare Act of 1918⁴ definitely requires that all councils exercising powers under that Act or the Notification of Births Act shall appoint a committee to which all matters under that Act are referred and which may exercise all the local authorities' powers except raising a rate. Not less than two-thirds must be members of the council and two must be women.

Another statutory committee must be established by the councils of all counties and of boroughs with a population in excess of 10,000 to administer the provisions of the Diseases of Animals Acts.⁵ It may be composed wholly

¹ Section 10. ² See Chap. XVII. ³ Section 2. ⁴ Section 2.
⁵ Diseases of Animals Act, 1894, s. 31, and Schedule IV.

of members of the local authority or partly of such members, and partly of rated occupiers of the district having the qualification fixed by the council. It may be designated an executive committee with all the powers of the local authority, except making a rate, and may delegate to a sub-committee or sub-committees all or any of such powers. The Ministry of Agriculture may, however, when making orders authorizing local authorities to make regulations, specify that such powers shall be exercised only by the local authority or their executive committee, in which case they cannot be delegated. Generally, the powers under this Act are delegated to the sanitary committee and by it to a sub-committee.

The powers to constitute committees have been exercised by all urban and many rural authorities. They vary in size, and are termed "health," "sanitary," or "public health" committees. As a rule they are constituted committees for the purposes of the Housing, Midwives, and Diseases of Animals Acts, as well as occasionally under the Small Holdings and Allotments Act, 1908, sub-committees acting in the latter capacity; at Blackburn the committee is entitled, the Health and Maternity and Child Welfare Committee; at Derby the Health Committee has a sub-committee for Maternity and Child Welfare, whereas at Leyton two separate committees are formed.

The duties and powers of these committees are not always formulated, and no fixed rule appears to determine them, except that they deal with all matters coming under the control or jurisdiction of the medical officer of health and the sanitary inspector—the statutory health officers. Beyond this region of activity their powers may be circumscribed by the resolution or standing orders of the parent council, or they may develop, by the growth of precedents, an elastic method facilitated by a standing order which charges the town clerk or clerk, under the direction of the mayor or chairman, to assign to the committees the various matters of business from time to time arising, including all correspondence addressed to the council.

When specially formulated the reference of business may be more or less on the lines of the resolution of the Huddersfield County Borough Council, which defined the duties and powers of the Health Committee to be :

“ To execute and perform in the name and on behalf of the council, but subject to the standing orders of the council and to confirmation by the council, all the powers and duties of the corporation in relation to the following :

Infectious and epidemic diseases.

Hospitals for infectious diseases.

Common lodging-houses.

Cleansing of infected houses.

Prevention of pollution of rivers and streams.

Health statistics and sickness and mortality returns.

Superintendence of the department of the medical officer of health.

All the powers and duties imposed upon the council by the Midwives Act, 1902.

Removal and disposal of nightsoil and refuse.

Public urinals and conveniences.

Nuisances.

Offensive trades.

Control of drains, privies, ashpits and cesspools.

Buildings and rooms unfit for habitation.

Polluted wells.

Adulteration of food and drugs.

Unwholesome food.

Cowsheds, dairies and milkshops.

Canal boats.

Factories and workshops.

Small holdings and allotments (pursuant to the Small Holdings and Allotments Act, 1908).”¹

The committees elect their own chairman, arrange their own time of meeting, special meetings being convened by the chairman, and are attended by the various officials as the business requires, a special clerk being usually deputed to record attendances, take minutes, and act generally under the supervision of the clerk of the council. No generalization can be made as to the composition of health

¹ Annual Report of the Medical Officer of Health for Huddersfield, 1904, p. 4.

committees, unless it is that builders and property owners are almost invariably well represented. Perhaps it is because of the great diversity of the matters dealt with or the absence of business of which a public show and parade can be made, that few public men appear to take a deep and prolonged interest in and study of public health administration. Finance appeals strongly to some minds, and the great trading committees attract the attention of efficient business men, but the work of public health administration is essentially a complexity of details with which, as a rule, the officials alone are competent to deal. It remains true, however, that "no progress at all can be made towards obtaining a skilled democracy, unless the democracy are willing that the work which requires skill should be done by those who possess it. A democracy has enough to do in providing itself with an amount of mental competency sufficient for its own proper work, that of superintendence and check."¹ On the whole the public health committees, of the most important areas at least, fulfil this function adequately and with a large degree of efficiency.

¹ J. S. Mill, *Representative Government* (Everyman's Library Edition), p. 248.

CHAPTER VII

THE LOCAL EXECUTIVE

MANY years ago J. S. Mill laid stress upon the fact that "there is a radical distinction between controlling the business of Government and actually doing it";¹ this is very evident when one views the actual working of public health administration. It is then realized that "behind the council and its committees, little seen by the public, but carrying the main burden of the public work, stand the permanent officials."² And it is possible to go rather farther and say that the better and more trustworthy the officials are the lighter is the control exercised over their actions, and the more it is tempered by the advice of those over whom it is exercised. The opinion of those who are doing or will have to do anything determined upon by the local authority must necessarily have great weight, especially in public health administration, where every duty and function is prescribed or limited by law.

Of course the number and importance of the officials varies considerably, but even in the smallest and least populous districts the medical officer of health and the sanitary inspector are to be found. As the districts increase in size and population the sanitary executive develops from these two officers as centres until the numerous, highly trained and specialized staffs of the modern health departments of the great county boroughs are reached.

It is compulsory upon every urban and rural sanitary authority to appoint a medical officer of health and a

¹ J. S. Mill, *Representative Government* (Everyman's Edition), p. 229.

² Lowell, *Government of England*, Vol. II, p. 170.

sanitary inspector ; but whilst urban authorities were, until 1921,¹ limited to one of each class of officer, with or without assistants, a rural authority might appoint as many as they deemed desirable.² Since the passing of the Housing and Town Planning Act of 1909,³ it is similarly incumbent upon county councils to appoint medical officers of health, and many of them have also appointed sanitary inspectors. Another official, whose duties are complementary to some of those of the medical officer of health and the sanitary inspector, is the public analyst, who must be appointed by all county councils and by the councils of boroughs containing a population of over 10,000.⁴ These three officials comprise the irreducible minimum of the public health executive of a town with a population of over 10,000 ; less populous towns and rural districts may not appoint public analysts, and county councils need not appoint sanitary inspectors. But the growth of public health and kindred legislation and the great increase of duties of various kinds thrust upon local authorities has led, in all great centres of population, to a considerable increase in numbers and kind of the official staff.

Since the Public Health Act of 1875 a number of statutes or orders of departments of the Central Government have required or authorized the specified local authorities to appoint or designate officers for their enforcement. Samples must be procured under the Sale of Food and Drugs Acts, canal boats must be registered and inspected, the provisions of the Shops Acts and of the Diseases of Animals Acts must be enforced, officers must be designated to act under the Housing Act, and as assistants to the medical officer of health under the regulations of the Ministry of Health made as provided in the Public Health (Regulations as to Food) Act, 1907,⁵ whilst the Tuberculosis Order of 1912 permitted the appointment of a Tuberculosis Officer.⁶

¹ Public Health (Officers) Act, 1921, and The Sanitary Officers Order, 1926.

² Public Health Act, 1875, ss. 189 and 190.

³ Section 68.

⁴ Food and Drugs (Adulteration) Act, 1928, s. 15

⁵ Public Health (Imported Food) Regulations, 1925, article 20.

⁶ Article 13.

This growth of executive duties has had a twofold effect : in the smaller districts it has concentrated a complexity of functions upon one or two officials, whilst in the county boroughs it has led to the development of a large staff of specialized officials detailed for comparatively simple, if important, duties and relieved of much work of a clerical character by a staff of clerks.

An idea of the character and extent of this specialization may be obtained by comparing the public health staffs of an urban district like Walthamstow (population, 125,500), or a borough like Leyton (population, 130,000), with those of a county borough like Liverpool (population, 849,593). At Walthamstow one medical officer, an assistant medical officer, six sanitary inspectors, four health visitors and eight clerks suffice for the health services of the district.¹ Leyton employs a medical officer with a deputy and five part-time medical men, eight sanitary inspectors (one being a woman) and five health visitors with an unspecified number of clerks ;² whilst at Liverpool, in addition to a large and varied staff of medical officers, there are chief and deputy chief sanitary inspectors, ten prosecuting sanitary inspectors, thirty-four district sanitary inspectors, nine food inspectors, four food and drugs inspectors (one woman), two inspectors of cowsheds and milkshops, three Shops Acts inspectors (one woman), four factory and workshops inspectors, three smoke inspectors, sixteen inspectors of common lodging and tenement houses, one inspector of canal boats, eleven rat catchers, fourteen ambulance and disinfecting inspectors, twenty disinfectors, three notice servers, eighty-nine health visitors and school nurses (fourteen temporary), two inspectors under the Midwives Act, two Ophthalmia Neonatorum nurses, and fifty-five clerks.³ To these staffs must be added an army of officials and employees at hospitals, sanatoria, dispensaries and clinics, the names of the chief officers and the distribution of duties being frequently

¹ Annual Report of the Medical Officer of Health, Walthamstow, 1926.

² Annual Report of the Medical Officer of Health, Leyton, 1926.

³ Annual Report of the Medical Officer of Health, Liverpool, 1926.

prefixed to the annual reports of the medical officers of health.

The decision as to the duties, qualifications, and appointment of these officers is usually left in the hands of the health committees, subject to the sanction and sometimes, in the case of the higher officials, to the final choice of the council. But in the case of the county district authorities desiring to receive the payment of a moiety of the salaries of their medical officers of health and sanitary inspectors from the Exchequer Contribution Fund, the sanction of the Ministry of Health to the appointment must be obtained. The conditions which must be complied with in order to obtain this sanction are specified in the Sanitary Officers Order, 1926. Vacancies must be advertised at least seven days before the council proceed to make the appointment by a majority of those voting at a meeting of not less than three members. The appointment is without limit of time,¹ and the proposal must be notified to the Ministry of Health, together with particulars as to the area and population of the district, salary, time (whole or part) devoted to duties, and other public offices held or private profession or business followed. The consent of the Ministry is not obtained as a mere matter of routine; proposals to make appointments are carefully considered and occasionally rejected, usually on the grounds of insufficient qualifications of the proposed official or that the appointment is against public policy. Upon the latter point the Local Government Board expressed its views strongly in a circular issued to local authorities,² in which it stated its agreement with the view of the Royal Commission on the Poor Laws that "a local authority should not be allowed to appoint an ex-member as a paid officer unless he or she has ceased to be a member of the local authority for a period of, say, twelve months before appointment," and intimated "that in future, unless very special grounds are shown, they will not be prepared to sanction the appointment to any office, in respect of which their sanction may be

¹ Public Health (Officers) Act, 1921.

² May 5, 1917.

requested, of any person who is or has been within twelve months a member of the council making the appointment." This opinion was acted upon in the case of a proposal for the appointment of a surveyor and sanitary inspector by the Dartmouth Borough Council which the Local Government Board refused to sanction.¹

The power of withholding its consent to appointments is by no means allowed to fall into abeyance by the Ministry of Health, the reasons for refusal generally falling under one of the following heads :

- (1) Inadequate salary.
- (2) Unsatisfactory officer.
- (3) Appointment of candidates without special qualifications in preference to others who possessed such qualifications.
- (4) Insufficient time devoted to duties.²

During the year 1925-6, 254 new appointments of sanitary inspectors were made in districts other than county boroughs, of which 244 were approved, in one case the qualifications prescribed by the Sanitary Officers Order of 1926 were waived.³

No generalization can be made as to salaries paid to health officers, who may in addition receive allowances for service outside the scope of their ordinary duties. Inference is complicated by the fact that whilst some salaries have varying additions by way of bonus to meet the post-war increased cost of living, others are on a consolidated basis. But there can be no questioning the fact that they have improved of late years and that they tend to be lower in

¹ *Municipal Journal* for May 9, 1913, p. 596. Compare the report on the sanitary circumstances of the borough of Dartmouth by Dr. Mivart, of the Local Government Board, in which he states that " the inspector of nuisances is a retired builder, with no previous experience of the work and no sanitary certificate ; he resigned from the council in order to apply for the post, and was appointed in preference to 108 other applicants, some of whom are said to have possessed certificates and to have had previous experience." Cp. a report of proceedings at a meeting of the Redruth Rural District Council reprinted in the *Sanitary Journal*, January, 1928, from *The West Briton*, of December 15, 1927.

² Forty-second Report of the Local Government Board, Part III, p. xli ; see also Seventh Annual Report of the Ministry of Health, pp. 43 and 174.

³ Seventh Annual Report of the Ministry of Health, pp. 43 and 174.

the industrial districts of the North than in the southern towns, the officers in the metropolitan boroughs being the best paid. During the year 1925-6, as a result of conferences between the Ministry of Health, the British Medical Association, the Society of Medical Officers of Health and others, certain scales of salaries were recommended for whole-time medical officers of health, and local authorities almost universally adopted them in making new appointments during the year.¹ Attempts have been made to establish an agreed scale of salaries for sanitary inspectors but without much success except in the metropolitan area.²

The offer of half the salaries of the medical officer of health and sanitary inspector on condition of the approval of the Ministry of Health to their appointment and dismissal has not tempted those authorities which prefer to keep a free hand in dealing with their officers,³ but there

¹ Seventh Annual Report of the Ministry of Health, p. 43.

² The Sanitary Inspectors Association, which has been instrumental in raising the status and improving the salaries of its members, puts forward the following scale of salaries:—

	Minimum Basic Salary.	Bonus as per Civil Service Scale at September 1, 1927.	Total.
	£	£ s. d.	£ s. d.
<i>Assistant Sanitary Inspectors—Commencing Salary</i>	180	92 10 6	272 10 6
<i>Rising by £15 per annum to maximum of</i>	240	108 14 6	348 14 6
<i>Sanitary Inspectors—Commencing Salary</i>	260	113 10 6	373 10 6
<i>Rising by £25 per annum to maximum of</i>	325	129 5 6	454 5 6
<i>Chief Inspectors—Minimum</i>	350	135 7 6	485 7 6

(1) Back service to count in all Scales.

(2) Travelling Expenses and Sustenance Allowance on the Treasury Scale.

(3) Office Accommodation and Stationery to be provided by or at the cost of the local authority.

(4) All figures to be considered as Minima.

(5) Part-time appointments to be paid pro rata.

³ See Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 178.

is not much evidence that this freedom is generally abused or that such officers are always inefficient or inactive. On the other hand, the contribution has the valuable effect of stimulating authorities who would otherwise be indifferent to appointing well-qualified men. Practice varies considerably: Walthamstow receives contributions towards the salaries of medical officers and sanitary inspectors;¹ Derby receives contributions in the case of medical officers, but not towards the salaries of sanitary inspectors;² whilst Blackburn receives no contributions.³

Security of tenure in their office during good behaviour is a condition of service only partly realized by public health officers, yet it is they, more, perhaps, than any other class of officials, who should be protected in the performance of their duties from the attacks of those whom their activity may have offended. The Ministry of Health has never succeeded in getting the same measure of control over the dismissal of the medical officer of health and the sanitary inspector that it possesses in the case of Poor Law officials, and its chiefs have not always been desirous of securing for them that security of tenure in their offices which all sanitarians recognize is a *sine qua non* for energetic and efficient service.⁴ Except in the cases of county and metropolitan medical officers of health, and of officers appointed to hold office without limit of time with the approval of the Ministry of Health, no sanction of the Ministry to dismissal is required. The later orders are more favourable to the officers than those previously in force, inasmuch as appointments were formerly only sanctioned for periods of one or two years, at the end of which a new resolution was required, thus opening up a debate giving opportunity for malice and spite to vent itself. Now, under certain conditions and for certain officers the appointment is permanent and terminable only with the consent of the Ministry

¹ Annual Report of the Medical Officer of Health, Walthamstow, 1926.

² Annual Report of the Medical Officer of Health, Derby, 1926.

³ Annual Report of the Medical Officer of Health, Blackburn, 1926.

⁴ This applies to the old Local Government Board rather than to its successor, the Ministry of Health.

of Health.¹ This brought these officials into line with the county medical officer of health, the appointment of whom for a limited period was prohibited by the Housing and Town Planning Act of 1909.² This is the position every health officer ought to be in, and no reason but political expediency can be seen for giving certain officials security of tenure whilst their fellow officers, it may be in the same district, do not enjoy this advantage.

An eminent foreign student of English public administration thought that "the Legislature, by prescribing for these local officers (medical officers of health and inspectors of nuisances) certain conditions of dependence upon the central authority, has given the latter a potent leverage on the work of local government," and asserted that "this peculiar device powerfully assists the Local Government Board and serves as a bulwark to the control which it exerts on behalf of the State over the local administration of sanitary law."³ This is undoubtedly far too optimistic a view, as the medical officer to the Local Government Board recognized when he wrote that

"in some districts the efficiency and zeal of the medical officer of health or inspector of nuisances or both have been called in question. When insanitary conditions promoting disease are allowed to persist, intimate local knowledge is needed to apportion blame between the official and the council. An official who is subject to reappointment, or who can be dropped at intervals of one or a few years, finds it difficult to carry out his duties; and, apart from this motive for inertia, the officer's efforts can always be thwarted by a council which refuses to serve the statutory notices required to enforce the provisions of the Public Health Acts, or refuses to take defaulters before a court of summary jurisdiction."⁴

As already noted a partial attempt has been made to remedy the difficulty, but it still remains true that sanitary

¹ See Public Health Officers Act, 1921, and the Sanitary Officers Order, 1926.

² Section 68.

³ Redlich and Hirst, *English Local Government*, Vol. II, pp. 292-3.

⁴ Thirty-ninth Report of the Local Government Board (Medical Officer's Report), p. xv.

administration is hampered by the existence of many part-time officials who enjoy no security and are subject to many local influences.¹

Whilst it is certainly desirable that health officers should possess security of tenure, it is very doubtful how far it can be maintained against the wishes of a local authority determined to rid itself of an official. The refusal of the Ministry of Health to sanction an appointment will inflict pecuniary loss upon a district ; but refusal to sanction a dismissal has no such unpopular effect, and may only result in the authority achieving its end by making the officer's life so burdensome and unpleasant that he gladly seeks an office elsewhere, even at a reduced salary. Such, at least, appears to be the experience where the Ministry and a local authority have come into conflict over the dismissal of sanitary officers.

¹ See Annual Reports of the Chief Medical Officer of the Ministry of Health for 1924 (pp. 194 *et seq.*), and 1925 (pp. 177 *et seq.*).

CHAPTER VIII

THE MEDICAL OFFICER OF HEALTH

FOREMOST among the officials of the sanitary department stands the medical officer of health, occupying, in the large districts, an equal official and social status to the other executive chiefs—engineer and treasurer—their duties being linked together, and, in some cases, co-ordinated under the general supervision of the town clerk. A century ago the office was unknown; to-day the position of medical officer of health to London, Liverpool, Bradford, or any of the other great urban centres is one to which all medical practitioners who have entered the public health service aspire.

The great sanitary pioneer, Sir Edwin Chadwick, recommended, as one of the means by which the sanitary condition of the labouring classes could be improved, "the appointment of district medical officers, independent of private practice, and with the securities of special qualifications and responsibilities, to initiate sanitary measures and reclaim the execution of the law";¹ and the Royal Commission, which, in 1844, inquired into the health of large towns, repeated the recommendation. These proposals quickly bore fruit. The honour of being the first authority to appoint a medical officer of health belongs to Liverpool, where, under the powers of a local Act, Dr. William H. Duncan was appointed in 1844, "the earliest of the profession to hold such office in this country."² The City of London, again under powers given by a private Act, speedily followed (1848) by appointing Dr. John Simon, who afterwards became medical officer to the Local Govern-

¹ Simon, *English Sanitary Institutions*, p. 195.

² *Ibid.*, p. 245.

ment Board, was later knighted as a reward for his services on behalf of the public health, and finally left his great work *English Sanitary Institutions* as an everlasting monument to his memory and worth.

With the passing of the Public Health Act in 1848, and the consequent creation of local boards of health, the medical officer of health became an essential part of the local administrative machinery, and by the great consolidating Act of 1875 every urban and rural sanitary authority was compelled to make such appointment. The Local Government Act of 1888, which established county councils, empowered these authorities to appoint a medical officer of health,¹ but in 1909 this optional power was converted into a compulsory one, and the county medical officer of health was placed in a peculiarly favourable position by the prohibition of his appointment for a limited period and by the making of his discharge dependent upon the consent of the Local Government Board.² The Public Health (Officers) Act, 1921,³ extends these advantages to all whole-time medical officers where any portion of their salary was or is paid out of the Exchequer Contribution Account.

It is essential that an officer with the important duty of acting "as an impartial public accuser and adviser against whatsoever unwholesome influences in his district should be removable under the sanitary law" should be not only highly trained, but removed from those influences "which might probably render his official judgment less short-sighted or his official activity less straightforward than it ought to be."⁴ It has therefore been generally recognized that the medical officer of health ought to be occupied solely in the public service, and that such service should involve duties sufficient to occupy his whole time, and carry with them a remuneration adequate to attract men of the highest qualifications and character. To this end, and for the additional reasons arising from the growth of co-ordinate duties and a desire

¹ Section 17.

² Housing and Town Planning Act, 1909, s. 68.

³ Section 1.

⁴ Simon, *English Sanitary Institutions*, pp. 336-7

to diminish expenses, local authorities are empowered to combine for the purpose of appointing a medical officer of health, who may be, with the sanction of the Ministry of Health, the district medical officer of a Poor Law union ;¹ the power given to district authorities to utilize the services of the county medical officer of health by arrangement with the county council² was revoked except so far as it prejudiced prior arrangements.³ In the same Act a county medical officer appointed after it became law was prohibited from engaging in private practice, and "the express written consent" of the Ministry of Health is required before he may be appointed to any other additional public office.⁴ In the Public Health Act, 1875,⁵ provision was made for the union by the responsible Minister of two or more county districts for the purpose of appointing a medical officer of health if he agreed with the representation made to him that such a course would diminish expense or otherwise be advantageous. In addition, power is given to the Minister to unite districts for the purpose by provisional order—subject to Parliamentary confirmation—even if some of them object. Boroughs with Quarter Sessions and urban districts with populations of 25,000 or over are exempt from this power which is not likely to lead to good results and has been very sparingly used.⁶

Another method of attaining the same end is the combination of other offices with that of medical officer of health, and the Local Government Board in a memorandum dealing with the appointment of medical officers of health urged the desirability of uniting the office with that of assistant school medical officer in counties or school medical officer in autonomous education areas. Considerable advantage has been taken of this possibility, no less than 118 county districts in eighteen administrative counties being served by medical officers of health of this class.⁷ They further

¹ Public Health Act, 1875, s. 191.

² Local Government Act, 1888, s. 17.

³ Housing and Town Planning Act, 1909, s. 68. ⁴ *Ibid.* ⁵ Section 286.

⁶ See Memorandum submitted by Ministry of Health to the Royal Commission on Local Government. ⁷ *Ibid.*

favoured the joint holding by the medical officer of health of the office of superintendent of the isolation hospital, of certifying factory surgeon, police surgeon, public vaccinator, district medical officer, and medical officer of the workhouse, and suggested that, where qualified, he might be allowed to make analyses and bacteriological examinations of water and for the diagnosis of disease.¹ Of course it is only in the smaller districts that one man, however capable and energetic he may be, can efficiently perform all or any extensive combination of these duties, but it is precisely in those districts where the securing of the whole time of a highly qualified man is most difficult unless, by such a combination of posts, an adequate salary can be assured.

There are 1,686 county districts in England and Wales each of which must have a medical officer of health. On March 31, 1925, less than a third (505) were served by an officer who gave his whole time to public duties, whilst in 385 of these cases he was also acting for other county districts or partly for a county and one or more county districts. In the remaining 1,181 districts the officer also engaged in private practice.²

	Whole Time Public Service.		Part Time Public Service.
	One District.	Two or more Districts.	
Boroughs	71	46	139
Urban Districts	35	144	605
Rural Districts	14	195	437

The policy of the Ministry of Health has made some, but by no means general progress. In 1925 only eleven out of forty-five vacancies previously filled by part-time officers could be filled by whole-time officers (five by combination and

¹ Issued in December, 1910. The problem and methods of meeting it are dealt with in the Reports of the Chief Medical Officer of the Ministry of Health for years 1924 (pp. 194 *et seq.*) and 1925 (pp. 177 *et seq.*), and the Memorandum quoted *ante*.

² See Memorandum submitted by Ministry of Health to the Royal Commission on Local Government for an exhaustive discussion of this question.

six by arrangement with the county council) and no less than fourteen of the vacancies were filled by part-time officers not qualified under Article V of the Sanitary Officers Order, 1926. In all but one of these "the circumstances left no alternative to waiving the requirements."¹ The following table is instructive as showing the progress made in the appointment of whole-time medical officers of health since 1873 :

Year.	Number of Districts.
1873	249
1881	308
1891	308
1901	395
1911	501
1926	559

It is essential that an officer having such important and highly technical duties as the medical officer of health should be able to furnish evidence of the possession of the training and skill necessary to ensure for him the confidence of the medical profession and the community, and to enable him to advise with effect his authority upon questions which may involve the health and lives of many people, and the spending of much public money. At first the system of grants in aid of the medical officer's salary was relied upon to secure this, but the Public Health Act of 1875² prohibited the appointment of anyone who "is not a legally qualified medical practitioner," and gave the Local Government Board (now the Ministry of Health) power to prescribe the qualifications, conditions of appointment, duties, salary and tenure of office of such officer where part of his salary was repaid out of public funds, but otherwise the power only extends to qualifications and duties. The recognized qualification is that required to constitute a "registered medical practitioner," who is defined in the Medical Act of 1886 as "a person who has passed a qualifying examination in medicine, surgery and midwifery held by a university

¹ Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 178.

² Section 191.

or legally qualified medical corporation or a combination of either or both." The Local Government Act, 1888, had the effect of weakening these requirements in one direction by giving the central department power to waive the qualifications in cases of county or county districts. This power of dispensing with any of the requirements of the Order is embodied in the Sanitary Officers Order, 1926¹ and is occasionally used ;² otherwise it is enacted that

" a person shall not be qualified to be hereafter appointed or reappointed as a medical officer of any district or combination of districts unless, in addition to the qualification provided by any Statute, he is also either registered in the Medical Register as the holder of a diploma in sanitary science, public health or state medicine, or has had not less than three years previous experience of the duties of a Medical Officer of Health."³

From time to time orders have been issued prescribing regulations with respect to the qualifications, appointment, duties, salary, and tenure of office of medical officers of health, and in 1922 all previous orders were rescinded in a consolidated order—the Sanitary Officers Order—which, amongst other things, enumerated the duties of medical officers of health of urban, rural and port sanitary districts, as follows :⁴

14. A medical officer of health, in respect of the district for which he is appointed, or if he is appointed for more than one district, then in respect of each district shall—

- (1) perform all the duties imposed on a medical officer of health by statute and by any orders, regulations or directions from time to time made or given by the Minister, and by any bye-laws or instructions of the local authority applicable to his office ;
- (2) forward to the Minister by post every week in time to ensure its delivery on Monday or the morning of Tuesday, at the latest, a return, in such form as the Minister may

¹ Article 21.

² See Annual Reports of the Chief Medical Officer of the Ministry of Health for 1924 (p. 194) and 1925 (p. 177), and Seventh Annual Report of the Ministry of Health, 1925-6, p. 43.

³ Article 5.

⁴ Article 14. Embodied in the Sanitary Officers Order, 1926, which revoked and consolidated previous orders.

from time to time require, of the number of cases of infectious disease notified to him during the week ended on the preceding Saturday night ; and shall also forward at the same time a duplicate of the return to the medical officer or officers of health of the county or counties in which the district is situated ;

- (3) as soon as practicable after the 31st day of December in each year make an annual report to the local authority up to the end of December on the sanitary circumstances, the sanitary administration and the vital statistics of the district, containing in addition to any other matters upon which he may consider it desirable to report, such information as may from time to time be required by the Minister, and furnish the Minister with as many copies of such report as the Minister may from time to time require ;
- (4) furnish the Minister with one copy of any special report which he may make to the local authority ;
- (5) forthwith report to the Minister any case of plague, cholera, or small-pox, or any serious outbreak of disease in the district which may be notified to him, or which may otherwise come or be brought to his knowledge, and, in the case of a county district, shall also notify the medical officer of health of the county.

Paragraphs 2 and 5 do not apply to medical officers of health of counties other than London.¹

In March, 1925, the Ministry of Health in a memorandum elaborated these duties so far as they applied to medical officers of counties and urban and rural districts, London County being excepted. After a few preliminary paragraphs the duties are set out as follows :

A.—GENERAL DUTIES

4. The chief function of the Medical Officer of Health is to safeguard the health of the area for which he acts by such means as are at his disposal, and to advise his Authority how knowledge of public health and preventive medicine can be made available and utilized for the benefit of the community. He should endeavour to acquire an accurate knowledge of the influences,

¹ Sanitary Officers' Order, 1926, Article 4 (4).

social, environmental and industrial, which may operate prejudicially to health in the area, and of the agencies, official or unofficial, whose help can be invoked in amelioration of such influences. While he has special duties for the prevention of infectious diseases, all morbid conditions contributing to a high sickness rate or mortality in the area from these or other causes should be studied with a view to their prevention or control.

5. The Medical Officer of Health should be prepared to advise on all matters concerning the public health services undertaken by the Council, and generally on questions affecting the health of the district ¹ or county, including public health considerations involved in the preparation of local legislation, in the adoption of statutory provisions and in the framing and subsequent working of bye-laws and regulations. He will also be called upon to take executive action where required to do so in the administration of the Statutes and Orders noted in Appendix B, and to certify for the guidance of the Council or of the Justices as to any matter in respect of which the certificate of the Medical Officer of Health or of a medical practitioner is required as the basis or in aid of sanitary action.

In accordance with Article 19 (1) of the Sanitary Officers Order, 1922, the Medical Officer of Health of a district is responsible for directing generally the performance by the Sanitary Inspector of all the duties imposed on the Sanitary Inspector by Statute, Orders, Regulations or Bye-laws.

6. For the above purposes it is essential that a Medical Officer of Health should, on appointment and periodically, familiarize himself with the statistical and other available information bearing on health conditions in his area, as well as with any local Acts and Bye-laws so far as they relate to matters in which he is officially interested. In this relation, the reports of predecessors, the census returns in regard to age, sex, occupation, distribution and housing accommodation of the population, the ordnance and geological survey maps of the area, and special reports, if any, by Medical Inspectors of the late Local Government Board or Medical Officers of the Ministry of Health, or (in the case of a district within an administrative county) by the County Medical Officer of Health, will be found useful. Further, he should systematically carry out periodical inspection of each part of his area, as well as inspections of special places as the result of complaints or adverse reports or as occasion may require.

¹ Throughout this Memorandum the word "district" is intended to mean any urban or rural sanitary area other than an administrative county, and to include a county borough and a metropolitan borough unless the context otherwise requires.

B.—SPECIFIC DUTIES

I.—HOUSING AND TOWN PLANNING

7. Important duties devolve on Medical Officers of Health under the Housing Acts. In addition to the duties expressly imposed on Medical Officers of Health of districts by the Housing of the Working Classes Act, 1890 (Sections ¹ 4, 5, 30, 31, 38, as amended), every Medical Officer of Health may be called on to advise his Authority on questions relating to the housing conditions in his area, and as to the preparation of housing and town planning schemes in the case of Authorities empowered to carry out such schemes.

8. The Medical Officer of Health of a district may be appointed to perform the duties devolving on his Council under the Housing (Inspection of District) Regulations, 1910, but normally another officer, who is usually the Sanitary Inspector, is the designated officer for the purposes of these Regulations, and the Medical Officer of Health is responsible for the direction and supervision of the work.

II.—INFECTIOUS DISEASES

(a) General.

9. It is the function of the Medical Officer of Health of a district to inquire into and advise his Authority on the adequacy of the arrangements in the district for the isolation and treatment of infectious diseases.

On being informed of the outbreak of any infectious or epidemic disease of a dangerous or unusual character within the district it is essential that he should visit the spot at once, in order to inquire into the causes and circumstances of the outbreak and to take such measures for the prevention of disease as he is legally authorized to take under any Statute or Regulation in force in the district. He should also investigate any doubtful or suspected cases of dangerous infectious disease of which he learns. If in any case he is not satisfied that all due precautions are being taken, he will, of course, advise the persons competent to act as to the measures which appear to him to be required to prevent the extension of the disease.

In conducting such investigations a Medical Officer of Health will bear in mind that the examination of patients in their own homes can be made only with the consent of the patient or of

¹ Sections 4 and 5 do not apply to rural districts.

those in charge of the patient. If a medical practitioner is in attendance, his co-operation should always be sought.

In this connection attention is drawn to the requirements of Article 14 (2) of the Sanitary Officers Order, 1922, in regard to weekly returns of notifiable infectious diseases, and to the requirements of Article 14 (4) of the same Order, and of the Public Health (Pneumonia, Malaria, Dysentery, etc.) Regulations, 1919, as to the reporting immediately to the Minister of individual cases of certain diseases or any serious outbreak of disease of which the Medical Officer of Health may become aware. In the execution of the requirements as to reporting individual cases (small-pox, cholera, typhus, etc.), the Medical Officer of Health should include suspected cases in which the diagnosis remains in doubt.

10. The attention of medical practitioners in the area should be drawn to any arrangements made by the Local Authority or by the County Council for the supply of diphtheria antitoxin or vaccines, and for the examination of material from suspected cases of infectious disease (including tuberculosis and venereal diseases), and the Medical Officer of Health should seek to encourage the use of such facilities, and of any arrangements for consultation with respect to doubtful cases of infectious disease.

11. There should be kept in a book, or by other suitable method, a separate and up-to-date chronological list of all cases of infectious disease notified in the district, giving in regard to every case notified all requisite particulars as to location, date of onset, contacts, milk supply, place of work or school attended by patient and contacts, removal to hospital, disinfection, notification to the Local Education Authority and any other action taken to prevent the spread of the disease.

(b) *Tuberculosis.*

12. The Medical Officer of Health of a county or county borough, unless his Council otherwise direct, should be responsible for the general supervision of the Tuberculosis Scheme of his Council with a view to co-ordinating the work of the officers engaged in that scheme, and securing the effective application of the provisions contained in the Acts and Regulations in force relating to the prevention and treatment of tuberculosis.

13. The fact that the Tuberculosis Scheme is administered by officers of the County Council does not affect the powers and duties conferred and imposed on the Medical Officer of Health of a district by the Tuberculosis Regulations of 1912, 1921 and 1924. Attention may be especially directed to Article XII of the

Regulations of 1912 and Articles 4 and 5 of the Regulations of 1921. It is, of course, desirable that the Medical Officer of Health of a district should familiarize himself with the details of the Tuberculosis Scheme of the County Council, and co-operate with the Medical Officer of Health of the county and the Tuberculosis Officer in the effective carrying out of the scheme.

(c) *Venereal Diseases.*

14. Medical Officers of Health of counties and county boroughs should study as far as practicable the incidence of venereal diseases in their areas and advise their Councils on matters affecting the prevention, diagnosis and treatment of these diseases. It is particularly important to secure that the arrangements made to this end are widely known and effectively utilized. Medical Officers of Health of districts should endeavour to bring the arrangements available under County Schemes to the knowledge of the medical practitioners and the inhabitants of their districts, and full advantage should be taken of such opportunities as occur for effective co-operation with County Medical Officers in this respect.

III.—MIDWIVES

15. The Medical Officer of Health appointed by a Local Authority which is a Local Supervising Authority under the Midwives Acts, 1902 and 1918 (i.e. the Council of a county or of a county borough or of a district to whom powers of supervision have been delegated by the County Council under the Midwives Act, 1902), is responsible for the supervision and inspection of the midwives practising in his area and for the administration of the Acts therein.

IV.—MATERNITY AND CHILD WELFARE

16. The Medical Officer of Health appointed by a Local Authority acting under the Maternity and Child Welfare Act, 1918, is responsible for the organization, supervision and administration of the measures adopted by the Local Authority for the physical welfare of expectant and nursing mothers, and of children under five years of age who are not on the register of a school, and he should be prepared to advise the Authority on all matters relating thereto. He should, as far as practicable, seek to co-ordinate all the voluntary agencies engaged in maternity and child welfare work in his area.

V.—SCHOOLS

17. Every Medical Officer of Health who is also appointed as School Medical Officer by the Local Education Authority

and recognized as such by the Board of Education, is responsible for performing, in his capacity as School Medical Officer, all the duties laid on him by the Education Acts or by Orders and Regulations of the Board of Education, and for co-ordinating, so far as practicable, the work of the public health and school medical services.

18. It is the duty of the Medical Officer of Health of a district, when required by the Council of his district or any two members thereof, or whenever he himself deems it necessary, to advise the Council or any two members thereof in regard to the closure of any public elementary school, or the exclusion of individual children from any such school, with a view to preventing the spread of disease or any danger to health likely to arise from the condition of the school. (*See Joint Memorandum issued by the Board of Education and the Minister of Health on Closure of and Exclusion from School, 1925.*)

VI.—CARE OF THE BLIND

19. The Medical Officer of Health of a county or of a county borough will be expected to familiarize himself with the facilities existing within his area for the treatment of disease and injury of the eye, and should include in his Annual Report to the Council a statement thereon. He should be prepared also to advise his Council as to the steps necessary to bring to the notice of medical practitioners and of affected persons the facilities available for assisting the blind in his area under any scheme made under the Blind Persons Act, 1920, or otherwise.

VII.—FOOD

20. It is necessary that the Medical Officer of Health of a district should inspect from time to time and exercise general supervision over slaughter-houses, cold stores, dairies, cowsheds, milkshops, and all other premises within his district where food of any kind is prepared, stored or otherwise dealt with for sale or preparation for sale and intended for the food of man.

21. He will be concerned to secure in his district the effective application of the provisions of the Public Health Acts and other Acts and Regulations in force in that behalf with regard to food which is diseased, unsound, unwholesome, or unfit for human consumption.

22. In boroughs where the Public Analyst is appointed by the Town Council the Medical Officer of Health will be called on to supervise the administration of the Sale of Food and Drugs Acts, and of provisions of a similar nature, the enforcement of which is entrusted to the Council, and to give such advice and

assistance as may be necessary to the officers charged with the duty of obtaining samples under those Acts or provisions.

23. The County Medical Officer of Health may be directed by his Council to supervise and report upon the administration of the Sale of Food and Drugs Acts, and of provisions of a similar nature, the enforcement of which is entrusted to authorities appointing Public Analysts, and to give such advice or render such assistance to the officers engaged in sampling duties under those Acts and provisions as may be necessary.

VIII.—OFFENSIVE TRADES

24. The Medical Officer of Health of a district¹ should be prepared to inquire into any offensive process or trade carried on within the district, and to report upon the appropriate means for the prevention of any nuisance or injury to health arising therefrom.

IX.—NUISANCES

25. The Medical Officer of Health of a district has all the powers of a Sanitary Inspector, and should be prepared, in cases in which his intervention appears desirable, to take such steps as he is legally authorized to take for the purpose of securing the early abatement of any nuisance injurious to health or of overcrowding in a house.

X.—MEETINGS AND RECORDS

26. The Medical Officer of Health may be required to attend at the offices of the Council or at some other appointed place at such times as the Council may direct for the purpose of carrying out his duties, and it is desirable, unless his Council otherwise direct, that he should endeavour to attend all meetings of the Council and of Committees of the Council dealing with matters of health.

27. It is advisable that at such meetings he should, whenever necessary, submit to the Committee or Council, as the case may be, in a book provided by the Council (or in such other manner as will ensure that a permanent record is kept of his proceedings), a report in writing of the advice which he gives in regard to the improvement and protection of the public health in the area and of the action taken by the Authority.

As a general rule it is important that the Medical Officer of Health should ensure that due record is kept, in books or other convenient form, of all essential matters arising in the course of his administrative duties.

¹ The Medical Officer of Health of a rural district will not be concerned this matter unless the Council have been invested with urban powers.

XI.—REPORTS

28. In addition to the Annual Report which he is required to make by the Sanitary Officers Order, 1922, the Medical Officer of Health may be called on by his Council or by the Minister of Health to make a report on any special subject. Six copies of the Annual Report and two copies of every special report should be sent to the Secretary, Ministry of Health, Whitehall, London, S.W.1; one copy of the Annual Report should be sent to the Under-Secretary of State, Home Office, Whitehall, London, S.W.1, and, if the Council is a Local Supervising Authority under the Midwives Acts, one copy of the Annual Report should be sent to the Central Midwives Board, 1, Queen Anne's Gate Buildings, Westminster, S.W.1.

One copy of the Annual Report of the County Medical Officer of Health should be sent to the Council and to the Medical Officer of Health of every district in the county, and three copies of any special report to the Council of every such district affected by the special report.

One copy of the Annual Report of the Medical Officer of Health of a district, and one copy of every special report should be sent to the Medical Officer of Health of the county or counties in which the district is situate. In this connection attention may be drawn to Section 19 of the Local Government Act of 1888.

C.—CO-OPERATION BETWEEN MEDICAL OFFICERS

29. Section 69 (2) of the Housing, Town Planning, etc., Act 1909 requires the Medical Officer of Health of a district outside London to give to the County Medical Officer of Health any information which it is in his power to give and which the County Medical Officer of Health may reasonably require of him for the purpose of his prescribed duties. In all matters pertaining to his duties the Medical Officer of Health of a district will naturally maintain close touch with the County Medical Officer, and an interchange of views may with advantage be sought, particularly in matters which affect the health of other districts in the county. On his side the County Medical Officer should keep Medical Officers of Health of districts informed of all matters which come to his knowledge affecting or likely to affect the public health within their respective areas, and should consult with the Medical Officer of Health of a district within the county whenever circumstances render this desirable. A County Medical Officer of Health intending to visit a district for purposes of inspection or inquiry in regard to any work for which the District Council is responsible should, whenever practicable,

arrange to make such visits in the company of that officer. He should also collaborate with Medical Officers of Health of districts within the county in necessary inquiries and action in relation to infectious disease (particularly when more than one such district is concerned), and should from time to time inquire into and report upon the arrangements available for the isolation and treatment of cases of small-pox and of other infectious diseases in the county, and upon any need for further hospital, nursing or other provision.

30. It is important that the Medical Officer of Health should keep in touch with the other officers of his Authority, whose work is concerned in any way with the health of the county or district, and also with the Medical Officers of Health of adjacent areas, and keep himself informed of the nature and extent of any institutional accommodation, situate outside his area, but available for the use of the inhabitants of his area. In order to prevent overlapping it is necessary that the Medical Officer of Health of a district should ascertain the scope of the various county health services operating in the district and of the services administered by any joint boards or other bodies with public health functions on which his Authority is represented.

In any case in which the posts of School Medical Officer and Medical Officer of Health are not held by the same officer complete co-operation between the two officers is essential.

The Sanitary Officers (Ports) Order, 1910, enumerated similar duties, *mutatis mutandis*, as regards ships and the area of the port sanitary district as defined by the constituent provisional order.

It will be seen that the relations of the county medical officer with the district medical officers, who are frequently part-time officials, are largely of a supervisory and co-ordinating nature. The attempt is being made to devolve some of the duties, formerly not very effectively performed by the central department, upon the county council acting through its medical officer of health in constant touch with local circumstances and in frequent communication with local authorities. Time alone will show how far an officer in close and permanent relation to the local authorities, in the small and well-defined area of a county will succeed in securing and maintaining a higher level of sanitation in smaller districts; petty interests and narrow parochial

patriotism die hard. But the experiment is an interesting one and may in time remove the necessity for many of the much disliked local inquiries by "officials from London."

The extension of public health effort has added to the duties of medical officers of health in recent years. The National Insurance Act, 1924,¹ re-enacts the section of its forerunner of 1911 and provides that

"for the purpose of assisting insurance committees in the exercise and performance of their powers and duties under this part of the Act, and with a view to promoting co-operation between such committees and the councils of counties, boroughs and urban and rural districts, any medical officer of health may, at the request of an insurance committee and with the consent of the council by whom he is appointed, attend meetings of the committee, and give such advice and assistance as is in his power."

The institution of a general attack upon tuberculosis by means of the provision of sanatoria, dispensaries and domiciliary treatment has still further augmented the advisory and administrative duties of the medical officer of health ;² and the orders³ which consolidated and extended the Public Health (Tuberculosis) Regulations of 1908 and 1911, have placed upon him the duties of receiving and registering notifications of tuberculosis, and, either himself or by another officer, "making such inquiries and taking such steps as are necessary or desirable for investigating the source of infection, preventing the spread of infection and for removing conditions favourable to infection."

To these already numerous and onerous duties are added the functions involved by the Education (Administrative Provisions) Act of 1907,⁴ which brought for the first time two departments of local public administration—public health and public education—into organic connection. The scope of the work carried on by the school medical service is indicated by the subject-matter of the school

¹ Section 50 (2).

² See Chapter XVIII.

³ Public Health (Tuberculosis) Regulations, 1912, 1921 and 1924.

⁴ See also Education Act, 1921.

medical officer's annual reports—two copies of which must be forwarded to the Board of Education. These include information upon :

- (1) The general condition of school premises from a health point of view.
- (2) Methods of medical inspection adopted.
- (3) Extent and scope of medical inspection.
- (4) Conditions revealed by inspection.
- (5) Means of treatment available.
- (6) Infectious disease and methods of prevention and detection adopted.
- (7) Physically and mentally defective children.
- (8) Instruction in personal hygiene, physical exercises, open-air schools, etc.
- (9) Employment of children and young persons.

In addition to which he must report on the working of any arrangements made for educating children at an "open-air school," school camp, or other place selected with a view to the improvement of the health and physical condition of the children ; he advises or approves the closure of a school on account of infectious disease ; and may authorize the exclusion of certain children from a school on specified grounds.

It is obvious that it is only in the smaller districts where the medical officer of health can expect or be expected personally to perform all of his duties. As the districts grow larger and more populous more and more of his work must be delegated to others acting under his control and supervision ; he tends to become an advisory and administrative officer rather than an executive officer, and the test of his capacity will be how far he can command, organize, and control a staff of specialized officials without having to be troubled with the details of their everyday duties. To this point we must return after dealing with these officials.

CHAPTER IX

THE SANITARY INSPECTOR

THE old title, Inspector of Nuisances, for long a misnomer, is a thing of the past. As will be seen from the statement of the duties of an inspector, his functions have far outgrown those which in the early days chiefly pertained to the abatement of nuisances. This fact was first recognized in the metropolis where the officer was more correctly designated as sanitary inspector. The old title was first applied to the officer of the nuisance committees which were formed early in the last century in various districts under powers obtained by local Acts. The Report on the Health of Towns ¹ mentions the rare case of Ashton-under-Lyne, where "the water, drainage, sewerage and cleansing is good," and although there are "no stated periods for cleansing the streets, the inspector of nuisances, who is a responsible officer, is armed with authority and adequate powers under a local Police Act to take strict cognizance of the scavenging of the town, and enforces, in all cases of necessity, the proper cleansing of all thoroughfares, courts and alleys, and the removal of all public nuisances within the town boundary." In 1847 an inspector of nuisances was appointed under a private Act at Liverpool,² and Dr. Simon, on taking up his appointment as medical officer of health for London, instituted a methodical sanitary superintendence of all the poorer parts of the city by means of district nuisance inspectors.³ Twenty years after the passing of the Public Health Act, 1848, police officers were

¹ Report of the Royal Commission on the Health of Large Towns, 1844.

² Liverpool Sanitary Act, 1846, s. 124.

³ Miss Hutchins, *The Public Health Agitation*, p. 118.

acting as inspectors at such places as Manchester and Oldham, the relieving officer at Chichester and a tradesman of the town of Tunbridge acting in similar capacities in those places, whilst at Stow-on-the-Wold there was "no inspector of nuisances which abound without ever being abated."¹ The name continued stamped with legal recognition by the Public Health Acts and the official approval of the Central Government until the passing of the Public Health (Officers) Act, 1921,² crowned with success the persistent efforts of the Sanitary Inspectors Association to secure a change to fit the present duties.

Every urban and rural district council is required to appoint a sanitary inspector,³ and urban authorities⁴ now share the powers of the rural authorities to appoint more if it is deemed desirable. There is no limit to the number of assistant inspectors who may be appointed, but their powers are very limited, and their appointment is not encouraged by the repayment of half their salaries. As in the case of medical officers of health, small districts are permitted by law⁵ and encouraged by the Ministry of Health to combine for the appointment of a fully-qualified officer who will devote his whole time to the duties of sanitary inspector, but sufficient advantage is not yet taken of this power.

The duties of the sanitary inspector, prescribed in the Sanitary Officers Order, 1926,⁶ are as follows :

- (1) perform under the general direction of the medical officer of health all the duties imposed on a sanitary inspector by statute and by any orders, regulations or directions from time to time made or given by the Minister, and by any bye-laws or instructions of the local authority applicable to his office ;
- (2) by inspection of his district both systematically and at intervals as occasion requires, keep himself informed of the sanitary circumstances of the district, and in

¹ Second Report of the Royal Sanitary Commission, 1871, Analysis of Evidence in Vol. II.

² Section 3.

³ Public Health Act, 1875, s. 191.

⁴ Public Health (Officers) Act, 1921, s. 2 (2).

⁵ Public Health Act, 1875, s. 191.

⁶ Article 19.

respect of the nuisances therein that require abatement ;

- (3) report to the local authority any noxious or offensive businesses, trades, or manufactories established within his district, and the breach or non-observance of any bye-laws or regulations made in respect thereof ;
- (4) report to the local authority any damage done to any works of water supply, or other works belonging to them, and also any case of wilful or negligent waste of water supplied by them, or any fouling by gas, filth, or otherwise, of water used or intended to be used for domestic purposes ;
- (5) from time to time, and forthwith upon complaint, visit and inspect the shops and places kept or used for the preparation or sale of any article of food to which the provisions of the statutes and regulations in that behalf apply, and examine any article of food therein, and take such proceedings as may be necessary :
 Provided that in any case of doubt arising under this paragraph, he shall report the matter to the medical officer of health, with the view of obtaining his advice thereon ;
- (6) when and as directed by the local authority, procure samples of food, drink, and drugs and submit such samples to be analysed by the analyst appointed under the Sale of Food and Drugs Acts, 1875 to 1907, and take such proceedings as may be necessary.
- (7) give immediate notice to the medical officer of health of the occurrence within his district of any infectious or epidemic disease or other serious outbreak of illness ; and whenever it appears to him that the intervention of such officer is necessary in consequence of the existence of any nuisance injurious to health, or of any overcrowding in a house or of any other conditions affecting the health of the district, forthwith inform the medical officer of health thereof ;
- (8) if directed by the medical officer of health to do so, remove, or superintend the removal of, patients suffering from infectious disease to an infectious diseases hospital, and perform or superintend the work of disinfection after the occurrence of cases of infectious disease ;
- (9) if so directed by the local authority, supervise the scavenging of his district or any part thereof ;
- (10) if so directed by the local authority, act as officer of the local authority under the Diseases of Animals Acts, 1894 to 1909, the Canal Boats Acts, 1877 and 1884, the

- Rats and Mice (Destruction) Act, 1919, and under any orders or regulations made thereunder ;
- (11) if so directed by the local authority, act as designated officer for the purposes of Part IV of the Housing Consolidated Regulations, 1925 ;
 - (12) if so directed by the local authority, superintend and see to the due execution of all works which may be undertaken by their direction for the suppression or removal of nuisances ;
 - (13) enter from day to day, in a book or on separate sheets or cards provided by the local authority, particulars of his inspections and of the action taken by him in the execution of his duties ;
 - (14) at all reasonable times, when applied to by the medical officer of health, produce to him his books, or any of them, and render to him such information as he may be able to furnish with respect to any matter to which the duties of sanitary inspector relate ;
 - (15) as soon as practicable after the 31st day of December in each year, furnish the medical officer of health with a tabular statement containing the following particulars :
 - (a) the number and nature of inspections made by him during the year ;
 - (b) the number of notices served during the year, distinguishing statutory from informal notices ;
 - (c) the result of the service of such notices.

The characteristic of these duties is their great variety and the consequent versatility required of the inspector. He must be something of a builder, a plumber, a butcher, a doctor, a veterinary surgeon, a lawyer and a clerk, and withal possess tact, patience and courtesy to enable him to deal with people of all grades from the slum-dweller to the professional agent or surveyor of the slum owner.¹ And for all this few can hope to attain to a higher salary than £300 per annum, the average probably falling somewhere about £220.²

To attract men of better calibre than would otherwise be possible it is frequently arranged to combine the office of sanitary inspector with some kindred office or offices. The Public Health Act, 1875,³ specially provides that the

¹ Cp. speech by Sir J. Crichton Browne, reported in *Local Government Chronicle*, February 14, 1914, p. 151.

² See salaries offered in *Local Government Press*. ³ Section 192.

same person may be both surveyor and sanitary inspector, and the Local Government Board enumerated the following offices as those which may be most conveniently combined with the office of inspector :—Inspector under the Infant Life Protection Act, inspector under the Shop Hours Act, inspector for certain purposes under the Factory and Workshops Act, assistant officer under the Unsound Food Regulations, superintendent of scavenging and officer for the purposes of the Housing (Inspection of District) Regulations.¹ The office of surveyor of highways is expressly omitted, and sanction to such combined appointments is only given in special circumstances. Other offices are, however, occasionally combined, such as gas, water and sewage works manager and inspector under the Petroleum Acts and of hackney carriages.² It is to be noted, however, that with the exception of the post of officer under the Housing (Inspection of District) Regulations, a moiety of the salaries of these offices is not repayable by the County Council. This fact tends to induce sanitary authorities to place the salary of sanitary inspectors at the highest possible proportion of the total in order to receive a larger reimbursement.

As in the case of medical officers of health, the inadequate financial resources of various districts inimically affect both the character of the appointments and the work of the officers appointed. As will be seen from the table below there were on March 31, 1927, only 412 areas served by officers giving their whole time to duties as sanitary inspectors, whilst 132 out of the total of 1,686 districts were served by sanitary inspectors who were permitted to engage in a profession or trade.³

¹ Memorandum of the Board in regard to the appointment of Inspectors of Nuisances, December, 1910.

² For examples, see advertisements in the Local Government Press.

³ See Memorandum submitted by the Ministry of Health to the Royal Commission on Local Government. During the year 1926-7 190 new appointments of sanitary inspectors were approved; of these, 182 will give their whole time to public duties (Eighth Annual Report of the Ministry of Health, p. 93).

	Whole Time Public Service.		Part Time Public Service.
	As Sanitary Inspectors.	Holding other offices in addition.	
Boroughs	102	144	10
Urban Districts	196	517	71
Rural	114	481	51

In the larger sanitary areas the tendency is reversed. Instead of concentrating numerous duties upon one officer, not only are different officers appointed for each office, but the various duties of the sanitary inspector are themselves split up amongst officers who are specialists in each particular branch of the work.¹ Thus, there are to be found in most important districts inspectors appointed to devote their time solely to work under the Food and Drugs Acts, as food inspectors or as smoke inspectors, the district inspectors being usually left with the residue of duties in their particular districts, but occasionally exercising power concurrently with the special inspector, although over a more limited area, such as a ward or other division of the district for sanitary purposes. This specialization is pushed very far in some districts, and it is possible that its obvious advantages may be somewhat counterbalanced by the multiplicity of officials thus created tending to arouse the feelings of being "inspected to death" which finds occasional expression in the Press.²

The introduction of the female inspector and, to some extent, the health visitor is due to this tendency to specialization. The "special and delicate nature" of some of the duties imposed upon public health departments by the Factory and Workshop Act of 1891 resulted in the appointment of a woman inspector of workshops at Nottingham in 1892, whilst in 1895 Islington created a precedent by appointing a woman with the legal status as sanitary inspector. Now there are few important districts without

¹ See Chapter VII.

² Compare the author's "A Plea for the Efficient Organization of Local Administration" in *Westminster Review*, October, 1911.

one or more women sanitary inspectors and there are about four thousand health visitors of whom about a quarter are employed by local authorities wholly on maternity and child welfare work.¹ In London, by the London County Council (General Powers) Act, 1908, the appointment of health visitors was legalized and made subject to regulations made by the Local Government Board in 1909, which prescribed their qualifications, mode of appointment, duties, salary and tenure of office ; and, what was most important, the repayment of half their salaries by the London County Council to the borough councils was freed from doubt and possible disallowance by the auditor of the central department. One line of development of maternity and child welfare work has been the extended recognition of the status of health visitor, provision for their training and grants in aid of their salaries subject to the approval by the Ministry of Health of their qualifications.²

An interesting memorandum³ issued by the Women Sanitary Inspectors Association in 1911 gave the following information about the duties of their members, which includes health visitors :

“ Women sanitary inspectors are usually appointed with definitely stated duties more or less of a special character, and are as a rule under the direct supervision of the medical officer of health. These duties may comprise any or all of the following :

“ A. (1) The enforcement of the provision in factories of suitable and sufficient sanitary accommodation in the way of sanitary conveniences in accordance with the requirements of the Public Health Acts, and the Order of the Secretary of State, dated February 4th, 1903.

“ (2) The carrying out of the provisions of the Public Health and Factory and Workshop Acts, with regard to the registration and inspection of—

¹ Eighth Annual Report of the Ministry of Health, p. 47.

² See Circular 879 (Health Visitors) of the Ministry of Health, issued March 28, 1928.

³ Reproduced from *The Public Health Service Directory*.

- (a) Laundries, workshops and workplaces (including kitchens of hotels and restaurants) where women are employed.
- (b) Outworkers' premises.
- " (3) The inspection of tenement houses and houses let in lodgings and the enforcement of the bye-laws of the sanitary authority relating to the same.
- " (4) House-to-house inspection in the poorer parts of the district.
- " (5) The inspection of sanitary accommodation for shop assistants, sleeping accommodation in business houses, and public lavatories for women.
- " (6) The inspection of infant and girls' schools according to the legal powers of the local authorities.
- " (7) The carrying out of the duties and inspection in connection with
- (a) Notifiable infectious disease, such as scarlet fever, etc.
- (b) Non-notifiable infectious disease, such as measles and whooping-cough.
- (c) The Public Health Tuberculosis Regulations Order, 1908, and the voluntary notification of consumption.¹
- " (8) Taking samples under the Food and Drugs Acts. (It is exceptional for this work to be given to women.)
- " B. In addition to the above the following duties may be required in the provinces :
- " (1) Work relating to the administration of the Midwives Act, 1902² (in cases where the county council have delegated its powers under the Act to the district council.
- " (2) The inspection of shops under the Shop Hours Acts and the Seats for Shop Assistants Act, 1899. (In London, except in the city, the duties in this section, as well as in the inspection of employment agencies where sleeping accommodation is provided, are undertaken by special inspectors appointed by the London County Council.)
- " C. *Health Visiting*.—Work in connection with the reduction of infantile mortality.³

¹ Made compulsory in 1912.

² Amended by the Midwives Act, 1918.

³ This work is now greatly increased and extended and is to a great extent carried on by a sub-department of the Public Health Department. See Chapter XIX.

- " (1) Notification of Births Act, 1907. The visiting of infants and the giving of advice to mothers as to the feeding and general management of young children.
 - " (2) Advising expectant mothers on the management of their health and as to the influence of ante-natal conditions on their infants.
 - " (3) Work in connection with milk depots and infant consultation centres.
 - " (4) To promote general cleanliness in the home and note sanitary defects remediable under the Public Health Acts.
 - " (5) Investigation of deaths of infants under one year of age.
 - " (6) Lecturing at mothers' meetings, girls' clubs and at factories during the dinner hour.
 - " (7) Organizing the voluntary health workers in the district and arranging their work.
- " D. Work in connection with the medical inspection of school children."

The duties of a health visitor in London, defined in the Health Visitors (London) Order, 1909, correspond in a general way to those of like officials in the provinces. They are as follows :

" Article VIII.—In addition to the duties specified in the Act as the purpose for which a health visitor may be appointed, the duties of every health visitor shall be as follows ; that is to say—

- " (1) The health visitor shall, in relation to each person visited, enter on a suitable card or in a book to be called ' the health visitor's report book ' all such particulars as the sanitary authority or the medical officer of health require to be ascertained and recorded, and shall submit the cards or health visitor's report book to the sanitary authority or the medical officer of health so often and at such times as may be required, and, subject to the directions of the medical officer of health, shall keep the cards arranged so that any card may be readily available for reference at any time when the card is not in use for the purpose of a visit.
- " (2) The health visitor shall, under the direction of the medical officer of health, discharge such duties, not being the duties of a sanitary inspector, as may be assigned to her by the sanitary authority in con-

nection with and for the purposes of the administration by the sanitary authority of any public and general Act or local and personal Act under which powers are conferred or duties are imposed upon the sanitary authority with respect to matters relating to public health, the housing of the working classes, and the notification of births, or of any bye-laws or regulations made under any such Act.

- “(3) The health visitor shall discharge such duties in substitution for, or in addition to, any duties assigned to her under the paragraph numbered (2) in this article in connection with any of the Acts, bye-laws or regulations mentioned in that paragraph, or in connection with other Acts, bye-laws or regulations as may be prescribed by us, whether generally, by further regulations made by us in pursuance of the Act, or, in the case of any particular health visitor, by an instrument issued by us in that behalf under our hand and seal.
- “(4) The health visitor shall observe and execute, in regard to matters not specifically provided for in this Order, any such instructions issued by us and any such order or direction of the sanitary authority or the medical officer of health as may be applicable to her office.”

The health visitor and her co-worker and fellow-official, the school nurse, are now well-recognized components of the machinery of public health administration. Little is now heard of the arguments¹ that the appointment of women as health visitors rather than as assistant sanitary inspectors acts prejudicially against the woman official by—

- “(1) Denying her a legal status recognized under the Public Health Acts.
- “(2) Depriving her of the right of entry to premises where nuisances were believed to exist.
- “(3) Lessening her direct responsibility.
- “(4) Narrowing down her scope of work by making her merely an advisory officer without the power to enforce compliance with the Public Health Acts, both on the part of the landlord and the tenant.
- “(5) Creating a new class of officials, unknown to the poor, on a lower scale with regard to both status and salary.

¹ See Memorandum quoted *ante*, p. 91.

"(6) By making possible the appointment of women with inadequate training and insufficient knowledge of sanitation and public health laws."

These arguments begged the question in favour of the inspector as against the health visitor. They ignored the fact that health visiting is not a specialization, but an extension and rounding-off of an inspector's work. "The work of the health visitor does not trench on the work of the sanitary inspector; she is not an inspector in any sense of the word, her functions are those of a friend of the household to which she gains access."¹ It is really the creation of "a new class of officials," intended to fulfil a function which no amount of legal status and power will enable them to carry out if they are unable to do so by cultivating a friendly relation with the poor and so gaining their confidence and trust; and the Ministry of Health rightly consider that it is undesirable for health visitors to exercise the functions of sanitary inspector.² As regards right of entry, the health visitor has just as much—or just as little—as the sanitary inspector, since such right is given to "the local authority or any of their officers."³

If overlapping and friction are to be prevented it is essential that the duties of health visitors should be co-ordinated with, not superimposed upon, those of sanitary inspectors. It is obviously unsatisfactory to have one officer to seek out nuisances and secure their abatement within a given area and at the same time another official, health visiting, is also inspecting and serving notices for the abatement of nuisances within the same area and frequently in connection with the same premises. It would appear that the best arrangement is a complementary and reciprocal relationship, the inspector dealing with premises and informing the health visitor where her sympathy and advice are

¹ The Medical Officer of Health for Warwickshire in his Report for 1903, quoted in the Minority Report of the Poor Law Commission, Vol. I, p. 273. (Fabian Society, 1909.)

² Circular of the Ministry of Health, July 14, 1919.

³ Public Health Act, 1875, s. 102.

most needed, whilst the latter deals with persons and informs the inspector of any premises requiring his attention. The methods at present in vogue of distributing duties and powers are, like the specialization of the inspector's duties, very varied, and must be considered as experiments out of which a coherent and scientific organization may ultimately emerge.

Unlike the case of the medical officer of health, there are no qualifications fixed by statute or by the Ministry of Health for sanitary inspectors—male or female, except in the metropolis and in county districts or county boroughs desiring the repayment of a moiety of the official salary. In these cases the sanction of the Ministry is necessary for the appointment or reappointment, and one of the following qualifications is required : ¹

16.—A person shall not be qualified to be hereafter appointed or reappointed as a sanitary inspector of any district or combination of districts unless he is the holder of—

- (a) a certificate of the Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board ; or
- (b) a certificate of the late Sanitary Inspectors Examination Board ; or
- (c) a certificate issued before the 1st day of January, 1899, by the Sanitary Institute, now known as the Royal Sanitary Institute ; or,
- (d) in the case of an appointment as sanitary inspector of a district or combination of districts outside London, a certificate of the Royal Sanitary Institute issued before the 1st day of January, 1926.

The Ministry of Health still retain the power, which however is very sparingly used, of dispensing with these requirements,² and special provision is made for endowing a qualified veterinary surgeon with a sanitary inspector's

- (4) - and duties in relation to meat, notwithstanding that
 not possess one of the qualifications enumerated
 of there are but few authorities which do not stipu-
 " (5) Creating possession of some qualifying certificate, and
 on a lower

¹ Order, 1926, article 16.

² See Men.

³ *Ibid.*, article 16.

many now require other qualifications, usually of a technical character, such as the meat inspector's certificate of the Royal Sanitary Institute or certificates for plumbing or building construction. If, as is generally recognized, the certificate of the Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board establishes competency to perform all an inspector's duties, it is difficult to see why special examinations and certificates are needed.¹ The Joint Board have followed the notable and desirable precedent set up some years ago by an authority which also required a certificate indicative of a good general education, and the passing of a university matriculation or similar examination is now a condition precedent to sitting for the certificate of the Board. It is a somewhat tardy recognition of the fact that the day has gone by when a carpenter, bricklayer, or a plumber with the inspector's certificate was thought to be the only person capable of performing an inspector's duties.

In the case of women inspectors the additional qualifications usually asked for are those of a trained nurse or midwife or both. For health visitors the Ministry of Health will require, as a condition of their sanction on and after the 1st April, 1928, that the appointee hold the Health Visitor's Certificate, and this may only be taken after an approved course of training in public health work. For trained nurses, holding the certificate of the Midwives Board, this course extends over at least six months, but for those who are not "trained nurses" the course must be of two years' duration and the students must have either obtained at least six months' hospital training and the certificate of the Midwives Board or undertake to fulfil such conditions.²

The demand for trained and qualified men and women

¹ "It was high time that the whole field of duties of sanitary inspectors were covered by one examining body. The Joint Board, if they liked, but only one authority." T. Foley Cass, in the Presidential Address to the North-Eastern Centre, Sanitary Inspectors Association, January 7, 1928.

² Memorandum (101/M.C.W.) and Circular on the *Training of Health Visitors* (557) by the Ministry of Health, 1925. See also Eighth Annual Report of the Ministry of Health, p. 47.

has given rise to organizations for training and examining aspirants to the public health service, and it is now possible to obtain, in most large centres of population, courses of study and practical demonstrations of the various sides of sanitary science and administration. Pioneer amongst these organizations is the Royal Sanitary Institute, founded the year after the passing of the Public Health Act, 1875. It not only provides courses of training for the various offices—sanitary inspectors, meat inspectors, smoke inspectors and health visitors—but has instituted examinations at various centres and granted certificates which are recognized throughout the empire.¹ In 1899 the Sanitary Inspectors Examination Board relieved the Institute of the work of examining for the certificate for sanitary inspectors in the metropolis; more recently, the above Board and the Institute have formed a joint examining body, the certificates of which are a recognized qualification for sanitary inspectors within or without the metropolitan area.

Before taking the examination candidates are required to produce evidence of experience in the practical work of a sanitary inspector and the Ministry of Health has suggested to local authorities the desirability of affording opportunities for this in one of two ways. Either they may appoint the aspirant to a subordinate post in the department and pay him a small salary, or they may establish a course of instruction for him, in which case he should be charged a fee.² This is very vague and in practice not altogether satisfactory. In the first place it opens the way to nepotism, unless an authority is prepared to accept all suitable applicants; secondly, it is encouraging the use of cheap labour, unless, if appointed on the staff, an adequate salary is not given; and thirdly, it puts a duty—that of teaching and training—upon the public health staff which

¹ See *Jubilee History of the Royal Sanitary Institute*, which also contains interesting special articles on the progress of sanitation during the fifty years of its existence.

² Memorandum on Facilities for Practical Training of Candidates for Sanitary Inspection. Issued by the Ministry of Health, October 4, 1926.

is not included in their terms of appointment and for which they are not as a rule paid. It is obviously unfair to ask officers who have secured knowledge at considerable cost to fit themselves for certain duties to impart such knowledge to others without reward. It is early yet to see how the idea will work, but it is a development which will need watching if favouritism and injustice are to be kept at bay. The Sanitary Inspectors Association, ever to the fore in matters affecting the efficiency of their own members, have established classes in various centres for specialized instruction in meat inspection, smoke abatement and clean milk production, for attendance at which by sanitary inspectors the Ministry of Health will sanction payment by local authorities of reasonable expenses.¹

The increasing amount of attention paid by the universities to social and administrative science, and the enlarged facilities for its study offered by a duplication of day lectures for evening students, is opening up to sanitary officers of all classes opportunities for obtaining a knowledge and outlook not restricted to their own department. The London School of Economics and Political Science (University of London) provides many courses of lectures upon public administration and social science,² and other centres of higher education offer similar facilities. This is an excellent move, since a knowledge of social conditions and problems and of the agencies for dealing with them, and a recognition of the fact that the public health department is only one amongst many public and voluntary institutions for social betterment, is bound to increase the efficiency of the sanitary official; and the provision of such opportunities will no doubt result in local authorities demanding something more from candidates for appointment than the possession of the sanitary inspector's certificate.

The figures of examining bodies show that the number of persons qualified to act as sanitary officers is obviously

¹ See Forty-Fourth Annual Report of the Council of the Sanitary Inspectors Association, 1927.

² See the Annual Calendar of the School.

far in excess of possible requirements and is undoubtedly one of the factors tending to keep salaries low. Whilst, no doubt, there are some who have taken the examinations without thinking of applying for a post, there are very many who never get the chance to exercise the knowledge patiently acquired at expense of time, thought and money. It appears desirable that some method, apart from the new educational conditions and increased examination fees, of limiting the numbers studying and sitting for the examinations should be devised in the interests of both prospective students and those already qualified. This might take the form at present in vogue for inspectors of weights and measures, the examination qualifying for which can be taken only by persons nominated by local authorities desirous of appointing them, or a permanent panel of qualified persons might be formed and recruited annually by an open competitive examination. At present there is undoubtedly very keen competition for vacant posts, and, although the examinations tend to become more difficult, the expenses increased¹ and the conditions precedent to sitting have been made less easy to fulfil, many more candidates present themselves and many more satisfy the examining body than can possibly be absorbed. As long as these conditions remain local authorities will have no difficulty in obtaining applicants with certificates and little incentive to offer a remuneration which is adequate for the knowledge and capacity required and the duties to be fulfilled, or sufficient to obtain and keep the best class of men. Despite this, however, it is true, and will be in the future, that "no history of public health would accord with experience which did not give sanitary inspectors a high position in the successful battle which has been waged against various forms of insanitation."²

¹ The examination fee was raised from £4 4s. to £8 8s. in 1927.

² Sir George Newman, *The Ministry of Health*, p. 49.

CHAPTER X

OTHER OFFICERS.—DEPARTMENTAL CONTROL

IN addition to the medical officer of health and sanitary inspector some sanitary authorities are required to appoint other officers for the enforcement of the provisions of various Acts, but, as we have seen, in some cases the result is the endowment of the above-mentioned officers, especially the latter, with extra powers and duties.

The option given to courts of quarter sessions and boroughs with separate police establishments to appoint analysts under the Food and Drugs Act of 1875¹ was transferred to county councils and boroughs with a population exceeding 10,000 by the Local Government Act of 1888.² In 1899 the power was converted into a duty, and the Ministry of Health or the Ministry of Agriculture is empowered to appoint a public analyst and depute an officer to take samples and enforce the law in the district of any local authority in default, and to recover the expenses incurred.³ The Act of 1875 directed that the public analyst should not be engaged directly or indirectly in any trade or business connected with the sale of food and drugs in the district for which he is appointed, but twenty-four years elapsed before proof of competency was required of such officers. In 1900 the Local Government Board issued an Order requiring analysts appointed after January 1st, 1900, to furnish documentary proof of skill and knowledge of analytical chemistry, therapeutics and microscopy.⁴ The duty

¹ Section 10.

² Sections 3, 38 and 39.

³ Food and Drugs Act, 1899, s. 3. Now repealed. See Food and Drugs (Adulteration) Act, 1928, s. 14 (2).

⁴ See Food and Drugs (Adulteration) Act, 1928, s. 15.

of an analyst consists solely in analysing and reporting upon samples of food and drugs and water submitted by the authority appointing him; he is neither an administrative nor an executive officer, as some foreign observers seem to suppose.¹ He determines neither what nor how many samples shall be obtained, nor what action shall be taken if his report shows that they contravene the standard of purity. It thus happens that he is usually engaged in private practice and frequently acts for several local authorities, seldom appearing in his official capacity unless required as a witness at the police court.

Another officer, who is frequently a part-time official, is the veterinary inspector, who must be appointed by the county councils, the City Corporation, and the councils of boroughs with a population exceeding 10,000 at the census of 1881, and the Hove urban authority, who are authorities under the Diseases of Animals Act, 1894.² The local authorities are also required to appoint as many inspectors and other officers as they deem necessary, and frequently designate their sanitary inspectors to carry out the duties involved; but the veterinary inspector must be a member of the Royal College of Veterinary Surgeons or be a veterinary practitioner with qualifications approved by the Ministry of Agriculture.³ A peculiarity of this branch of public administration, which partly pertains to public health and partly to agricultural economy, is the power given to the police force in each police area to execute and enforce the Act and orders made by the Ministry of Agriculture, and for that purpose to stop, question, detain, and apprehend persons engaged in committing an offence against the Act.⁴

¹ Maltbie, *English Local Government of To-day*, pp. 103-4.

² Sections 2, 3, 35 and 58. Compare Section 10, Milk and Dairies (Consolidation) Act, 1915.—Local authorities may, and when required by the Ministry of Health shall, appoint or combine with another local authority in appointing one or more veterinary inspectors or may employ any veterinary inspector appointed under the Diseases of Animals Act, 1894, and may, and if required shall, provide facilities for bacteriological or other examination of milk.

³ Diseases of Animals Act, 1894, s. 59.

⁴ *Ibid.*, s. 43.

For the purposes of the Public Health (Imported Food) Regulations, 1925, a local authority may, with the consent of the Ministry, appoint and pay a legally qualified medical practitioner to act in place of or as assistant to the medical officer of health and also an assistant officer to act under his directions and discharge any duties assigned to him by the sanitary authority.¹

For the purposes of the various Acts and Orders relating to shops the authorities are somewhat different. In London the City Corporation and, beyond its area, the County Council are responsible, but in the provinces all borough councils and the councils of urban districts with populations exceeding 20,000, and elsewhere the county councils, are required to enforce the law and for that purpose to appoint inspectors.² For these inspectors there is no legal qualification required, and the sanitary inspector is often appointed, but where a special officer is appointed the local authorities usually stipulate that he shall have had experience of shop life in some form or other.

Every local authority, designated by the Ministry of Health as a "registration authority" for the purposes of the Canal Boats Acts,³ must employ a fit and proper person to examine and report upon canal boats for which registration has been applied.⁴ Other local authorities whose areas include or abut upon canals are required to provide for the inspection of boats thereon. The sanitary inspectors are frequently appointed for this purpose, but in the chief canal centres special inspectors perform the duties.

Under the Alkali, etc., Works Regulation Act of 1906⁵ sanitary authorities have an unusual power. The requirements of this Act are enforced by inspectors appointed by and responsible to the Ministry of Health, but a local authority may, if they deem it desirable, apply to the Ministry for the appointment of an additional inspector to act within their district, on condition that they provide

¹ Section 20.

² Canal Boats Act, 1877, s. 7.

⁴ Canal Boats Act, 1878, s. 2.

³ Shops Act, 1912, s. 13.

⁵ Section 14.

not less than one-half the salary of the inspector over whom they exercise no control. There does not appear to be any instance of local authorities taking advantage of this power.

The first appearance of a division of labour and a specialization of function in a public health department is usually the appointment of a clerk to relieve the medical officer of health or the sanitary inspector or both of the great and increasing amount of clerical work involved by their ever-growing duties. And as the work and staff of inspectors and other officers increase so the clerical assistants become more numerous and in their turn specialized. The result is that there are to be found in the most important offices, clerks for dealing with correspondence, notifications of diseases, notices, registration and records, and statistics, acting under the general supervision of a chief clerk responsible to the medical officer of health ; but some of these are, in the frequent cases where the sanitary inspector occupies a co-ordinate position, under the control of that officer. Until comparatively recently the clerical assistants, however efficient and instructed they might become, had no opportunity of obtaining a diploma or certificate indicative of their knowledge other than the sanitary inspector's certificate. Many obtained this certificate, but for some years the National Association of Local Government Officers, in a well-thought-out scheme of examinations for officers engaged in various departments of local government, have included an examination for clerks in the public health service. The scheme provides for a preliminary examination in the absence of a certificate indicative of a good general education, and then two examinations of progressive difficulty and comprehensiveness, on the actual work of a public health department, conducted by officers of high standing and experience in the public health service. Certificates are given for each, and success at the intermediate examination entitles the clerk to become an associate of the association (A.L.G.A.) and at the final, to become a fellow (F.L.G.A.)

The syllabus of these examinations, which were quite

a new development in local government, are of considerable interest. They are set out in the official prospectus as follows :

INTERMEDIATE

Office Practice.

Correspondence ; Agendas ; Filing ; Minutes ; Reports ; Indexing ; Multigraphing ; Précis Writing ; General Office Management and Organization.

Elements of Statistics.

History ; Scope and Meaning of Statistics ; Method of Statistical Investigation ; The Unit of Comparison ; Distribution ; The Questionnaire ; Classification and Tabulation ; Averages ; The Mode ; The Median ; Means ; Dispersion or Variability ; Skewness ; Probability ; Sampling ; Trend ; Graphs and Diagrams ; Curves ; Index Numbers ; Weighting ; Interpolation ; Accuracy ; Error ; Correlation.

Outlines of Local Government.

The Origin and Development of Local Government ; A General Knowledge of the Local Government and Municipal Corporation Acts and the Public Health Acts.

Elements of Public Administration.

Functions and Machinery of Government (Central and Local) with special reference to Great Britain, including the Organization, Powers and Duties of Government Departments and Local Authorities ; Financial Policy and Control ; Relations between Local Authorities and (a) the Central Executive, (b) the Legislative and (c) Judiciary.

Elements of Economics.

The Requisites of Production ; Labour ; Capital ; Division of Labour ; Distribution of Wealth ; Private Property ; Rent ; Ricardo's Theory ; Wages ; Profits ; Interest ; Co-operation ; Exchange ; Prices of Commodities ; Money as a Medium of Exchange and as a Standard of Value ; Exports and Imports ; Foreign Exchange ; Credit ; Its Influence on Prices ; Taxes, Direct or Indirect : Local Taxation ; The Incidence of Local Taxation.

FINAL EXAMINATION

Three compulsory subjects :

1. *Municipal Organization, Office Management and Conduct of Meetings.*

The Principles of Organization ; Delegation of Responsibility in Relation to Committees and in Relation to Staff ;

Statutory Committees; Relations between Committees; Order of Reference and Standing Orders; Office Management; Inwards and Outwards Correspondence; Registration; Filing; Indexing Systems; The Use of Forms; The Use of Mechanical Aids in Office Work; Typewriting and Manifolding; Mechanical Calculators; Stock-taking; Control of Stationery; Preparing Copy for Printers and Proof Reading.

Law of Meetings; The Chairman—his Powers and Duties; Quorum; Order in Debate; Motions; Amendments; Previous Question; Closure; Fair Comment and Privilege in Speech; Preservation of Order; Expulsion from Meetings; Police; Public Meeting Act, 1908; Minutes; Reports; Reference Back; Adjournment; Closure; Voting; Publicity; Licensing Procedure; Appeals; Local Authorities (Admission of the Press to Meetings) Act, 1908.

2. *Contract and Tort.*

The Main Principles of the Law of Contract; Contracts under Seal; Verbal and Written Contracts; The Statute of Frauds; Corporate Bodies as Contracting Parties; The Position of Local Authorities in Relation to Contracts; Rules for the Interpretation of Deeds.

Definition and Classification of Torts; Libel and Slander; Nuisance; Negligence; Trespass; Justification and Excuse; Statutory Protection; Limitations of Actions.

3. *Master and Servant.*

Relationship of Master and Servant; Contracts and Conditions of Service; Transfer of Assignment of Contract; Parties; Contract of Hiring and Service; Contracts in Writing; Parole Contracts; Relationship set up by Contract (Apprentice, Tenant, Agent, Bailee, Contractor); General Hiring; Duties as between Master and Servant; Tort (Criminal and Civil Liability).

General Principles of Employers' Liability (Common Law); and any two out of fourteen optional subjects, those recommended for officers in the Public Health service being:

Public Health.

The Public Health Acts, Local Government Act, 1894; Housing and Town Planning Acts.

Constitution of Districts; Sewerage and Drainage; Scavenging and Cleansing; Mortuaries; Highways and Streets; Private Street Works; Housing and Town Planning; Gas, Electricity, and Water; Commons and Parks; Pleasure

Grounds ; Markets and Fairs ; Slaughter Houses ; Food and Drugs ; Milkshops and Dairies ; Contracts ; Purchase of Lands ; Bye-laws, Officers and Meetings of Local Authorities, Rating and Borrowing Powers ; Finance and Audit ; Legal Proceedings, etc.

Control of Food Supply.

Sale of Food and Drugs Acts. Powers and Duties of Local Authorities and their Officers ; Methods of Sampling ; Standards, Presumptive and Customary ; Analyst's Certificates ; Offences and Penalties ; Informations and Summonses ; Defences ; Forms of Adulteration ; Milk and Cream Regulations.

Milk and Dairies Acts, 1882 to 1926, and Orders and Regulations made thereunder.

Markets and Fairs. History ; The Act of 1847 ; Bye-laws ; Establishment of Market ; Orders of 1903, 1904, 1910, 1914. Sale of Food (Weights and Measures Act), 1926.

Meat. Diseases of Animals Acts, 1894-1925, and Orders and Regulations made thereunder.

Public Health (Foreign Meat) Regulations, 1908 ; Public Health (Meat) Regulations, 1924 ; Public Health (Imported Food) Regulations, 1925.

Fertilizers and Feeding Stuffs. The Act, 1926 ; Statutory Statements ; Warranties ; Enforcement of Act by County and County Borough Councils ; Sampling and Analysis ; Registration ; Deleterious Ingredients in Feeding Stuffs ; Poisons and Pharmacy Act, 1908, Section 2.

Merchandise Marks Acts, 1887 to 1926. Infringements of Trade Marks ; Marking of Imported Goods ; Application of False Trade Description to Goods.

Shops Acts. Powers and Duties of Local Authorities ; Registration ; Taking Votes of Traders ; Home Office, Powers and Duties ; Conditions Governing the Employment of Assistants ; Employment of Young Persons ; Closing of Shops ; Closing Orders ; Half-holiday Orders ; Exempted Trades.

High Court, County Court and Summary Jurisdiction.

Supreme Court of Judicature ; High Court of Justice ; (1) King's Bench Division ; (2) Chancery ; (3) Probate, Divorce and Admiralty. Court of Appeal. House of Lords. Judicial Committee of the Privy Council.

County Court. History ; Original Jurisdiction ; Transferred Jurisdiction ; Procedure ; Bankruptcy ; Winding-up.

Summary Jurisdiction Procedure, with Special Reference to Penal Acts Administered by Local Authorities; Form of Information; How to be Laid; Time Limits; The Summons; Its Service; Procedure at Petty Sessions; Appearance; Plea; Rules of Evidence; *mens rea*; Criminal Liability of Corporations; Partners; Agents or Servants; Aiding and Abetting; Right of Appeal; Appeals to Quarter Sessions and Divisional Court; Recovery of Penalties; Special Procedure under certain Acts.

The question of the control of the sanitary departments of the different authorities is constantly exercising the minds of the chief officials concerned—the medical officer and the sanitary inspector; that friction has resulted is from time to time made manifest,¹ and has given reasons for the authorities in many places reviewing the position and reorganizing the department.

The Public Health Act of 1875 appears to have been framed with the intention of creating two officers with co-ordinate powers; indeed the medical officer is deliberately omitted from Section 266, which specifies that where notices, orders, and other documents require authentication by the local authority the signature of the clerk, surveyor, or sanitary inspector shall be sufficient, although an earlier section invests the medical officer of health with any of the power with which a sanitary inspector is invested by the Act;² and the orders of the Local Government Board and Ministry of Health dealing with these officers invariably gives the medical officer of health a general, not a special, supervision over the activities of the sanitary inspector.³ So long as areas were comparatively thinly populated this worked quite well. The medical officer of health, usually a busy private practitioner, interfered little, and the inspector enjoyed practical immunity from official control; this condition of affairs still continues in many districts. But in

¹ See Report of Local Government Board Inquiry at Ilford in *Ilford Recorder*, July 11 and 18, 1913.

² Section 191.

³ In questions affecting infectious disease the sanitary inspector is subject specially to the directions of the medical officer of health. See Sanitary Officers' Order, 1926, article 19 (8).

the more populous areas, with increased and specialized staffs and a highly qualified and whole-time medical officer of health, the councils found it necessary to define the functions and relations of the two chief statutory officers. In many, perhaps most, districts the old conditions were maintained, each officer being responsible for his own staff and the performance of the duties allocated to him, attending the committee and council meetings and reporting directly to them, but working in harmonious and close relationship for the good health of the district. Of late years, however, a decided tendency has shown itself to depress the status of the sanitary inspector and to correspondingly increase his subordination to the medical officer of health, and whilst, on the grounds of economy and the necessity for having one responsible departmental head, this is often justified, it is felt strongly and widely amongst inspectors that the greatest factor is professional ambition, and that the tendency has gone too far.¹ That this feeling is not without some justification was shown by a proposal put forward some years ago, and revived more recently, that young public health practitioners should be appointed as chief inspectors in order to gain experience to qualify them for the office of medical officer of health.² The suggestion has met with a considerable amount of condemnation, which it fully deserved, but strong influences are still at work in favour of the medical officer of health and against the sanitary inspector,³ and the Sanitary Inspectors Association frequently has to make representation against efforts to make the sanitary inspector quite subordinate to, dependent upon and related to the local authority and the Ministry of Health only through the medical officer of health.

Present methods of departmental control appear, there-

¹ See *Sanitary Record*, February 13, 1914, query 7,185, p. 174, and letter from the Local Government Board to Ilford Council, published in *Stratford Express*, January 17, 1914.

² See *Sanitary Journal*, June, 1927.

³ The Sanitary Inspector is not mentioned either in the Housing Act, 1925, or the Public Health (Imported Foods) Regulations, 1925, although upon him falls the bulk of the duties.

fore, to fall into three classes : (a) Those in which the two statutory officers, with or without separate staffs, exercise co-ordinate powers and are separately responsible to their authority ; (b) those in which the medical officer of health is ultimately responsible to the authority, but exercises a general control over the sanitary work through a chief sanitary inspector who is responsible to him for the work of the inspectorial department ; and (c) those in which the medical officer of health is solely responsible to the authority and exercises direct personal control over every inspector and other member of the staff, each of whom is responsible to him for their own sphere of work. The first method undoubtedly serves its purpose admirably in the minor districts, especially where the medical officer is only a part-time officer or where he holds several combined offices the duties of which suffice to occupy his whole time. The second method is that to which the first may be expected naturally to lead as the district gets more populous, the work of the department increases, and the staff becomes larger and more specialized. The medical officer may be expected to be a man of considerable attainments and experience, and as such will realize the desirability of centralizing control over a staff having graduated responsibility in its separate departments. It is the method followed in all great business and industrial concerns : a responsible chief having subordinate heads with wide discretion and ample powers. The remaining method is condemned by the canons that justify the latter, and the more populous the area, the greater and more specialized the work and staff become, the greater is the condemnation. A highly qualified, experienced, and paid medical officer of health who attempts adequately to supervise the details of the work of each member of the staff is undertaking labour which cannot be justified on any grounds, least of all on those of economy or efficiency of administrative effort. He tends to become overwhelmed with details, worried with petty affairs that he ought never to hear of and with petty officers he ought seldom to see, and in consequence

his capacity as an administrator is impaired, as he lacks the time and leisure to make those broad surveys and plans of organization upon which the ultimate efficiency of the department depends. His position may be likened to that of Parliament; every year brings fresh duties and an extended application of those existing, the machine becomes congested, and devolution becomes essential.

"The classification of functionaries should correspond to that of subjects, there should not be several departments independent of one another to superintend different parts of the same whole. . . . The entire aggregate of means provided for one end should be under one and the same control and responsibility."¹

In the case of the public health service this is possible; the more so since the method of organization invariably depends upon the medical officer of health, the natural and logical head of the service. It may, therefore, be confidently expected, despite some contrary tendencies, that sooner or later ordinary business principles will prevail, and that the public health departments will be organized in a series of sub-departments each with a chief responsible to and controlled by the medical officer of health.

The third system has another disadvantage which is, perhaps, not quite so evident. To remove the stimulus to ambition and the opportunity of improving his position, and to deprive him of openings for the exercise of power and initiative is harmful to the employee, whether he be workman or official, and equally so to the employer, whether it be a private business or a public authority. If there be no incentive to increased knowledge and efficiency they will seldom be secured; to write "abandon hope of advancement all ye who enter here" over the portals of a profession must ultimately act as a deterrent to the best quality of men and affect the general level of capacity in the service.² That this is not obvious amongst sanitary inspectors is not evidence that the factor is not at work. The organiza-

¹ J. S. Mill, *Representative Government* (Everyman's Edition), pp. 331-2.

² One very seldom hears of the son of a sanitary inspector following his father's footsteps.

tion of departmental control is in a transition stage, and its results upon the position of inspectors are not yet apparent enough to affect lay aspirants; but the public health service has need of the best men and women, and these will not be secured where hope and opportunity are denied them.

There are, fortunately, two factors which may weigh strongly in favour of the second method of control when reorganization is based upon scientific lines. The first is the inherent incapacity of any one man to efficiently check and control every individual of a large and specialized staff; sooner or later the limit must be reached in all districts. The second is the ease with which the work of a public health department can be divided into sub-departments with chiefs under the control of the medical officer of health. Work under the Factory and Workshop, Shops and Employment of Children Acts naturally forms one department of activity; the inspection of slaughter-houses, dairies, cowsheds and milkshops, food and animals, and the sampling of foods and drugs may reasonably be comprised in another sub-department, leaving general sanitary inspection as a third, and health visiting in conjunction with maternity and child welfare, together with the duty of investigating and dealing with infectious disease, as a fourth. The clerical work of each should be separate, but the results collated and classified by a staff dealing also with the general clerical work of the department. This classification is suggestive rather than dogmatic, and indicates the lines along which many well-organized departments have been developed.¹

¹ Many interesting papers upon the subject-matter of the latter part of this chapter may be found in the proceedings of the Institute of Public Administration and the Sanitary Inspectors Association.

CHAPTER XI

THE POWER OF COMPLAINT

So far we have seen that in order to remove or prevent the occurrence of conditions which harmfully affect health, and to prevent the spread of disease when such efforts have not warded it off, Parliament has established a system of local authorities having varied and extensive powers and duties, and enabled, where it has not required, them to appoint a staff of officials to do the actual work. It is now necessary to inquire in what ways the activities of these officials originate.

The answer to such an inquiry is to be found partly in the order of the Ministry of Health which enumerates the duties of the medical officer of health and the sanitary inspector,¹ partly in specific requirements of various Acts of Parliament, and partly in the powers of complaint given to various classes of persons generally and in specific cases by the statute law. The former two classes form the basis of the routine work of the department, whilst the last is a power given to the public—mainly to persons aggrieved—of calling the authority's or its officials' attention to matters which have not come under the latter's notice during the performance of their routine duties. These duties, in the main, consist, as indicated by the title of the most numerous class of officials (inspectors), of inspection and investigation.

The medical officer of health is required to inspect his district systematically, both periodically and as occasion requires, in order to keep himself informed of conditions which are injurious to health ; and a similar duty is placed upon the sanitary inspector as regards nuisances that require

¹ Sanitary Officers Order, 1926.

abatement. And both have the same duties to perform in regard to the sanitary inspection and control of shipping coming within their area of authority as they have with regard to houses within their district.¹ Other duties involve the systematic inspection of dairies, cowsheds, milk-shops, common lodging-houses, slaughter-houses, offensive trade premises, workshops, bakehouses, food shops and food and the observation of chimneys—other than those of domestic premises—to see that no smoke nuisance arises, and of rivers and streams to see that no pollution occurs. But systematic does not mean at fixed periods, although that also is necessary in several cases ; such a procedure would fail to realize the object of the law, which is to secure a constant and consistent good standard of sanitary conditions.

Local authorities are, however, frequently expressly required to provide for the inspection of their district, and as will be seen in a later chapter² the Central Government, through the Ministry of Health, is empowered to enforce these requirements. The Housing Act, 1925,³ repeats the provision of the Housing of the Working Classes Act, 1890,⁴ requiring every local authority to cause inspections of their district to take place in order to ascertain whether any dwelling therein is unfit for human habitation and to take proceedings where such occur ; and the Ministry of Health is given power to prescribe procedure to be followed and records to be kept.⁵ The more general duty of inspecting the district is provided in the parent Act⁶ for the purpose of ascertaining what nuisances exist, enforcing provisions of the Act to secure their abatement, and to secure that fireplaces and furnaces consume their own smoke.

It is evident that these duties offer adequate scope for the activities of the most energetic officials, and, without

¹ Circular of Ministry of Health, *Sanitary Inspection of Shipping*, issued July, 1921.

² See Chapter XXV.

³ Section 8.

⁴ Section 3.

⁵ Housing Act, 1925, s. 8.

⁶ See Housing (Inspection of District) Regulations, 1910, consolidated 1925.

additions, could be reduced to routine. This, in fact, is in part the *raison d'être* of the specialization of inspectorial functions in the larger towns. But even in these areas the routine work of the district inspector is more or less broken into by the receipt of a constant stream of complaints of various kinds; and in areas where specialization is non-existent or very slight the necessity of inquiring into the validity of complaints, investigating cases of infectious disease, and paying the frequent but irregular visits to the various regulated premises makes it extremely difficult, if not impossible, to carry out the systematic house-to-house visitation and inspection enjoined by the Acts quoted.

The stream of complaints flowing into the office of a public health department is constant and often very large; but the number of complaints received is not necessarily an indication of neglect. It is frequently quite the contrary, for in a well-administered district the officials, recognizing their limitations, encourage reasonable complaints, and thus bring public-spirited citizens to their assistance in the work of keeping themselves acquainted with the sanitary conditions of their district, especially such conditions as are injurious to health. Complaints may be either written, in which case they are sometimes anonymous, or verbal, and invariably receive immediate attention, although some officials have discouraged verbal complaints made to them whilst on their round of duties by referring the complainants to the office. This policy is not one to be recommended or supported; the same fear that prompts some persons sending written complaints to remain anonymous (although it is a maxim of public health officers that the source of the information be not disclosed) is usually the reason for the action of those who prefer to make the complaint to the inspector in the street. To discourage this is to stop the source of much valuable information, and may result in leaving serious sanitary defects unknown and unremedied.

A general power of complaint of the existence of a nuisance

is given to any aggrieved person, any two inhabitant householders of the district, any officer of the local authority, relieving officer, constable or officer of the police force.¹ Similar powers are given to any person to complain of the pollution of a source of water supply used or likely to be used for drinking or domestic purposes,² and of the existence of a drain or other sanitary convenience which is a nuisance or injurious to health.³ In this last case it is essential that the complaint be in writing, as proceedings under this section would be invalid otherwise, but it may be made by the surveyor or the sanitary inspector of the local authority.⁴

It is a matter for regret that this power of complaint given to police officers and relieving officers, particularly the latter, is not made more use of than it is. Both ought to be able to lend valuable assistance in this way to the local sanitary officials, and it ought to be one of the first duties of a relieving officer to ensure that persons in receipt of relief are living under proper conditions, to which end he has the power to call in the sanitary inspector.

Other powers of complaint are given to specified classes or numbers of people, and involve distinctions which it is impossible to justify, as the fact that one person, rather than four or twelve, complains of certain conditions is no criterion of the validity or utility of the complaint. In the case of various trade premises being a nuisance or injurious to health the medical officer of health, two legally qualified medical practitioners, or any ten inhabitants of the district are allowed to certify the fact to the local authority who must lay complaint before a justice.⁵ This appears to give equal powers to the three classes of complainants, but in actual work does nothing of the kind.

¹ Public Health Act, 1875, s. 93.

² *Ibid.*, s. 70.

³ *Ibid.*, s. 41.

⁴ See *Wood Green Urban District Council v. Josephs* (1907), 1 K.B. 182, referred to in note on p. 108, Lumley's *Public Health Acts* (7th edition).

⁵ Public Health Act, 1875, s. 114.

The medical officer of health is the real arbiter ; without his advice and support the complaint of the others will not, as a rule, be acted upon, and, if it were, would seldom, if ever, be successful.

Under the Housing Act, 1925, " a justice of the peace acting within the district, or any four or more local government electors " may complain of the " unhealthiness of any area within such district " and the medical officer of health must forthwith inspect and report to the local authority.¹ Section 10 of the same Act enables a complaint as to the existence of a dwelling-house which is in a condition so dangerous or injurious to health as to be unfit for human habitation to be made by a justice of the peace, the parish council or any four local electors, and the complaint must be in writing. The same persons may make complaint of obstructive buildings, but in this case a written document is not specifically required.² The slight variations in these powers contained in the same Act and intended to secure similar objects are characteristic of much sanitary legislation ; they help to make the law confusing and more difficult for the layman to understand, and serve no practical purpose, however much theoretical justification they may have had.

In addition to the inhabitants and officers of a sanitary district, other authorities and officials have various powers of complaint. The factory inspector is required to give notice in writing to a local authority of any matter in a factory or workshop remediable or punishable under the Public Health Acts, and he may himself enforce the law if the local authority do not report that they have done so within a month of receiving the complaint.³ On the other hand, the medical officer of health is required to give written notice to the factory inspector of any case of the employment of a woman, young person or child in a workshop in which no abstract of the Act is affixed.⁴ Complaint

¹ Section 36.

² Section 19.

³ Factory and Workshop Act, 1901, ss. 5 and 14.

⁴ *Ibid.*, s. 133.

may be made to the Ministry of Health by the county council, a justice of the peace or four or more electors of the neglect of an urban district council to exercise its powers under Part I of the Housing Act, 1925, the parish meeting and council being added in the case of rural districts.¹ Somewhat similar provision is made as regards Parts II and III of the same Act.² A general power of complaint to the Ministry of Health seems to be implied in Section 14 of the Town Planning Act, 1925, dealing with default by a local authority to adopt or execute a town-planning scheme. The power given to urban and rural district and parish councils under the Isolation Hospitals Act, 1893, is implicitly one of complaint; they may petition the county council to provide a hospital for infectious disease, and the county council may do so if satisfied that such an institution is necessary.

The administration of the Alkali, etc., Works Regulation Act, 1906, which consolidated and amended the Acts of 1881 and 1892, is controlled by the Ministry of Health, to whom local authorities are empowered to complain if their officers or any ten inhabitants give information of any contravention of the Act. The Ministry is required to hold an inquiry into the matter complained of, but the fact that the Ministry may require the local authority to pay the expenses of such inquiry is not one to encourage complaints.³

An Act, the enforcement of which was delayed until 1925, gave power to any medical officer of health who has reason to believe that tuberculosis is caused or likely to be caused by milk obtained from cows in another district to complain to the medical officer of health of that district. The latter officer must thereupon cause the suspected cattle to be inspected and the milk examined, giving notice of such inspection both to the complaining medical officer and the dairyman. The council of the local authority (county or county borough) must forward to the medical officer of health who complained copies of all reports made upon

¹ Section 23.² Sections 48 and 73.³ Section 22.

the cattle and milk and inform him of any resultant action taken by them.¹

The National Insurance Act of 1924² repeated with slight amendment, what on the face of it, appeared to be a very formidable power of complaint against the local authority. If an approved society or an Insurance committee allege that any excessive sickness among insured persons is due to (1) the conditions or nature of employment of those persons, or (2) bad housing or insanitary conditions in any locality, or (3) insufficient or contaminated water supply, or (4) neglect on the part of any person or authority to observe or enforce the provisions of any Act relating to the health of workers in factories, workshops, mines, quarries, or other industries, or relating to public health or the housing of the working classes, or any regulations made under such Act, or to observe or enforce any public health precautions, such society or committee may claim from the person or authority alleged to be in default the cost of such excessive sickness. Failing a settlement an appeal may be made to the Ministry of Health. This power is much less formidable than it appears and no use appears to have been made of it, but the fact that it exists may have the effect of stimulating the responsible parties to greater activity, which, after all, is its main object.³

The growth of a civic consciousness and the development of the idea of collective responsibility for the general well-being has given rise to many voluntary associations, national and local, for collecting information on health matters and bringing to the notice of the authorities concerned any conditions which are remediable under the law. Such bodies as the Mansion House Council on Health and Housing, the Rural Housing and Sanitation Association, the Coal Smoke Abatement Society and the various health societies and associations formed in many of the larger towns do

¹ Milk and Dairies (Consolidating) Act, 1915, s. 4.

² Section 107.

³ See article on "Sanitary Authorities and the National Insurance Act," by the author, in the *Westminster Review*, October, 1912.

excellent work; they receive information which would never be given to the local officials, and they are often enabled to arouse and focus strong local opinion upon negligent local authorities.

There is, therefore, no lack of means of deriving information about the sanitary condition of a district. How far they are used will depend upon the local officials; if the latter cultivate the confidence of the people, they will reciprocate by affording early information of conditions which it is the sanitary officer's duty to remove. If not, no surprise must be evinced when an outbreak of disease reveals the existence and responsibility of long-standing sanitary defects.

CHAPTER XII

THE RIGHT OF ENTRY

IN order to carry out their various duties it is necessary that the officials of the sanitary authority should have the right of entering and inspecting the different classes of premises, and of examining the animals and foodstuffs the condition of which may adversely affect the public health. The officials are required to keep themselves acquainted with conditions inimical to health, to search out and secure the abatement of nuisances, and to seize and obtain the condemnation and destruction of all food that is "diseased, unsound, unwholesome or unfit for the food of man"; these duties can only be performed by entering upon private property. Hence, without legal sanction, no search, inspection or examination could be adequate without exposing the officer to an action for trespass. To protect him against such action and to give him the power effectively to perform his duties the numerous statutes have given the officer the right to enter, inspect, and examine various places and things, but at the same time have carefully safeguarded the rights of individuals by prescribing certain forms of procedure. Although these powers are not always adequate and the procedure is often cumbersome and dilatory, it remains true, nevertheless, that whilst the Englishman's home is his castle he now has to lower the drawbridge to permit the sanitary officer to enter when the latter has good grounds for making the request to be allowed to do so.

It might be expected that in such a comparatively simple matter as the right of entry legislation would proceed upon a simple and uniform plan, and such an authority

as Sir Courtenay Ilbert justifies this expectation.¹ The drafting of legislation is a specialized legal business the workers in which, whilst adhering strongly to precedent and similarity of treatment, endeavour to frame laws in as simple a manner as possible compatible with legal lucidity and certainty. The *dictum* of Bentham that "the same thing should always be done in the same way, that way being the best," ought to be indelibly impressed upon the legislator's mind, but a consideration of the statutory powers of entry given to sanitary authorities and their officers gives ample reason to doubt if draftsmen or legislators ever heard of it. In the successive efforts to secure simplicity they have succeeded in creating a complicated variety without obtaining either legal lucidity or certainty.

At the end of this chapter a partial analysis of over thirty different powers of entry and inspection is given, and it is practically impossible to say anything in general terms of them, except that there is an utter lack of system or consistency. At first glance it appears as if the Legislature intended that wherever it is imperative by reason of the circumstances to be dealt with that the inspector should have immediate entry, that should be granted on demand or a penalty incurred. It would seem to be obvious that where the only remedy for refusal to admit the inspector is for the latter to obtain an order from a magistrate, the person offending against the law, whilst refusing to allow the inspector to enter when requested, would be quite willing to do so later when confronted with a magistrate's order, since by that time his offence is removed or discontinued and he is no longer liable to a penalty. Yet this is the case where efforts are made to discover and deal with persons who turn or permit chemical refuse, steam, condensing water, or other liquids above a prescribed temperature to enter into any sewer; and to make matters more difficult the officer must give reasonable notice in writing to the person having custody of the premises he desires to enter of his intention to complain to the

¹ Ilbert, *Legislative Methods and Forms*.

magistrate.¹ Very similar procedure, but without requiring notice of intention to apply for the magistrate's warrant, is prescribed for the case where access to the land or premises to inspect any article of imported food has been refused.²

In all cases the officer is required to have the general or special authorization of his authority to apply for entry and to make the necessary inspection, but in some cases, notably when proceeding under Section 41 of the Public Health Act, 1875, it is essential that the authority be specifically given, and its absence invalidates the subsequent proceedings. In many cases a written notice of intention to apply for entry must be given to the occupier, but apparently its absence cannot be raised by the owner as a defence against subsequent proceedings.³ The Housing Act, 1925, is the only case where the owner, if known, must be notified, as well as the occupier, of the officer's intention to apply for entry, and in this case again, specific authority must be given.⁴

In general practice it is not necessary to fulfil the letter of the law by giving written notice; the vast majority of inspections are carried out with the immediate consent of the occupiers, and it is only in cases where refusal to a verbal request is given or anticipated that the written notices are resorted to. In the same way, although each officer is armed with the certificate of appointment by his authority, it is seldom used, tact and courtesy obviating the necessity except in the rare case of ultra-suspicious or obstinate persons.

One of the witnesses before the last Royal Sanitary Commission affirmed that "sanitary officers wish to have the right to inspect house after house in the same street systematically," and he declared that "in order to obtain a magistrate's order to enter it should not be necessary to show that there is a reasonable ground for believing the nuisance to exist." The sanitary officer ought to be

¹ Public Health Acts Amendment Act, 1890, s. 17.

² Public Health (Imported Food) Regulations, 1925, article 7 (4).

³ See *Bromley Borough Council v. Cheshire* (1907), 72 J.P. 34.

⁴ Section 127.

able to obtain power of entry "whosoever in his discretion he shall think proper to do so."¹ Nearly forty years passed before any definite attempt was made to deal with the difficulties so clearly foreseen. Officers have been burdened with duties, but left without adequate powers to effectively perform them. It was not until this century was well advanced that the right of entry into dwelling-houses was secured, and now it is restricted to those the rentals of which fall below a specified amount, varying according to the population of the district within which they are situated.² The duty of periodically inspecting his district—termed house-to-house inspection—which is imposed upon the sanitary officer could, apart from the above-mentioned provisions of the Housing Act, be rendered quite nugatory if the occupiers uniformly refused to admit him. The remedy is to apply for a magistrate's order requiring the occupier to admit the inspector,³ but the case of *Vines v. The North of London Collegiate School*,⁴ which was an application for a warrant giving power to enter,⁵ decided that some reasonable ground for entry must be shown; it is not sufficient merely to show that the official was acting honestly with a view to the discharge of his business. This rendered the right of entry inoperative except in cases where a complaint had been received or sickness, which made it possible that sanitary defects existed, had occurred. Fortunately, as already noted, tact and discretion on the part of the official, combined with indifference, and, perhaps, ignorance of the law on the part of the occupiers, has made it possible for an immense amount of systematic inspection to take place and a great deal of necessary work to be carried out in rectification of the defects found.

The prescribed times at which inspections may take

¹ Second Report of the Royal Sanitary Commission, 1871 (Cd. 281): Analysis of Evidence (questions 12, 421-6), p. 218.

² Housing and Town Planning Act, 1909, ss. 14 and 15. Cp. Housing Act, 1925, ss. 1, 124 and 127.

³ Public Health Act, 1875, s. 102.

⁴ (1899), 63 J.P. 224.

⁵ Action taken under Public Health (London) Act, 1891, s. 115.

place are not, as a rule, very important, but that cannot be urged as justification or as an excuse for the great diversity shown by the statutes. "All reasonable times" leaves that uncertainty which is the delight of the lawyers, but this is sometimes limited by the addition of "by day" without defining "day," a separate section of a subsequent Act being needed for this purpose in the case of canal boats.¹ And "day," as defined in various Acts, differs; in general it is between 9 a.m. and 6 p.m., but for the purposes of the Infectious Diseases (Prevention) Act, 1890,² it is shortened to the period between 10 a.m. and 6 p.m., whilst the unrepealed Section 9 of the Housing of the Working Classes Act, 1885, extends it to include the time between 6 a.m. and 9 p.m., variations having no practical justification which does not apply in many other cases.

When the official, having, if required, given notice of his intention to apply for admission, makes application for the opportunity of exercising his powers of inspection and is refused or in any way obstructed, he has open to him two courses of action, determined by the particular purpose for which he desires entry. In some cases he may take proceedings in a court of summary jurisdiction and recover penalties for obstruction or refusal, but in others he may only apply for an order of the court calling upon the responsible person to admit him, refusal being then met by a penalty. In either case it will be noted that the final decision rests with the court, which must be convinced that the official has the right to apply for entry, has good reasons for wishing to enter, and, having complied with any necessary procedure, has made application within the limits of time allowed. With the two not unimportant exceptions already indicated, penalties for obstruction are provided for in cases where it is essential that the officer should have instant entry. In all these cases no notice of intention to enter is necessary; such notice

¹ Canal Boats Acts, 1877 (s. 3) and 1884 (s. 9), "6 a.m. to 9 p.m."

² Sections 5, 16 and 17.

would defeat the object of the statute giving the power, since it is obvious that no butcher would ever have diseased or unsound meat on his premises and no regulated premises would be dirty if the inspector notified his intention of calling.¹

In certain circumstances a police officer, who cannot be appointed as a sanitary inspector,² can be endowed with such officer's power of entry and taking proceedings in respect of nuisances. Such powers, however, do not come from the local authority. In cases where individuals complain direct to the justices of the existence of a nuisance, the justices may authorize a constable or any other person to do everything necessary to execute any order made and to recover from the person upon whom the order is made any expenses incurred thereby; for this purpose he has the powers of an officer of the local authority.³ The following section gives power to the Ministry of Health to authorize an officer of police to act where the local authority neglect their duties, and empowers him to recover from the local authority any expenses incurred and not otherwise recovered. The power of entry is not given in this section by reference to the powers of the local officers, but the latter powers are, in the light of the case of *Vines v. The North London Collegiate School* quoted above, clearly if unconsciously stated by the provision that "such officer of police shall not be at liberty to enter any house or part of a house used as the dwelling of any person without such person's consent or without the warrant of a justice." This appears to indicate that the decision of the courts as to the sanitary officer's right to enter is contrary to the intention of the Legislature. Neither of these powers are often used, individual complaints being usually addressed or referred to the local authority, and the Ministry of Health has other means of dealing with neglectful local authorities.

¹ See, however, the Public Health (Meat) Regulations, 1924, which require notice of the slaughtering of animals for human consumption to be given to the local authority.

² Home Office Circular, December 2, 1873.

³ Public Health Act, 1875, s. 105.

The provisions of the Public Health Act, 1875,¹ by which a justice's order for the removal of persons suffering from an infectious disease to a hospital may be addressed to a constable are now practically obsolete, but the same cannot be said of the powers given to local authorities, under the various Food and Drugs Acts, to empower police constables to procure samples and take the necessary subsequent proceedings.² The tendency, however, is to transfer these powers from the police officers to the sanitary inspector or a special officer of the public health department, it being generally recognized that it is not desirable either that the police should be entrusted with what is essentially public health work or that such work should be divided between departments of local administration under the control of different chief officers.

On the whole the consideration of the statutory powers of entry illustrates the oft-quoted opinion that all legislation is to meet exceptional cases. The bulk of public health work is carried on without any explicit reference to these powers; occasionally the officer finds it necessary to produce his authority, sometimes notice of intention to enter is needed, and on rare occasions he is compelled to take proceedings for refusal or obstruction or to assert his rights by securing the order of a justice, but such cases are lost amidst the thousands of entries and inspections that are daily made without hindrance, unpleasantness or challenge.

¹ Section 124.

² Food and Drugs (Adulteration) Act, 1928, s. 16.

POWERS OF ENTRY

Premises.	Purpose.	Notice.	Time.	Provision for Refusal.	Statutes, etc.
Any premises or ships .	To examine as to the existence of nuisance and to enforce abatement	None	9 a.m. to 6 p.m. or when business is in progress or usually carried on	Magistrate's Order	Public Health Act, 1875, ss. 98, 102, 104 and 110
Any premises	To examine water fittings	"	All reasonable times	Dealt with as breach of agreement	<i>Ibid.</i> , s. 58
Any premises	To inspect and examine any animal, carcass, meat, etc., exposed or deposited for sale or intended for human food	"	"	Penalty for obstruction. Magistrate's Warrant	Public Health Act, 1875, ss. 116 to 119; Public Health Acts Amendment Act, 1890, s. 28
Any premises	Ditto, as regards horseflesh intended for human food	"	"	"	Sale of Horseflesh Act, 1889, ss. 3 and 4
Occupied dwelling-houses	To ascertain if house has a supply of water	"	Public Health Act, 1875, ss. 102-3 apply	Public Health Act, 1875, ss. 102-3 apply	Public Health (Water) Act, 1878, s. 7.
Any premises	To examine drains, etc., of which a written complaint has been received	24 hours' written notice to occupier except in cases of emergency	9 a.m. to 6 p.m.	Magistrate's Order	Public Health Act, 1875, s. 41

Any houses, premises or buildings to which Housing Act, 1925 applies	In performance of any duty imposed by Act	24 hours' notice to occupier and to owner	All reasonable times	Penalty for obstruction	Housing Act, 1925, ss. 123 and 127
Roads, streets, places and lands	For purpose of making sewers	Reasonable notice in writing to owner or occupier	None prescribed	Authority to commence action for a declaration of their right to enter	Public Health Act, 1875, s. 16
"	For making and maintaining water mains	"	All reasonable times	"	<i>Ibid.</i> , s. 54.
Any land or premises . . .	For making plans, surveying, measuring, levelling. Making, examining, or repairing works. Ascertaining course of drains or sewers. Ascertaining or fixing boundaries	Reasonable notice in writing to owner or occupier	9 a.m. to 6 p.m.	Magistrate's Order	Public Health Act, 1875, s. 305
Any premises	To examine whether any matter is being turned into sewers so as to cause a nuisance or danger or injury to health	None	Any time	"	Public Health Acts Amendment Act, 1890, s. 17 (Adoptive)
Common lodging-houses	Inspection of premises	"	"	Penalty for obstruction	Public Health Act, 1875, s. 85

POWERS OF ENTRY—*contd.*

Premises.	Purpose.	Notice.	Time.	Provision for Refusal.	Statutes, etc.
Dwelling-houses, including lodging-houses provided under Housing Act, 1925 or Acts repealed thereby	Inspection of Premises	None	Any time	Penalty for obstruction	Housing Act, 1925, ss. 69 and 123
Houses let in lodgings .	To enforce bye-laws	"	All reasonable times	"	Public Health Act, 1875, s. 90
Tents, vans, sheds, or similar structures	To enforce provisions of Act and bye-laws	"	6 a.m. to 9 p.m.	"	Housing of the Working Classes Act, 1885, s. 9
Any premises or vessel	To execute or superintend execution of orders of Ministry of Health under s. 134, Public Health Act, 1875	"	Any time	"	Public Health Act, 1875, ss. 137 and 140; Public Health Act, 1896, s. 1
Any premises, ship or vessel	To remove any person suffering from any dangerous infectious disorder, and is without proper lodging accommodation, to hospital (certificate of a medical practitioner and a magistrate's order required).	"	None	"	Public Health Act, 1875, s. 124
Any ships	To determine whether there are any cases of cholera on board	"	All times	"	<i>Ibid.</i> , s. 130, and Regulations of the Ministry of Health

Any house or part thereof	To cleanse and disinfect any house or part of a house or any articles likely to retain infection	24 hours' written notice to owner of occupier	10 a.m. to 6 p.m.	Penalty for obstruction	Infectious Disease (Prevention) Act, 1890, ss. 5, 16 and 17
Any premises (including tents, vans, sheds or boats) infested or suspected of being infested with vermin, or containing articles so infested or suspected of being so infested	For purposes of inspecting, cleansing, etc., such premises or articles	None	Public Health Act, 1875, ss. 102-3 apply	Public Health Act, 1875, ss. 102-3 apply	Public Health Act, 1925, ss. 45-6-7 and 50
Slaughter-houses . . .	To inspect premises, animals or meat	"	All reasonable times	Penalty for obstruction	Public Health Act, 1875, s. 169
Cowsheds	To examine and have milked any bovine animal therein and take samples (veterinary inspector)	"	"	"	Tuberculosis Order, 1925, s. 4; Diseases of Animals Act, 1894.
Any lands or premises, or any ship on which food is imported	To inspect and sample food	"	"	Magistrate's Warrant	Public Health (Imported Food) Regulations, 1925
Any premises	To enforce orders and regulations of Ministry of Health	"	Public Health Act, 1875, ss. 102 and 103 apply	Public Health Act, 1875, ss. 102 and 103 apply	Contagious Diseases (Animals) Act, 1886, s. 9
Butter Factories	To inspect and sample (special authority)	"	All reasonable times	Penalty for obstruction	Food and Drugs (Adulteration) Act, 1928, ss. 22 and 24

POWERS OF ENTRY—*contd.*

Premises.	Purpose.	Notice.	Time.	Provision for Refusal.	Statutes, etc.
Any land, shed, building, place or vessel	To enforce provisions of Act	If required, reason for entering must be stated in writing	Any time	Penalty for obstruction	Diseases of Animals Act, 1894, ss. 44, 51 and 52
Dairies, cowsheds and milkshops	To inspect premises, utensils and animals	None	All reasonable times	..	Milk and Dairies (Consolidation) Act, 1915, ss. 2 and 14
Cowsheds, within or without district, from which milk is suspected to cause or be likely to cause tuberculosis in consumers	To inspect cattle	Sufficient notice	Public Health Act, 1875, ss. 102-3 apply	Public Health Act, 1875, ss. 102-3 apply	<i>Ibid.</i> , ss. 2 and 4
Rooms in which food is prepared, sold or stored or kept with view to future sale	To inspect premises	None	All reasonable times	Penalty for obstruction	Public Health Act, 1925, s. 72
Any premises where articles to which Regulations apply are prepared, packed, labelled or stored	To inspect premises, foodstuffs, etc., and take samples	..	All reasonable times	Penalty for obstruction	Public Health (Preservatives in Food) Regulations, 1925, s. 6
Any premises where dried milk is prepared, packed, labelled or stored	To inspect any process and take samples	Public Health (Dried Milk) Regulations, 1923, s. 6

Ditto, as regards condensed milk	"	"	"	"	Public Health (Condensed Milk) Regulations, 1923, s. 6
Bakehouses	To enforce provisions of Act	"	All reasonable times by day or night	"	Factory and Workshop Act, 1901, ss. 102 and 119. Ministry of Health (Factories and Workshops Transfer of Powers) Order, 1921.
Workshops, workplaces and laundries	"	"	"	"	Factory and Workshop Act, 1901, ss. 119 and 125. Factory and Workshop Act, 1907, s. 6
Factories and workshops	To inspect lists of out-workers employed by occupier of factory or workshop	"	All reasonable times	"	Factory and Workshop Act, 1901, s. 107
Retail Shops	To enforce provisions of Acts	"	All reasonable times by day or night	"	Shops Act, 1912, s. 13
Canal boats	To enforce provisions of Acts	"	9 a.m. to 6 p.m.	"	Canal Boats Acts, 1877 (s. 5) ; 1884 (s. 9)
Any premises	To examine and take samples of rag flocks	"	All reasonable times	"	Rag Flock Act, 1911, s. 1
Any land	To enforce provisions of Act	None for inspection ; 24 hours' notice to carry out works in default	No time specified	"	Rats and Mice (Destruction) Act, 1919, s. 5

CHAPTER XIII

OBJECTS AND METHODS OF INSPECTION

THE surveys already made of the duties of the sanitary authorities and their powers of entry upon private property of various classes have disclosed one of the chief functions of the officers of a public health department to be that of inspection. The oldest officer is the sanitary inspector, under his previous title of inspector of nuisances, but the powers of inspection have been extended to many things, to many places, and for other purposes than merely looking for nuisances, using the word in a sense restricted to its legal connotation. In general terms the object of inspection is the prevention of the occurrence of those conditions which are prohibited by law, their removal where they are discovered, and, in certain cases, the punishment of those persons who cause or allow them to exist.

The various classes of nuisances categorically specified in the very important 91st section of the Public Health Act, 1875, have been added to by later legislation bringing special conditions within the scope of this and the succeeding sections. The fact that the terms "nuisance or injurious to health" ¹ are used disjunctively relieves the officer from the onus of proving injury in the majority of cases; "it is sufficient if the nuisance is one which interferes with personal comfort." ² In addition to the conditions defined as nuisances in and by reference to the above section, there are others specifically aimed at in the same and succeeding Acts, it often happening that the inspector has

¹ In the Public Health (London) Act, 1891, s. 2, the words are "nuisance, dangerous or injurious to health."

² *Bishop Auckland Local Board v. Bishop Auckland Iron Company* (1882), 10 Q.B.D. 138.

a choice of proceedings in order to secure abatement. It is worthy of note that as public health legislation has developed and various new conditions have been specially prohibited, officials in their reports have included all these conditions under the head of "nuisances" although they could not be dealt with under the "nuisance" clause of the Public Health Act. The periodical cleansing of bakehouses, cowsheds, and common lodging-houses can be enforced by the sanitary authority, and, if official action has been necessary, each case is considered as the abatement of a nuisance, although without the special law it might not be possible to deal with them.¹

Conditions causing a nuisance may arise in connection with premises, animals or things, of which the first are the most numerous and include premises which as a result of their use are subject to special regulation. Administrative efforts have been made to extend the application of the clause "premises in such a state as to be a nuisance or injurious to health" so as to include the existence of conditions on, but not of, the premises, but the courts have expressed the opinion that "it is confined to cases in which the premises themselves are decayed, dilapidated, dirty or out of order."² Other conditions, such as an accumulation of offensive matter, must be dealt with under other clauses.

The inspection of a dwelling-house, to be complete, includes a survey of the structure from top to bottom and the testing of the drains by one or the other of the various methods in use. These methods, as well as the various defects which inspection of the premises may reveal, are enumerated in most books dealing with practical sanitation. Each defect may constitute a separate nuisance, but the sum of defects may be such as to bring the house within the scope of the term "unfit for human habitation" and liable to be closed and demolished under the provisions

¹ See statements of nuisances abated in the reports of medical officers and sanitary inspectors. Cp. list of nuisances on pp. 130-1 of the index to Lumley's *Public Health Acts* (7th edition).

² In *Regina v. Parby* (1889), 22 Q.B.D. 520.

of the Housing Act, 1925.¹ The provisions prohibiting overcrowding direct the inspector's inquiry as to the number and ages of the occupants and their relation to the number of rooms and amount of air space occupied by each family group, which may include lodgers. Unfortunately there is no legal definition of overcrowding of a dwelling, and officers are compelled to adopt standards of their own, which are not always identical; the legal standard for common lodging-houses of 300 cubic feet of air space per head or the more empirical one of permitting an average of two adults per room seem to find the most favour with officers engaged in the actual work. For canal boats² and factories and workshops³ standards are prescribed by law, and bye-laws for the regulation of common lodging-houses and houses let in lodgings invariably fix a standard for such premises.

Recent legislation has facilitated the inspector's work and created a new offence by requiring persons collecting rents from working-class dwelling-houses to inscribe in the rent-book the names and addresses of the medical officer of health and of the landlord or other person directly responsible for keeping the house reasonably fit for human habitation.⁴ The abnormal character of post-war housing conditions resulted in legislation to limit increases of rent of certain classes of houses and gave the tenants power to apply to the local authority for a certificate that the "house is not in all respects reasonably fit for human habitation, or is otherwise not in a reasonable state of repair." If, on inspection, the complaint is found to be justified, the certificate is granted, and if the tenant delivers a copy to the owner, certain deductions may be made from the rent until such time as the necessary works are done and the certificate discharged by the local authority.⁵

¹ Sections 11 to 15.

² Canal Boats Act, 1877, s. 2, and Regulations issued in March, 1878.

³ Factory and Workshop Act, 1901, s. 3.

⁴ Housing Act, 1925, s. 5.

⁵ Increase of Rent and Mortgage Interest (Restriction) Acts, 1920 (s. 2) and 1923 (s. 5).

Where Part IV of the Public Health Act, 1925, has been adopted the further duties of inspecting the premises to see if they or any persons or articles therein are infested with vermin falls upon the officer, whilst the Rats and Mice (Destruction) Act, 1919, gives power to deal with land infested with rats or mice, the responsibility for which is often a difficult matter as these rodents frequently lodge in one place and board in another.

The keeping of animals so as to be a nuisance or injurious to health is prohibited, and the prohibition is amplified as regards one class of animals (swine), which, in an urban district, may not be kept in any dwelling-house.¹ These provisions sometimes give rise to much misconception on the part of the public as to their application and the consequent complaints of barking dogs, crowing cocks or cooing pigeons; such things are quite outside the range of the sanitary officer's activity, as they are not remediable under the Public Health Acts. The cow, as being the source of the milk supply, is the subject of special legislation affecting its health and dwelling, to which reference will be presently made. It is, however, interesting to note that the cow occupied a more favourable position in sanitary legislation than the ordinary human being, inasmuch as a minimum air space per head was usually prescribed for it in the shed;² it has, however, now fallen from its high estate since all local regulations have been revoked.³

The nuisances arising from conditions of things are often difficult to dissociate from places; in the case of verminous things, mentioned above, it may be also from persons. Accumulations of refuse and other matter or dirty and offensive receptacles for the storage of organic matter frequently arise from the keeping of animals, especially in places unsuitable for them, or on trade premises where substances of animal or vegetable origin are dealt with; either entails slightly different procedure to secure its

¹ Public Health Act, 1875, s. 47.

² Local Regulations for Dairies, Cowsheds and Milkshops.

³ Milk and Dairies Order, 1920, article 5.

removal. The water supply of many districts is under the control of an authority—public or private—or department other than that to which the medical officer of health or sanitary inspector belongs, but there are many wells in various parts of the country. The sanitary officer is required to see that the supply is not only sufficient in quantity but pure in quality, and, in the case of wells, to take steps to prevent the pollution of the water or its use if polluted. The determination, by chemical analysis and bacteriological examination, of the purity of the water supply is sometimes, but not often, a duty of one of the medical men employed by the local authority; in general it is delegated to the public analyst. The sanitary officer, however, has to decide when it is desirable to have the water tested, and upon him falls the duty of taking the sample and submitting it, together with notes of the reason for taking it and the structure and environment of the well or other source from which it has been taken, to the analyst.

The prevention of pollution of rivers is not altogether disconnected from the question of water supply. In industrial districts it entails long and monotonous watching of the banks of streams upon which manufacturing premises abut, and the careful sampling of the water to secure scientific evidence of the effects of effluents which the vigilance of the inspector has detected. The detection of smoke nuisances involves extended and wearisome observations similar to those for the prevention of the pollution of rivers, but here the nuisance arises in a different element and the inspector has to rely upon his own ocular evidence of the density and duration of the smoke, and his mechanical knowledge of fireplaces and furnaces, and the best means of preventing the emission of smoke which need no longer be black in order to constitute a nuisance.¹ It is increasingly becoming the practice to utilize the camera as a means of recording the emission of smoke. The length of time during which the chimney is kept under observation varies in different districts, and the character and period of

¹ Public Health (Smoke Abatement) Act, 1926.

emission of smoke deemed to be a nuisance is subject to wide variations.

There are many premises, used for particular purposes, which are specially regulated. Slaughter-houses and knackers' yards may not be used until they are licensed, common lodging-houses and canal boats must be registered before use, and offensive trades may not be established in an urban district without the consent of the local authority, which in each case must be satisfied that the premises are suitable for their proposed purpose. The duty of reporting upon the premises and of inspecting them at irregular intervals afterwards devolves upon the sanitary officers, who in the former case direct their attention first to the general condition of the premises, and next to their suitability for the special purpose to which they are to be put. In the case of offensive trades this involves a consideration of the methods and machinery which are proposed to be adopted, and in common lodging-houses and canal boats, of the numbers and sexes for which the cubic capacity and arrangement of the rooms and cabins are suitable. After establishment these premises and the businesses carried on therein are regulated by bye-laws or regulations providing for cleanliness of premises, utensils and implements, inoffensive storage of material, absence of overcrowding, and other details with which the inspector must be familiar. In houses let in lodgings, fruit-pickers' dwellings, tents, vans and sheds the object of the inspection is to ensure that the bye-laws, if any, are complied with, the same purpose, directed by regulations prescribing air space, lighting, ventilation, and cleanliness of animals, utensils and premises being behind the inspection of dairies, cowsheds and milkshops. The object of inspecting factories, workshops, laundries and bakeries is to secure that the provisions of the Factory and Workshop Acts are not infringed, and, like the inspection of all regulated places, resolves itself into investigating the structural soundness, special fitness and constant cleanliness of the premises.

The inspection of houses occupied by "outworkers" is

based upon the returns of such persons, which must be supplied twice yearly by the employers to the local authority. The inspection is directed to securing that the premises are hygienically suitable, and that there is no danger of the carriage of infectious disease by means of the commodities dealt with therein.

Inspections made for the purposes of the Shops Acts are difficult on account of the complexity of their provisions, and so far appear to be not altogether satisfactory in results. Visits for these purposes involve observation of the display of the various notices required to be exhibited, and the presence of the requisite number of seats for shop assistants, although the use of such seats is a matter of no moment. To enforce the provisions as regards the weekly half-holiday and closing orders the inspector must not only keep a constant watch on the shops, but, in order to secure evidence of the infringement of the law, finds it necessary to engage an assistant to make test purchases. This procedure, necessary as it is, is open to much misconception. The officer, or the authority for which he acts, is always liable to the charge of acting as an *agent provocateur*, and of "deliberately seducing citizens to break the law."¹ The difficulty is not singular to the administration of the Shops Acts; it arises in other cases² where, in order to lull the suspicions of offenders, it is essential that agents should act as much as possible like members of the general public.

To obtain evidence of breaches of the law relating to hours of employment of children and young persons all the tact and discretion that an inspector is likely to possess are required.³ In the main, he must rely upon the evidence of the employee, whom he has power to question, but who, as a rule, is more concerned with keeping his employment than with giving evidence that may incriminate his employer. It is not surprising that in such circumstances

¹ Leading article, *Evening News*, November 27, 1913.

² Food and Drugs and Weights and Measures Acts.

³ Shops Act, 1913, Employment of Children Act, 1903, and Employment of Women, Young Persons and Children Act, 1920.

the inspector finds himself up against "a wall of lies," and that when he has obtained the necessary evidence and taken legal proceedings the employee often contradicts under oath in the witness-box the signed information he has given to the inspector at the time of his visit.

The methods of investigating cases of infectious disease, of inspecting food and of sampling food and drugs, must be dealt with separately,¹ but a class of inspections which occupies a large part of an inspector's time must be noted. As a result of the various inspections different nuisances are found and steps taken to secure their abatement by the persons responsible.² But the matter cannot be left here; it is necessary to see that they are properly abated and not likely to recur, hence "re-inspections" are entailed. The number and duration of these will be determined by the alacrity with which the persons responsible obey the demands for abatement and the extent of the works necessary to secure the removal of the nuisance. A single visit may suffice, or a long series of daily inspections may be required in cases where large and complicated re-drainage works must be carried out.

The Royal Sanitary Commissioners in their Report of 1871 laid down as one of the principles of successful public health administration that "the efficiency of officers is as important as their ubiquity. They must be well instructed and capable, without the pedantry and officiousness of sciolists. Ignorance, pretentiousness, or overmeddling would bring into disrepute any sanitary system. In a free country disrepute means failure." In carrying out his multifarious duties the sanitary officer must necessarily be endowed with a considerable amount of tact, courtesy and discretion. Technical and legal knowledge is not sufficient; it must be combined with the capacity to adapt means to ends and an absence of that superiority and aloofness which too many officials adopt. He is the eyes and ears of the department. If well advised he, rather

¹ See Chapters XV and XVI.

² See next chapter.

than rely upon his unaided memory, makes careful notes and sketches of what he finds, and, whilst giving careful and courteous attention to what he is told, is very cautious how he relies upon information received. It is due to the fact that the staffs of the sanitary authorities of this country possess these characteristics in a marked degree that inspection creates little friction or resentment, and that no small measure of success has attended the administrative efforts on behalf of the public health.

CHAPTER XIV

THE ABATEMENT OF NUISANCES

IN the early days of public health legislation and administration the chief object sought was the abatement of nuisances ; hence the first official title—inspector of nuisances. As time passed, however, other duties, such as food inspection, have been added, and the list of prohibitions and requirements have been greatly extended until, as already indicated, the title became a misnomer and has been changed.¹ But for statistical purposes it is customary to class under the head of “ Nuisances ” all those conditions which are prohibited and the absence of those conditions which are required by law. The term “ nuisance ” has therefore a positive and negative aspect which appears to have had some little influence upon the procedure prescribed for their abatement.

It is necessary to keep in mind the fact that whilst in the last resort official action must be strictly in accordance with the terms of the law, this does not preclude the official from exercising his powers of persuasion—verbal or written—to secure compliance with the law. This is a practice very extensively followed, and with great success. It has the advantages of saving time otherwise lost over the formal but necessary details of procedure, of obviating friction with owners and others, many of whom are more amenable to personal persuasion than to legal pressure, and of frequently securing the rectification of minor matters which do not come within the ambit of the law.

Nuisances arise as the result of individuals doing what they are expressly forbidden to do (such as establishing an offensive trade in an urban district without the authority's

¹ Public Health (Officers) Act, 1921, s. 3.

consent, or overcrowding any premises), or failing to do those things which they are required to do (as neglecting to provide a water supply to dwelling-houses or to keep drains in good order) by statute, bye-law or regulation. The distinction is not of great importance, but it seems to have been used to divide those cases in which an official notice of the existence of a nuisance is necessary from those in which it is not, although, as will be gathered from the tabular statement at the end of this chapter, there are exceptions. As a matter of fact, it is customary to serve a notice upon the offenders in practically all cases, whether legally necessary or not; such a policy avoids the possibility of the official or the authority being charged with harsh or high-handed action, and it gives an opportunity to those who are not the actual offenders, although legally responsible, to take steps to remedy the nuisance and prevent its recurrence.

In London and in Scotland an intimation of the existence of a nuisance is required to be sent to the person responsible for its abatement,¹ and the bulk of the nuisances are remedied in this way. In the provinces this policy, although not compulsory, is frequently followed, with equal success. In both cases this applies to breaches of bye-laws no notice of which is required. If the nuisance remains unabated the next step lies with the local authority, which has to consider the facts and sanction the subsequent proceedings, which may be either the service of a statutory notice to abate the nuisance, or the laying of an information in the prescribed court, or the carrying out of the necessary works by the authority's officers and the recovery of the costs incurred. It is essential that this authority be first secured, or the subsequent proceedings may be pronounced invalid; the officer can seldom take action on his own initiative. It has been held, however, in a case under the Metropolis Management Act, 1855,² that a resolution of the duly appointed public health committee was sufficient

¹ Public Health (London) Act, 1891, s. 3; Public Health (Scotland) Act, 1897, s. 19.

² Section 85.

without the previous approval of the vestry.¹ An exception to this procedure is found in the case where the sanitary inspector of an urban district is empowered to act on his own initiative and deal with accumulations of offensive matter.²

The same line of division which separates the cases in which a statutory notice is necessary from those in which it is not also appears to separate those cases in which the local authority have the alternatives of themselves causing the work to be done and recovering the costs or of complaining to the courts from those cases which must go to the courts for adjudication, but again there are exceptions which prevent a clear-cut classification. Local authorities are, however, chary of exercising the powers of doing work and incurring expenses which may be recovered with great difficulty, and in general prefer to obtain the order of the court to abate the nuisance and the infliction of penalties where they are provided for.

The persons responsible for abating nuisances are specified in the various enactments designating the nuisance. The occupier is liable for keeping swine in a dwelling-house ;³ the owner in the case of a house without a proper supply of water ;⁴ whilst in the cases of defective drains and sanitary fittings⁵ or offensive accumulations,⁶ notice may be served upon the owner or occupier, but if the local authority carry out the work in default, the expenses incurred thereby can only be recovered from the owner, although in the former case, where a penalty for non-compliance with the notice is provided for, the occupier may be fined if the notice has been served upon him. For the purpose of the " nuisance " clause of the Public Health Act, 1875,⁷ notice must be served upon " the person by whose act, default or sufferance the nuisance arises or continues," or " if such person cannot be found, upon the owner or occupier of the premises on which the nuisance arises." To this there are the provisos that the owner is

¹ *Firth v. Staines* (1897), 2 Q.B. 70; see also Chapter VI.

² See Table at end of chapter.

³ Public Health Act, 1875, s. 47.

⁴ *Ibid.*, s. 62.

⁵ *Ibid.*, s. 41.

⁶ *Ibid.*, s. 49.

⁷ Section 91.

responsible where "the nuisance arises from the want or defective construction of any structural convenience or where there is no occupier," and if "the person causing the nuisance cannot be found and it is clear that it does not arise or continue by the act, default or sufferance of the owner or occupier the local authority may themselves abate the nuisance without further order."¹ The question of responsibility is a large one, which has led to considerable litigation and many judicial decisions which are not altogether consistent and clear.² In determining upon whom to serve the notice the local authority is under no necessity to consider any arrangement entered into between owner and tenant; if the owner is responsible the notice is served and may be enforced upon him, leaving him to seek any remedy he may have against the tenant.

It is noteworthy that a mere rent collector comes within the definition of "owner" and as such may be served with a notice to abate a nuisance, and an order may be made upon him even if he has resigned his post since service of the notice to abate.³ "The object of the legislature seems to have been that as the occupier was often poor, and the real owner might be difficult to discover, it was as well to get at the collector of rents who could always be found out; and therefore the person who receives the rack-rent from the occupier is deemed the 'owner'."⁴ It was not always easy to discover even the collector's name and address, but the task is now greatly simplified in the cases of houses intended or used for occupation by the working classes by the requirement that every tenant must be furnished with "the name and address of the landlord or other person who is directly responsible for keeping the house in all respects reasonably fit for human habitation."⁵ The question as to whether or not an actual owner who sells his property between the receipt of a notice and the

¹ Public Health Act, 1875, s. 94.

² See Notes to Section 104 of the Public Health Act, 1875, and others dealing with specific nuisances in Lumley's *Public Health Acts*.

³ *Broadbent v. Shepherd* (1901); 2 K.B. 274.

⁴ Blackburn, J., in *Cook v. Montague* (1872), L.R. 7 Q.B. 418.

⁵ Housing Act, 1925, s. 5.

hearing of the complaint by the justices thereby divests himself of his responsibility has not apparently been decided, but the probability is that he does not, although the difficulties in the way of enforcing such responsibility do not encourage local authorities to pursue him.

The form of the statutory notice is specified in the Fourth Schedule of the Public Health Act, 1875, together with other forms required in pursuance of the duty of the local authority to secure the abatement of nuisances. The time within which the nuisance must be abated must be specified on the notice, and varies from "forthwith" in the case of choked drains or the more urgent and gross nuisances to fourteen or twenty-one days where more or less considerable work is required. In the metropolis and Scotland a specification of the works necessary to abate the nuisance is not required, but for the provincial districts it has been decided that "an order under Section 96 of the Public Health Act, 1875, whether it be made at the instance of the local authority or of a private individual, and whether it be for the abatement of a nuisance or for the prohibition of the recurrence of a nuisance, must specify the works necessary to abate the nuisance or prevent its recurrence as the case may be, if any works are necessary for that purpose. But where the recurrence of a nuisance can be prevented by merely refraining from doing the acts which caused it, and no works are necessary to prevent its recurrence, an order simply prohibiting the doing of any acts which may lead to a recurrence of the nuisance is good."¹ This requirement, which, of course, does not apply in the case of nuisances arising from the emission of smoke from a chimney other than that of a dwelling-house,² is open to some objection. Nuisances may often be abated in more than one way, and since the local authority are concerned solely with their abatement, it should be a matter of indifference to them which method is adopted. From the point of view of the person called

¹ *The Queen v. Horrocks and Others*, 64 J.P. 661; 69 L.J.Q.B. 688.

² *Millard v. Westall* (1898), 1 Q.B. 342.

upon to abate the nuisance it is a matter of importance to choose the cheapest way, a fact which need not enter into the consideration of the local authority causing the notice to be served. It is, moreover, very doubtful if the authority can enforce the work specified on the notice if the nuisance has been abated in some other way and is not likely to recur.

Notices, orders and other documents may be wholly or partly in writing or print, and are sufficiently authenticated by the signature of the clerk, surveyor or sanitary inspector of the local authority.¹ The medical officer of health is here omitted, but in many places the medical officer of health signs by virtue of his power to exercise any of the powers of a sanitary inspector.² As a rule notices are served by pre-paid post at the residence of the person to whom they are addressed, but they may be served by hand, and in cases where they are addressed to the owner or occupier of the premises, and where there is no one on the premises to receive them, they may be affixed on a conspicuous part of the premises. In either case it is necessary in subsequent proceedings to prove that service has been properly carried out.

If the notice served is not complied with, the local authority have various methods of proceeding to secure compliance. In some cases they may enter the premises and carry out the necessary works, recovering the costs incurred; in others they may lay an information at a court of summary jurisdiction, asking for an order upon the person at default to comply with the notice and for penalties; whilst in other cases they may do either, and in some cases both.³ But the final word, except in procedure under the Housing Act, 1925,⁴ for the closing and demolition of houses unfit for habitation, always rests with the courts, which must be satisfied of the existence of the offence and that the prescribed procedure has been complied with.

In dealing with insanitary areas under Part II of the Housing Act, 1925, the ultimate factor is the Ministry of

¹ Public Health Act, 1875, s. 266.

² *Ibid.*, s. 191.

³ See tabular statement at end of chapter.

⁴ Sections 10 to 14, and as regards obstructive buildings, s. 19.

Health which must be petitioned to make an order confirming the scheme of improvement.¹ A closing order is obtainable from the courts in the case of cellar-dwellings for which two convictions for illegal occupation have been obtained within three months ;² or where a " house is unfit for human habitation,"³ or where two convictions for overcrowding have taken place within three months.⁴ In the second case proceedings may be taken under Part I of the Housing Act, 1925, in which event, if notice to render fit has not been complied with, a demolition order may be made, and where default still exists, the local authority may do the work and sell the material, any excess of receipts over the expenses incurred being handed to the owner.⁵ This procedure, incorporating provisions of the repealed Housing and Town Planning Act, 1909, considerably simplifies the work of the local authorities, removes the necessity of appeal to the courts and makes the Ministry of Health the ultimate arbiter between the local authorities and owners. That these powers are a powerful lever in the hands of local authorities for securing improved housing conditions is shown by the fact that in 1,677 districts for which returns were tabulated for 1925, notices were served in respect of 24,369 houses, of which 18,961 were rendered fit by their owners, 785 by the local authorities, while in 463 cases the owners gave notice of their intention to close the houses. As regards closing and demolition orders the figures were as follows :⁶

Representations made with a view to closing orders	3,141
Dwelling-houses in respect of which closing orders were made	2,287
Closing orders determined after houses were made fit	443
Dwelling-houses in respect of which demolition orders were made	549
Dwelling-houses demolished in pursuance of demolition orders	678

¹ Section 40. ² Public Health Act, 1875, s. 75.
³ *Ibid.*, ss. 91 *et seq.* ⁴ *Ibid.*, s. 109.
⁵ Section 15.
⁶ These and preceding figures taken from Eighth Annual Report of the Ministry of Health, pp. 62-3.

METHODS OF ABATING NUISANCES

Offence.	Notice Required.	In default.		Statutes.
		Powers of Local Authority.	Powers of Court.	
Erection of houses without privy accommodation	None	Complain to Court	Penalty	Public Health Act, 1875, s. 35
Absence of privy accommodation for houses	Notice	May do necessary work and recover costs	—	<i>Ibid.</i> , s. 36
Absence of privy accommodation for factories, etc.	"	—	Penalty and daily penalty	<i>Ibid.</i> , s. 38; also Public Health Acts Amendment Act, 1890, s. 22, and Factory and Workshops Act, 1901, s. 9
Drainage, etc., not being in proper order	"	May complain to Court or do necessary work and recover costs	Daily penalty	Public Health Act, 1875, s. 41
Illegal connection of drain to sewer	None	May complain to Court or do necessary work and recover costs	Penalty	<i>Ibid.</i> , s. 21
Undrained buildings . .	Notice	May do necessary work and recover costs	—	<i>Ibid.</i> , s. 23
Unauthorized building over sewers or under streets	"	May do necessary work and recover costs. Forfeit and daily penalty to L.A.	—	<i>Ibid.</i> , s. 26

Causing or permitting petrol spirit or carbide of calcium to enter sewer	"	Complain to Court	Penalty and daily penalty	Public Health Act, 1925, s. 41 (Adoptive)
Unventilated soil pipes	Notice	May do necessary work and recover costs	—	Public Health Act, 1925, s. 42 (Adoptive)
Houses requiring to be cleansed or purified	"	May complain to Court or do necessary work and recover costs	Daily penalty	Public Health Act, 1875, s. 46
Verminous houses . . .	Notice	May complain to Court and do necessary work and recover costs	Penalty and daily penalty	Public Health Act, 1925, s. 46 (Adoptive)
Verminous articles . . .	None. Certificate of Medical Officer of Health or Sanitary Inspector	May cleanse, disinfect or destroy, compensating for any damage if condition is not fault of owner	—	<i>Ibid.</i> , s. 45
Verminous persons . . .	Report by Medical Officer of Health	May cause removal to a cleansing station with person's consent	If consent is withheld Court may order removal	<i>Ibid.</i> , s. 48.
Swine in dwellings; waste or stagnant water in dwellings; soakage from w.c., etc. (Urban)	None	May complain to Court or do work and recover costs	Penalty and daily penalty	Public Health Act, 1875, s. 47
Accumulation of filth (Urban)	24 hours' notice	L.A. may remove and sell, recovering any excess of cost over receipts or paying to owner any excess of receipts over cost	—	<i>Ibid.</i> , s. 49

METHODS OF ABATING NUISANCES—*contd.*

Offence.	Notice Required.	In default.		Statutes.
		Powers of Local Authority.	Powers of Court.	
Non-removal of manure at stated intervals (Urban)	Public Notice	Complain to Court	Daily penalty	Public Health Act, 1875, s. 50
Foul or offensive water-courses or ditches on or near boundary of district	None	Complain to Court having jurisdiction in area	Order execution of necessary work and apportion costs	<i>Ibid.</i> , s. 48
Culverts requiring repair or cleansing (Urban)	Notice	May do necessary work and recover costs	—	Public Health Act 1925, s. 53 (Adoptive)
Watercourses choked or silted up (Urban)	„	Sections 91 <i>et seq.</i> of the Public Health Act, 1875 apply	Sections 91 <i>et seq.</i> of the Public Health Act, 1875 apply	<i>Ibid.</i> , s. 54 (Adoptive)
Absence of water supply to houses	„	May provide or contract for supply and recover costs	—	Public Health Act, 1875, s. 62
Pollution of water with gas washings	24 hours' notice from L.A. or owner of water	—	Penalty (£200) and daily penalty (sued for in superior courts during continuance or within six months of cessation of offence)	<i>Ibid.</i> , s. 68
Polluted public or private water supply	None	Complain to Court. May do work and recover costs if order is made and disobeyed	Order to temporarily or permanently close supply or restrict its use to certain purposes only	<i>Ibid.</i> , S. 70.

Cellar-dwellings illegally occupied	Notice	Complain to Court	Daily penalty. Closure if two convictions within three months	<i>Ibid.</i> , ss. 71 to 75
"	Notice of Closing Order; appeal within 14 days to Ministry of Health	Make Closing Order; complain to Court on default	Order compliance with Closing Order	Housing Act, 1925, s. 18
Breaches of law relating to common lodging-houses	None	Complain to Court	Penalty and daily penalty	Public Health Act, 1875, ss. 76 to 89, and bye-laws
Nuisances as specified in section 91 of the Public Health Act, 1975	Notice	Complain to Court. If order of Court is disobeyed work may be done and costs recovered	Penalty and Order; daily penalty for disobeying Order; Closing Order where house is unfit for human habitation or where two convictions for overcrowding have been recorded within 3 months	Public Health Act, 1875, ss. 91 <i>et seq.</i>
Houses not kept reasonably fit for human habitation according to implied contract	21 days' notice. Owner may appeal within this time to Ministry of Health	If notice is not complied with and owner has not notified his intention of closing houses, work may be done and costs recovered	—	Housing Act, 1925, ss. 1 to 3

METHODS OF ABATING NUISANCES—*contd.*

Offence.	Notice Required.	In default.		Statutes.
		Powers of Local Authority.	Powers of Court.	
Houses unfit for human habitation	Notice of Closing Order; appeal to Ministry of Health within 14 days	Make Closing Order, followed by Demolition Order at expiry of 3 months, and demolition after Order has been operative for three months	—	Housing Act, 1925, ss. 11 to 15
Obstructive buildings	Notice of intention to consider making of a Demolition Order	Demolition Order and demolition. Appeals as in foregoing case	—	<i>Ibid.</i> , ss. 19 and 20
Insanitary areas	Publication and notice to owners, lessees and tenants (for greater period than a month) of proposed scheme of reconstruction	Preparation of scheme and submission to Ministry of Health praying for a Confirmation Order	—	<i>Ibid.</i> , ss. 35 <i>et seq.</i>
Establishment of offensive trade without consent of local authority (Urban)	None	Complain to Court	Penalty (£50) and daily penalty	Public Health Act, 1875, s. 112, and Public Health Act, 1925, s. 44 (Adoptive)

Effluvia nuisances . . .	"	"	Penalty	Public Health Act, 1875, s. 114
Non-cleansing and disinfection of premises and things	Notice	Complain to Court. May carry out work and recover costs except in cases of poverty	Daily penalty	<i>Ibid.</i> , s. 120; repealed where Infectious Disease (Prevention) Act, 1890, s. 5, has been adopted. See also ss. 6, 7 and 13 of the latter Act
Exposure of infected persons and things; non-disinfection of infected public conveyances; letting infected houses and rooms	None	Complain to Court	Penalties	Public Health Act, 1875, ss. 126 to 129; Infectious Disease (Prevention) Act, 1890, s. 11
Removal of body of person dying of infectious disease in hospital, etc., to place other than a cemetery or mortuary	"	"	"	Infectious Disease (Prevention) Act, 1890, s. 9
Dead bodies kept in certain places and conditions	"	Apply to J.P. for an Order for removal, etc.	J.P. may order removal to mortuary and burial within specified time; Relieving Officer to bury in case of default and recover costs	<i>Ibid.</i> , s. 10
Pollution of rivers . . .	"	Complain to County Court	Daily penalty; Order to cease offence and direction to any person to carry out Order and recover costs	Rivers Pollution Acts, 1876 and 1893

METHODS OF ABATING NUISANCES—*contd.*

Offence.	Notice Required.	In default.		Statutes.
		Powers of Local Authority.	Powers of Court.	
Passing injurious matters into sewers	None	Complain to Court	Penalty and daily penalties	Public Health Acts Amendment Act, 1890, s. 16
Passing chemical refuse, steam, etc., into sewers	One notice only of provisions of section	Complain to Court	Penalty and daily penalty	Public Health Acts Amendment Act, 1890, s. 17
Dirty or offensive common sanitary conveniences	None	"	"	<i>Ibid.</i> , s. 21
Rooms over privies, etc., used as sleeping-rooms	7 days' notice	"	"	<i>Ibid.</i> , s. 24
Erection of new buildings on ground made up with offensive matter	None	"	"	<i>Ibid.</i> , s. 25
Common courts and passages not kept clean	"	May do work and recover costs from occupiers	—	<i>Ibid.</i> , s. 27
Throwing cinders, etc., into streams	"	Complain to Court	Penalty	<i>Ibid.</i> , s. 47
Unpaved and undrained private courts, yards or passages	Notice	May do work and recover costs	—	Public Health Act, 1907, s. 25, and Public Health Act, 1925, s. 20 (both adoptive)

Water from houses, etc., falling upon street pass-engers or flowing on to or over footpath	"	Complain to Court	Penalty	Towns Improvement Clauses Act, 1847, s. 74; Public Health Act, 1875, s. 160; and Public Health Act, 1925, s. 21 (Adoptive)
Breaches of Canal Boats Acts and Regulations	None	Complain to Court	Penalty	Canal Boats Acts, 1877 and 1884
Effluvia from drains, etc., in workshops and work-places	Notice	"	Penalty and Order (as ss. 91 <i>et seq.</i> P.H.A., 1875)	Factory and Workshop Act, 1901, s. 2
Dirty workshops . . .	"	Complain to Court; may do work and recover costs	Daily penalty	<i>Ibid.</i>
Bakehouses illegally let or occupied	None	Complain to Court	Penalty and daily penalty after conviction	<i>Ibid.</i> , s. 97
Insanitary bakehouses	"	"	Penalty and Order	<i>Ibid.</i> , ss. 98 and 100
Permitting land to become infested with rats and mice	None	Complain to Court and may after 24 hours' notice enter and do necessary work and recover costs	Penalty	Rats and Mice (Destruction) Act, 1919
Failure to execute works required under bye-laws for tenement houses	21 days' notice	Complain to Court; or may do work and recover costs	Penalty	Housing Act, 1925, s. 7
Breaches of various bye-laws	None	Complain to Court	Penalty	Various bye-laws

CHAPTER XV

PROTECTION OF THE FOOD SUPPLY

It is a matter of great economic and hygienic importance that the condition and quality of the food purchased and consumed by the public should be above suspicion ; deception invariably involves fraud, and quite frequently may be an immediate danger to health. These facts have long been recognized, and in every mediæval town searchers were employed by the guilds to seek out offenders and secure their punishment. An interesting relic of this system is the Fishmongers Company of London which still exercises control over fish brought to Billingsgate Market.

To-day these duties are defined by statute and in general devolve upon the sanitary authorities, being exercised by officers of the health department. The distinction between condition and quality is only used to simplify classification ; bad condition indicates a state which renders an article otherwise perfect, unfit for food—e.g. diseased, decaying, or damaged foodstuffs ; bad quality denotes a defect from the usually accepted or legally defined composition of any food—in this case, of any drug also. The detection of both are branches of a sanitary inspector's duties,¹ but where specialization has proceeded far, the former becomes the function of the meat inspector acting under the Public Health Acts, and the latter of the food and drugs inspector working under the Food and Drugs and kindred Acts.

The Public Health Act, 1875² gives powers to enter

¹ See, however, Chapter IX for exceptions as regards food and drugs.

² Sections 106 to 119.

premises and inspect, and examine any animal, carcass, meat, poultry, game, flesh, fish, fruit, vegetables, corn, bread, flour, or milk exposed for sale, deposited for the purpose of sale, or of preparation for sale, and intended for the food of man. If it is found to be diseased, unwholesome, unsound, or unfit for human food it may be seized and submitted to a justice, who may condemn it and make an order for its destruction. Penalties may then be obtained from either the person to whom it belongs or did belong at the time of exposure for sale, or in whose possession or on whose premises it was found. It is to be noted that the *onus* of proving that it was not intended for human consumption is thrown upon the person charged, but in practice the inspector must be provided with evidence rebutting such a defence, which is frequently made when a case is taken into court. Where the Public Health Acts Amendment Act, 1890¹ has been adopted the power of seizure and condemnation extends to all articles of food even if already sold, and the inspector is thereby enabled to deal with such foods as eggs, butter and cheese, and to take proceedings upon unsound food submitted to him immediately after purchase by the purchaser.

It is a great disadvantage that food, however unfit, cannot be seized by an assistant to the inspector or to the medical officer of health,² and it is to be noted that these latter officers may seize but not destroy food which they deem unfit for consumption ; this can be ordered only by a magistrate, who may hear the owner on the question of soundness. The officer is not required to ask the owner to be present when food he has seized is submitted to the justice, but this practice is very generally followed, as it removes any possibility of an allegation of unfairness.

This branch of work bristles with difficulties ; the inspector's duties tend to be those of a detective, and he must, by constant and unexpected calls at the various places

¹ Section 28.

² This disadvantage is reduced since urban authorities may now appoint as many inspectors as they deem fit.

where foodstuffs are dealt with, endeavour to strike the fear of detection into the hearts of evilly disposed dealers and to make illegal action too expensive to be pursued. The chief difficulty is with meat, the signs of disease in which are not easy for the ordinary person to detect ; they are frequently very easy to remove, and as a last resort the sausage machine, spices, and a final attractive dressing as potted meats, pastes, sausages, or other delicacies puts an effective disguise upon food which may be totally unfit for the purpose. The only place and time at which meat can be efficiently inspected is at the slaughter-house just after slaughter before any of the offal has been removed¹ ; but to attain this was difficult until the Ministry of Health issued the Rural District Councils (Slaughter Houses) Order which required all slaughter-houses in rural districts to be registered or licensed, and the Public Health (Meat) Regulations of the same year (1924) which required, amongst other things, notices of slaughtering and of evidence of disease in carcasses slaughtered to be given to an officer of the local authority. There is now no reason, except paucity of staff, why all meat should not be inspected immediately after slaughter, and the further provision is made² that the Ministry may authorize an authority to empower their inspectors to affix an approved mark to all meat examined and passed as fit and, if desired, to make a charge for such mark.

These comparatively new powers take much of the point out of the arguments in favour of local public abattoirs and the abolition of private slaughter-houses, but the fact remains that the latter are widely scattered, need a large staff for adequate supervision and are often badly situated. The approximate numbers of slaughter-houses in England and Wales in 1925 were :³

¹ A Memorandum (62/Foods) on a System of Meat Inspection was issued by the Ministry of Health, on March 16, 1922.

² Part III. Forty-five local authorities had been authorized to use official marks of fitness by 1927. In twenty-seven areas no charge was made for marking.

³ Eighth Annual Report of the Ministry of Health, p. 22.

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Owned by local authorities—		
(a) Available for general use		100
(b) Leased to individual butchers		150
		<hr/>
	Total	250
Owned privately—		
(a) Registered		9,000
(b) Licensed		7,000
		<hr/>
	Total	16,000

To eliminate the disease—tuberculosis—with which, more than any other, the meat inspector has to deal, and so ultimately ensure both meat and milk free from tubercular taint, the Ministry of Agriculture¹ has provided for the notification by veterinary surgeons of cases of various kinds of tuberculosis in bovine animals. Owners of such cattle are also enabled to notify the local authority of any animals which are or appear to be suffering from various forms of tuberculosis and where such animals when slaughtered are found to be affected with a generalized form of the disease compensation to the extent of 25 per cent. of the market value of the animal is paid, 75 per cent. being payable if the animal is only partly affected. If, however, diagnosis is shown on slaughter to be erroneous, the full market value plus £1 is paid. The cost of compensation is shared by the local authority and the Ministry of Agriculture and the former receives any proceeds from sale of carcass, hide and other parts. If any portion of such carcass is passed as suitable for food the Medical Officer of Health must be notified to ensure further supervision, and it may not be moved for the purpose of use for food without the written permission of the authorized meat inspector.²

The growing importance of imported foodstuffs, especially meat, has resulted in special legislation to ensure that such food shall be sound and free from disease. The Public Health (Imported Food) Regulations, 1925, consolidated three previous regulations and extended the

¹ Tuberculosis Order, 1925.

² Tuberculosis Order (2), 1925.

inspection to foodstuffs imported by train, ferry and aircraft. All foodstuffs, with special provision as to meat, are brought under inspection, for which purpose the Ministry of Health may order two or more local authorities to act together and may appoint some person to enforce and execute any provision of the regulations in case of an authority's default. Certain classes of meat are excluded unless it bears an official certificate of the country of origin which is recognized by the Ministry as a guarantee of freedom from disease; this has been done in the case of meat, lard, dripping and various edible fats from many sources.¹

The inspection of fish, fruit, vegetables, and other foods is not subject to such difficulties as that of meat; unsoundness is more obvious and more difficult to disguise. It is often the practice of the best wholesale salesmen who sell closed parcels by sample to allow for any which are found by purchasers to be unsound, if the latter submit them to the local inspector and receive his certificate of destruction.

Foodstuffs, otherwise fit, may be contaminated or suffer depreciation whilst in storage or during preparation or exposure for sale and very exhaustive provision is now made to prevent this happening. The aforementioned Meat Regulations² dealt with the transport, storage, preparation and exposure for sale of meat, and the Public Health Act, 1925,³ in effect, extended the bulk of these provisions to "every article used for food or drink by man other than drugs or water, and to any article which ordinarily enters into or is used in the composition or preparation of human food, and flavouring matters and condiments." A further section⁴ prohibits the sale or distribution of any article of food or balloons or other toys from carts or other vehicles or any premises used in connection with the business of a rag and bone merchant. These two sections enable the sanitary officers adequately to deal with many objectionable practices and conditions.

¹ Seventh Annual Report of the Ministry of Health (p. 32), and Eighth Annual Report (p. 22).

² Parts IV, V and VI.

³ Section 72.

⁴ Section 73.

The protection of milk from dirt and disease is an object of great solicitude on the part of many local authorities ; its capacity for carrying the germs of disease and its general use as an article of food, especially for young children and babies, make it very important that its purity should be stringently safeguarded. The regulations which local authorities were empowered to make for the inspection of cattle, the sanitary condition of cowsheds and milkshops and the protection of milk against contamination have now been revoked and replaced by the Milk and Dairies Order, 1926, which applies more comprehensive requirements to the whole of the country. This order deals with—

- (1) Registration of cowkeepers and dairymen.
- (2) Health and inspection of cattle.
- (3) Cleanliness of dairies and protection of milk against infection and contamination.
- (4) Cleanliness of cowsheds, cows and milkers.
- (5) Cleanliness of buildings used for sale of milk or for manufacture of milk products.
- (6) Nature and marking of receptacles for and transport of milk.

The Milk and Dairies (Consolidation) Act, 1915, which did not, owing to the intervention of the War, come into operation until 1925, considerably strengthened the law relating to the milk supply. Especially was this so in the case of tuberculous milk, the sale or offer or exposure for sale of which, or its use in the manufacture of milk products is definitely prohibited ;¹ and provisions are made for the sampling and bacteriological examination of any suspected milk, the local authority of any area within which such milk is produced being required to take samples and forward them to the medical officer or other authorized officer of another authority who has sent a notice requiring such action to them.² Similar powers are provided as regards cattle from which tuberculous milk is suspected to be supplied, in which case an examination of the cows is

¹ Section 5. For diseases to which, in addition to tuberculosis, this Section applies, see Schedule II.

² Section 8.

undertaken by a veterinary surgeon.¹ Where it is proved that tuberculosis is caused or likely to be caused, an order prohibiting the supply of milk from the dairy may be made by the local authority. Before this is done a notice, accompanied by copies of any relevant reports, must be served upon the dairyman requiring him to appear before them or explain by writing, within not less than forty-eight hours, showing cause why such order should not be made. Such order may apply to any milk from the dairy or from any particular cow or cows and a copy must be forthwith served upon the dairyman, and statements of the facts sent to the Ministry of Health and the Ministry of Agriculture. When satisfied that the danger has been removed the local authority may withdraw the prohibition order against the making or continuance of which an aggrieved dairyman may appeal to a court of summary jurisdiction.²

In 1924 the chief medical officer of the Ministry of Health wrote :³

“ In many of the great milk-producing rural areas the powers and duties of the local authority have *not* been effectually administered ; in many such districts there has been no real and honest attempt to carry out the letter and still less the spirit of the law, and in others the attempt has not been made with an intelligent understanding of the real issues at stake.”

This is due partly to large areas and inadequate staff and partly to the vested interests of the farming class, causes which are often closely related. The problem has been attacked along another line by permitting the sale under licence of milk under special designations which give a higher value to the milk and therefore an incentive to an improved standard of production. Under the Milk (Special Designations) Order, 1923, milk may be sold as “ Certified,” “ Grade A (Tuberculin tested),” “ Grade A ” or “ Pasteurized,” subject in the first three cases to stringent regulations applying to production and handling by producers and vendors and to maximum bacterial content, and in the last

¹ Section 4. See Part IV of the Milk and Dairies Order, 1926, for powers to inspect cattle and take samples of their milk.

² Schedule I.

³ Annual Report, 1924, p. 173.

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case, applicable to vendors only, to conditions of pasteurization and bacterial content. Licences are issued by the councils of counties and county boroughs to producers to sell milk as "Grade A," and by district councils to vendors of "pasteurized" milk and of "Certified," "Grade A (Tuberculin tested)" and "Grade A" milk from establishments other than those where such milk is produced; the Ministry of Health retains the power¹ to license such producers, the farms, depots and equipment of which are inspected by the Ministry's milk inspectors who keep records of the examinations and testing of herds, bacteriological reports and inspections, and also do much advisory and supervisory work. In 1925 there were in licensed herds about 7,300 cows producing approximately 1,750,000 gallons of "Certified" milk and 1,900,000 gallons of "Grade A (T.T.)" milk.² The following table indicates the growing popularity of this method of securing a pure and wholesome milk supply: *

LICENCES TO SELL MILK UNDER SPECIAL DESIGNATIONS

	1925.	1926.	1927.
Certified Milk :			
Producers	73	94	118
*Distributors	715	724	866
Grade A (Tuberculin Tested) Milk :			
Producers (including cases in which milk is bottled at place of production)	71 (9)	99 (9)	138 (17)
*Bottling establishments	46	72	115
*Other distributing premises	334	496	673
Grade A Milk :			
*Producers	89	179	245
*Bottling establishments	47	77	114
*Other distributing premises	207	394	550
Pasteurized Milk :			
*Pasteurizing establishments	62	79	117
*Other distributing premises	367	485	571

* These Licences are granted by local authorities.

¹ Milk and Dairies (Amendment) Act, 1922, s. 3.

² Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 167.

³ Eighth Annual Report of the Ministry of Health, p. 21.

Improved methods of transport have increased the quantity of milk imported, and importers must be registered by the local authority into the district of which the milk is brought. Such milk must be free from tubercle bacilli and contain not more than 100,000 bacteria per cubic centimetre, failing which the authority may remove the importer from the register either absolutely or as regards a specified source of supply, the procedure being similar to that prescribed in the case of prohibition orders under the Milk and Dairies (Consolidation) Act, 1915.¹ In this case the order must be reported to the Ministry of Health who may order the removal of the importer from the register of any other authority.

The widespread use of condensed milk and the growing popularity of dried milk has led to legislation defining these commodities, and providing for their constitution and labelling and the sampling and analysis necessary to secure that the regulations are complied with.²

The difficulties besetting the task of securing a wholesome milk supply were so great, and the necessity for such a supply so imperative, that a few authorities adopted the positive practice of themselves providing a supply for consumption by infants who came under the care of their officials. The first infants' milk depot in this country was established at St. Helens in 1899, and was followed during the next few years by Liverpool, Ashton-under-Lyne, Dukinfield, Battersea, Bradford and Burnley. With the passing of the Milk and Dairies (Consolidation) Act, 1915, a general power was given, enabling a local authority, with the approval of the Ministry of Health, to establish and maintain depots for the sale, at not less than cost price, of milk especially prepared for consumption by children under two years of age. Doubt was expressed as to whether the condition as regards price was a wise one. The infants most in need of such milk are those whose parents are least

¹ Public Health (Imported Milk) Regulations, 1926.

² Public Health (Dried Milk), 1923, and Public Health (Condensed Milk) Regulations, 1923 and 1927.

able to purchase it. There are necessitous infants as well as necessitous school children. This was recognized when, after the passing of the Maternity and Child Welfare Act, 1918, local authorities were permitted to formulate schemes for the provision of milk, free or at less than cost price, for expectant or nursing mothers, and children under five years of age. During 1925-6 local authorities expended upon this service the sum of £188,000, which appears to be about the average annual expenditure for this purpose.¹

The object of the various Food and Drugs Acts² and the regulations made thereunder is to protect the consumer from fraud and injury to health and the tradesman doing an honest and straightforward business from the unfair competition of unscrupulous rivals. To ensure this the councils of counties, county boroughs and non-county boroughs having a population exceeding 10,000 are required to appoint analysts,³ to whom must be submitted samples of various foods and drugs obtained by the inspectors appointed for the purpose. The officer usually detailed for this duty (sampling) is a sanitary inspector, but cases are not infrequent where the duty is given to an inspector of weights and measures or a police officer. The offences may be briefly summarized as: (1) the abstraction of essential ingredients; (2) the addition of improper substances, including prohibited colouring matter or preservatives; (3) the application of a false name or description; and (4) selling milk from vehicles or receptacles without the vendor's name and address thereon, or margarine in wrappers not marked "margarine" in letters of the prescribed size. Should the analyst's certificate show that the food or drug has been improperly dealt with, the local authority may take proceedings in a court of summary jurisdiction. It is only since the beginning of this century that analysts have had any definite standards of purity to work to, except in the case of drugs, the purity of which is generally

¹ Eighth Annual Report of the Ministry of Health, p. 54.

² Now consolidated in the Food and Drugs (Adulteration) Act, 1928.

³ See Chapter X.

judged by the standard laid down by the British Pharmacopœia. Now, however, there are legal standards for the three foods which are most numerously sampled—i.e. milk,¹ butter² and cream.³ The laws respecting food and drugs had become so numerous and complex, and the loopholes for dishonesty remain so plentiful, that a general survey and consolidation was urgently called for. Consolidation was effected on the initiative of a private member in 1928, but little alteration was made. In addition to this Act and many departmental regulations dealing with kindred matter, the Milk and Dairies (Consolidation) Act of 1915 amends by a section and a schedule⁴ the procedure for sampling milk for analysis and empowers the medical officer of health of any district in which milk from another district is sold or kept or exposed for sale, to require the medical officer of the district within which the dairy is situated to take samples of the milk at the dairy or in course of transit from the dairy to the place where it is retailed. A part of the sample must be forwarded for analysis or bacteriological examination to the officer who gave the notice, who may if necessary take the same proceedings as if the sample were taken within his district.⁵

In appearance an inspector's duties under the Food and Drugs Acts present no difficulty and call for the exercise of little skill or knowledge; to purchase pounds of butter and pints of milk and go through the formal and not complex procedure required by law seems a simple matter. In reality the duties require the exercise of a considerable amount of discretion and ingenuity in order to checkmate the nefarious practices of those who make their profits largely at the expense of the poorer classes of the community. The tricks of the dishonest tradesmen call forth

¹ Sale of Milk Regulations of the Board of Agriculture, 1901.

² Butter and Margarine Act, 1907. Repealed by Food and Drugs (Adulteration) Act, 1928, of which see Part II.

³ Milk and Cream Regulations, 1912.

⁴ Section 9 and Schedule III. See also Schedule II of the Food and Drugs (Adulteration) Act, 1928.

⁵ Section 8.

considerable resource on the part of the inspector to secure fair samples of the goods he buys and to prove his case when finally it comes before the Courts ; and, on the other hand, the sophistication of food products has become a fine art requiring all the scientific knowledge of the chemist to detect it. The latter difficulty was clearly described by the medical officer of health for Islington, who reported that—

“the detection of adulteration is becoming more and more difficult, and is due, in the first place, to the astuteness of the vendors of adulterated articles, and, in the second, to the more highly scientific means now practised. In the latter case, however, the adulteration is effected by the original makers of the article or by the wholesale vendors. It has been pointed out in previous reports that the vendors of milk ‘tone’ it or, in plain English, adulterate it with separated milk ; but they take great care that they do not ‘tone’ it below the standard set up by the Board of Agriculture. The addition of separated milk to new milk has become almost a fine art with some milk purveyors, who, although they are known to receive large quantities of separated milk, which they do not sell, yet mix it so skilfully that it is impossible to bring them within the four corners of the law.”¹

Of course, the inspector himself seldom makes a purchase ; he is too well known. He must and frequently does employ at irregular intervals a number of agents of varying ages and both sexes to buy the goods to be analysed. But this alone is not sufficient. The cunning vendor has to be lulled into fancied security by the purchasing agent buying other goods at the same time or, since some tradesmen only swindle regular customers, by making regular purchases for a longer or shorter period, some of the samples being for analysis to secure indication of the quality of the goods being served. The inspector has, however, one advantage over his assistant, he can demand to be served with a portion of any article he indicates, the assistant cannot do so. The tricks and counter-tricks are too numerous to enumerate and can be found described in the various papers read at

¹ Quoted in the Forty-second Report of the Local Government Board, Part III, p. lxvi. Cp. cases of adulteration in the Eighth Annual Report of the Ministry of Health, pp. 23 *et seq.*

conferences by those concerned with the detection of adulteration, but they result in a battle of wits from which the most patient and resourceful inspectors do not always emerge successful by bringing the delinquents to justice.¹ During 1926, 120,617 samples were submitted by local authorities and private persons for analysis, and 7,044 of these (5·8 per cent.) were returned as adulterated or not up to standard. Milk (62,507) accounted for more than half, and butter (11,478) for nearly a tenth of these samples, of which spirits (12·9 per cent. adulterated), closely followed by cream (11·1 per cent.), proved to be the worst from the point of view of purity. It is interesting to note that the percentage of butter adulterated was low (1·5), that of milk was high (7·4), whilst condensed milk was much more reliable (1·9). Sugar, once popularly believed to be a common subject of adulteration, gave only three out of 767 samples taken as not up to standard.²

The extension of milk grading under the operation of the Milk (Special Designations) Order, 1923, has greatly added to the work of the inspectors undertaking duties under the Food and Drugs Acts, and increased the demand for facilities for the bacteriological examination of milk. During 1925, 880 samples (794 of "Certified" and 86 of "Grade A, Tuberculin tested" milk) were taken and submitted to examination on behalf of the Ministry of Health. Of the former, 79·60 per cent. complied with the standard, a result achieved by 83·7 per cent. of the latter.³

In the struggle of the sanitary authorities to secure pure and wholesome food for the people it will usually be found that where administration is most thorough it is also most effective—it pays to deal neither in unsound nor impure food. The eternal vigilance of the inspectors is the price of pure, sound food for the public.

¹ For procedure under Sale of Foods and Drugs Acts, see Memo. 36/Foods, issued by the Ministry of Health in January, 1927; cp. "Some Notes on Sampling," by G. E. Oates, M.D., M.R.C.S., Medical Officer of Health, Paddington, in the *Local Government Journal*, July 16, 1927, p. 452.

² Eighth Annual Report of the Ministry of Health, pp. 23 and 213.

³ Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, pp. 166-7.

CHAPTER XVI

INFECTIOUS DISEASE

THE great object of sanitary administration is the prevention of disease. In order to attain this object sanitary authorities adopt, to use a military metaphor, two lines of attack: by a flank movement they endeavour to seize the base from which disease operates, and, by destroying its supplies, starve it into submission or severely limit its powers and activity; whilst, on the other hand, they make a frontal attack by isolating and defeating it wherever it has seized upon members of the community. To the first class belong all those activities aiming at preventing and abating nuisances, securing sound and pure food, and maintaining those conditions which hygienic science shows are necessary for healthy life; in the second class are included those efforts which deal with infected persons, places and things, providing for the isolation and treatment of the first and the disinfection of the two last. Having dealt with the first class, it is now necessary to outline public health administration as it conducts the second line of attack.

It is obviously of primary importance, if the sanitary authority is effectually to deal with infected persons, places and things, that it should have early and exact knowledge of the existence of infection. With a few exceptions where the most progressive towns had obtained compulsory powers under private Acts this essential was, however, not widely obtained until the Infectious Disease (Notification) Act was passed in 1889; and even this Act was adoptive until 1899.¹ Since the latter date every case of "small-

¹ Infectious Disease (Notification) Extension Act, 1899.

pox, cholera, diphtheria, membranous croup, erysipelas, scarlatina or scarlet fever, and the fevers known under any of the following names—typhus, typhoid, enteric, relapsing, continued or puerperal,"¹ must be forthwith notified to the local authority by the medical attendant and by the head of the family, nearest relative present in the building or in charge of the patient, or the person in attendance or in charge of the patient.² Subject to the consent of the Ministry of Health this list may be added to by a temporary or permanent order of the local authority made for that purpose at a specially convened meeting, public notice by handbills and advertisement being given of the order when made.³ Amongst the diseases which have been made notifiable by various local authorities are anthrax, chicken-pox, hydrophobia and measles.

The addition in 1903 by the Sheffield Corporation of tuberculosis to the list of infectious diseases notifiable in that town was an intelligent anticipation of and a great stimulus towards the future events which culminated in the issue of the Public Health (Tuberculosis) Regulations in 1912, by means of which all cases of all forms of tuberculosis everywhere became notifiable to the local authority. A similar precedent has been set by the Bradford Corporation which, in a private Act, secured powers to require the notification by medical men of certain cases of venereal disease.⁴

Under Section 130 of the Public Health Act, 1875, the central department have added ophthalmia neonatorum,⁵ tuberculosis,⁶ cerebro-spinal fever and acute poliomyelitis,⁷

¹ Infectious Disease (Notification) Act, 1889, s. 6.

² *Ibid.*, s. 3. The Public Health (Notification of Infectious Disease) Regulations, 1918, prescribed forms of notification of infectious diseases (see Schedule) and the Public Health (Puerperal Fever and Puerperal Pyrexia) Regulations, 1926, prescribes forms for the notification of these diseases.

³ *Ibid.*, s. 7.

⁴ See Seventh Annual Report of the Ministry of Health, p. 82.

⁵ Public Health (Ophthalmia Neonatorum) Regulations, 1914.

⁶ Public Health (Tuberculosis) Regulations, 1912.

⁷ Public Health (Cerebro-Spinal Fever and Acute Poliomyelitis) Regulations, 1912.

and malaria, dysentery, acute primary pneumonia and acute influenzal pneumonia ¹ to the diseases which must be notified, and for the purposes of Sections 57, 58 and 59 of the Public Health Act, 1925, the Ministry of Health may, by Order, require any other disease to be notified generally or in any particular area.² There were in 1926 twenty-one notifiable infectious diseases.³

At the present time, therefore, every case of the chief infectious diseases is immediately notified to the local authority. But cases occur where the disease is so slight as to be overlooked, or delay occurs in calling in a doctor, or difficulty of diagnosis arises; and it is just these cases which frequently frustrate the best efforts of the local authorities and spread the disease broadcast before the necessary steps to check it can be taken. The disease having been notified to the local authority, there is no delay on the part of the officials in dealing with the case; this duty takes precedence of all others. The sanitary inspector, however he may be related otherwise to the medical officer of health, in dealing with infectious disease acts directly under his instructions and control. His duties in this respect, as a rule, may be reduced to routine, although they vary slightly with the different types of disease. The premises occupied by the patient are immediately visited and inquiries made with the object of tracing the source of infection, learning the adequacy of the means of isolation and treatment, and securing removal to hospital where necessary and possible, and discovering the existence and whereabouts of persons and articles likely to have become infected by contact with or use by the patient; and finally advice is given to those in charge of the patient and premises.

The certificate of notification should give the full name, age, and address of the patient, the disease from which he or she is suffering, the date, the signature of the medical

¹ Public Health (Infectious Diseases) Regulations, 1927.

² Public Health Act, 1925, s. 63.

³ See Eighth Annual Report of the Ministry of Health, p. 27, for list.

practitioner, and a statement that the case occurs in private practice or is attended by the doctor acting as medical officer to a public body or an institution; the last item deciding whether the fee paid for notification shall be 2s. 6d. or 1s.¹ This information, provided on forms which the local authority must supply gratuitously to any medical practitioner residing or practising in their district, directs the inspector's visit and forms the basis of his inquiries, the results of which are reported to the medical officer of health.

The facts thus garnered may be summarized under three headings as affecting persons, places and things. The patient is, of course, the most important of the persons, the essential information being the date of attack, the time and place at which he was in contact with infection or consumed food or drink which might possibly be infected, and, in case of small-pox, whether and when vaccination and revaccination was carried out. Other persons dealt with are "contacts," those who have been in contact with the patient between the probable date of infection and that of the discovery of the disease—a fact of particular importance when dealing with small-pox, as such contacts are often isolated until the possibility of their having contracted the disease is beyond a doubt. The schools—day and Sunday—attended by the patient and any children in the house and the employment of any working inmates of the dwelling are also noted. The latter knowledge being required in case they deal with foodstuffs, clothing, or other goods to which they might convey infection. The chief point as regards the premises is the arrangement made for isolating the patient if he is not removed to hospital; unless there is an actual pressing nuisance existent upon the premises, these are first thoroughly inspected and dealt with, after the removal or recovery of the patient, by the methods previously indicated.² Under the heading "things" come goods received by outworkers living in the

¹ Infectious Disease (Notification) Act, 1889, s. 4.

² See Chapters XIII and XIV.

house, books borrowed from libraries or schools, and bedding, clothing, and other articles used by the patient, but not contained in the sick-room. At the conclusion of the inquiry the official gives all necessary advice and warning, usually leaving a card or leaflet containing both set out in an easily intelligible form.

The information thus obtained determines the subsequent procedure. If isolation is inadequate or other good reasons exist, removal to hospital is provided for, the bedding removed for disinfection, and the premises immediately disinfected and inspected. In certain cases the patient may be compulsorily removed to hospital.¹ When the patient is treated at home surprise visits are made where there is reason to think that necessary precautions against spreading infection may not be taken, cases of such neglect being visited by legal proceedings or by admonishment in the less flagrant instances.

It is usual to notify the heads of schools attended by children from an infected house, and they are excluded until such time after the patient is removed or has recovered as makes it unlikely that they have contracted the disease, when a further notice is sent to the school. To facilitate the work of the school teachers these notices are frequently printed on different coloured paper—red for infection, and white for freedom therefrom. The reports of the schools attended are frequently scanned by the medical officer of health, who is often the school medical officer, as it may be deemed necessary to close a school or schools when a considerable number of the children are suffering from an infectious disease; a special examination of the children in a school or a class may also take place with a view to the discovery of unrecognized cases or "carriers." Children may be excluded or schools or departments closed either by the local education authority acting on the advice of the school medical officer, or by the sanitary authority or two members thereof, on the advice of the medical

¹ Public Health Act, 1875, ss. 124 and 125.

officer of health.¹ In cases of exclusion of individual children the grant is lost unless the attendance falls below 60 per cent. and such fall is certified by the school medical officer to be due to epidemic disease, whilst if the school is closed the grant is secured. This is a grave defect ; the loss of grant makes education committees very keen on compelling the attendance of scholars, and fear of the school attendance officers often results in children attending school when really unfit and sometimes when suffering from mild and ill-defined or unrecognized infectious disease. On the other hand, it is widely held that to close schools, especially in urban areas, is not a very useful precaution, since the children still mix very much in their play and are out of the surveillance of their teachers, who are constantly on the look-out for suspicious symptoms of disease. In view of this opinion it appears to be much more desirable that the grant should be paid for all children excluded by the medical officer of health or the school medical officer.

A point to which the medical officer of health pays careful attention is the source of the milk supply² ; in cases of typhoid fever the inquiries are extended to include the recent consumption by the patient of such foods as shell-fish, fried fish, ice-cream and salads. If the evidence indicates the possibility that any milk supplied within the district has caused or is likely to cause infectious disease, the medical officer may prohibit its sale by notice operating for twenty-four hours, but renewable until the cause is removed. If the notice is upon registered premises outside the district, the medical officer of health for the area within which they are situated must be informed.³

If there is reason to believe that any of the inmates of a common lodging-house suffering, are or have recently

¹ On this question, see Memorandum on *Closure of and Exclusion from School*, issued jointly by the Ministry of Health and the Board of Education, in January, 1925.

² See the Report of the Medical Officer of Health for Croydon for 1924 for an interesting description of the tracing of scarlet fever infection to milk.

³ Milk and Dairies Order, 1926, s. 18 ; see also Sections 3, 4 and 5 of the Milk and Dairies (Consolidation) Act, 1915.

suffered from any dangerous infectious disease, a Justice of the Peace may authorize the medical officer of health to examine such inmates, a penalty being provided for obstruction;¹ and a petty sessional court may order a common lodging-house to be closed on account of the existence or recent existence of dangerous infectious disease, compensation being provided for.²

It is usual to furnish the public libraries within the district with lists of newly infected and disinfected houses, borrowed books being removed from the former by the sanitary officers, and, if not destroyed, they are disinfected before return to the library or school.

The Factory and Workshop Act, 1901,³ makes it an offence to give out any wearing apparel to be made, cleaned or repaired in any place in which the employer knows that there is a case of small-pox or scarlet fever. It is therefore necessary for the sanitary authority to notify such persons of any case of these diseases occurring at an outworker's house, thus removing all doubts as to their knowledge of the fact. Any work on the premises is taken charge of by the sanitary officer and disinfected before its return to the owner, a similar course being pursued in the case of homeworkers such as dressmakers. The local authority have the further power of making an order prohibiting the giving out of the same kind of work to any inmate of a house wherein a person is suffering from any of the notifiable infectious diseases, the prohibition remaining until the medical officer of health is satisfied that the house is free from infection.⁴

Communications are constantly passing from one local authority to another with reference to cases of infectious disease. Disease is often contracted in one district where the patient has been visiting and notified in another (e.g. hop and fruit pickers), and persons visiting an infected

¹ Public Health Act, 1925, s. 58.

² *Ibid.*, s. 59.

³ Section 109. See also Public Health (Factories and Workshops Transfer of Powers) Order, 1921.

⁴ Section 110.

house return to their homes in a different district. Such information enables the sanitary officer to seek out possible sources of infection in the one case and to keep observation upon the contacts in the other ; the latter duty is especially important in cases of small-pox, when some authorities subject the "contacts" to a rigorous quarantine under medical supervision and observation, indemnifying them for loss of wages and freedom ; others constantly visit them during the incubation period. On the arrival of a ship from an infected foreign port, or with a case of infectious disease on board, the port sanitary officials secure the names and addresses of all on board before they are permitted to land, and these are at once forwarded to the authorities to whose districts the "contacts" are proceeding. The local officials are thus enabled to visit and advise the "contacts" and to act promptly in cases where the disease develops ; these efforts are, however, frequently frustrated by the "contacts" giving fictitious addresses to the port sanitary officers.

Most authorities provide a free supply of disinfectant—powder or liquid or both—to the occupiers of infected houses, directions as to its use being given by the inspector and on the "precaution paper" handed by him to them ; several authorities manufacture their own disinfectant for the use of the public health department. Immediately after the patient is removed to hospital or has recovered, the room or rooms are disinfected by one of the various methods in use, and the house is inspected, notice being served where necessary for the removal of any defects found. In cases where the patient is isolated at home it frequently happens that he is removed from one room to another more suitable, in which case the former is disinfected before use. The fact that a doctor is not always in attendance throughout the illness, and so does not notify recovery to the local authority, requires the sanitary officer to keep careful record in a diary of the date at which, in the normal course of events, disinfection would be necessary. At this date, inquiry is made as to the patient's condition,

and, if necessary, disinfection is postponed to a later date, under which a new entry must be made.

The administrative methods of inquiry into and dealing with infectious disease are, on the whole, very thorough and efficient, especially in large urban districts. In these places considerable specialization of officials has taken place, and the staff includes, besides the medical officer of health and sanitary inspector with his colleagues and assistants, one of whom perhaps devotes his whole time to visiting and inquiring into cases of infectious disease, disinfectors, ambulance men and nurses, and men to remove infected articles from the home and return them from the disinfecting station, which is frequently attached to the hospital and has a staff of attendants. The general use of the telephone, and adequate provision of motor ambulances and cars for collecting infected articles, makes it easy for such an organization to deal rapidly and efficiently with any call made upon it.

In most rural districts and in many urban districts all or most of these functions devolve upon the sanitary inspector, who is usually without many of those appliances which facilitate the expeditious performance of his duty. The time occupied in performing these duties and doing the necessary clerical work, for which in larger districts a clerk is appointed, undoubtedly does much to account for the presence of insanitary conditions which foster disease, but with which the inspector has no time to deal.

The Board of Education directs the weekly notification by head teachers to the medical officer of health of cases where children are absent from school on account of any of the minor non-notifiable infectious diseases, such as measles, whooping-cough, mumps, etc., but in practice the more direct method of notification by the school attendance officer is often adopted. The information thus obtained directs the visit of the health visitor, one of the latest developments of the humanizing and educational tendency of public health administration, who gives to the mother the advice and encouragement necessary to secure the best

possible treatment for the patient. But here is the borderline of effort of the public health department on the one hand and the school medical service on the other.

"A new principle in public health legislation applying compulsion mainly in the interests of the persons compelled rather than in those of the general public" was introduced into a private Act of the Bradford Corporation. This gave power, on certificate of the medical officer of health and with the consent of a Court of Summary Jurisdiction, to remove to a hospital or other institution, any aged or infirm persons living under insanitary conditions or suffering from grave chronic disease.¹ This will no doubt be a useful precedent, and later find its way into a general Act.

Military life has always fostered venereal disease and the Great War once more brought it into such prominence that a false sense of niceness or decency was no longer permitted to blind Parliament and the public to its danger to health and life. In 1916 the Report of the Royal Commission on Venereal Diseases² established the fact that by early and efficient treatment venereal diseases could be brought under control and considerably reduced. To this end the Commission recommended the provision of facilities for diagnosis and for the adequate and skilled treatment of affected persons. The urgency of the problem recognized, the Local Government Board at once issued regulations³ which imposed on the councils of counties and county boroughs and the Common Council of the City of London the duty of making arrangements for (1) enabling medical practitioners to obtain scientific reports on materials obtained from suspected sufferers from venereal diseases; (2) the treatment of affected persons at or in hospitals or other institutions, and (3) supplying medical practitioners with drugs for the treatment and prevention of the disease. The local authorities were required to submit schemes for this purpose, which includes provision for giving instruc-

¹ Seventh Annual Report of the Ministry of Health, pp. 81-2.

² Cd. 8189.

³ Public Health (Venereal Diseases) Regulations, 1916.

tional lectures and the publication of information on questions relating to venereal diseases, to the central department, the approval of which carries with it a substantial grant-in-aid.

Bradford Corporation, by a private Act, has obtained powers requiring medical practitioners to notify cases of venereal disease in (a) children under 2 years of age; (b) adults who refuse or neglect to obtain treatment after being notified by a medical practitioner or the medical officer of health.¹ Otherwise notification is non-existent and knowledge of cases depends solely upon the voluntary action of those who are or suspect themselves to be affected. In order to encourage such a course the medical officer of health must not only provide the facilities for diagnosis and treatment but must in all directions enlist public and voluntary agencies in the work of educating the public to the dangers of the disease and the importance of securing early and efficient treatment.

At the close of 1925 there were 193 treatment centres in England and Wales, attended by 401 approved venereal diseases officers (whole or part time) who held 738 weekly sessions, where there was a total of 1,719,148 attendances. Out of 78,210 persons treated at the centres for the first time, 57,157 proved to be V.D. Nearly 50,000 examinations of matter from suspected sufferers were made at treatment centres and 251,807 examinations at the 73 approved laboratories. Beds for in-patient treatment are provided at most centres, in addition to which there are 14 hostels, accommodating 262 women and girls, where 866 cases were treated during the year. During the year ended March 31st, 1926, the Ministry of Health paid £289,904 in grants-in-aid of V.D. schemes, £9,615 being in respect of propaganda work to the British Social Hygiene Council.²

Compulsory notification will no doubt follow as soon as the public are fully alive to the personal and racial dangers

¹ See Seventh Annual Report of the Ministry of Health, p. 82.

² *Ibid.*, p. 13. For comparative statistics since 1919-2, see Eighth Annual Report of the Ministry of Health, p. xxviii.

of venereal disease. Meanwhile, no one who suspects infection need go unassured and no one who is infected need go untreated; and Parliament has wisely prohibited the pernicious practices of treatment of, prescription for, and advice on venereal diseases by unqualified persons.¹

¹ Venereal Diseases Act, 1917.

CHAPTER XVII

HOSPITALS AND HOSPITAL ADMINISTRATION

THE early efforts of sanitary authorities and their staffs were directed against an evil environment ; the discovery and abatement of nuisances were their main functions. But as medical and bacteriological science advanced it became more and more evident that man himself, especially the sick man, was an important factor in the dissemination of disease. The whole theory of infectious and contagious disease indicated the necessity for proper isolation and disinfection, and the growing knowledge of social conditions proved beyond dispute the impossibility of securing this in the homes of many, perhaps most, of the sufferers. To meet the want, collective effort, voluntary or public, was shown to be essential. The treatment and care of disease in institutions was found to be an integral and necessary part of the work of prevention. The utility of isolation had, in fact, been recognized as early as the eighth century, when leper-houses or "lazars" were first founded in France, and later, when "pest-houses" were established on the outskirts of many mediæval towns for the isolation of persons suffering from plague, and, perhaps, other diseases recognized as infectious.¹ In two directions institutional treatment was provided in the early years of the nineteenth century ; the foundation and maintenance of hospitals for the sick and infirm was a favourite form of philanthropic effort in the seventeenth and eighteenth centuries,² two important London hospitals, the Small-pox Hospital and the Lock Hospital for venereal diseases, being established

¹ H. F. Parsons, *Isolation Hospitals*, pp. 1 and 2.

² B. Kirkman Gray, *The History of Philanthropy*.

in 1745 and the following year;¹ and these persisted alongside the institutions in which the Poor Law authorities were compelled of necessity to make some sort of provision for infectious paupers, although accommodation, apart from the mixed workhouse, was rare. Later, when general hospitals were still largely used for infectious diseases, serious epidemics occurred, chiefly in the crowded urban areas, and these hospitals were unable to cope with the great pressure upon their accommodation, the Poor Law authorities were doing little or nothing, and thus the onus of providing isolation was thrown directly upon public health authorities, who responded by renting buildings or constructing temporary institutions. When the voluntary hospitals ceased to provide for infectious disease the sanitary authorities were compelled by circumstances to extend their efforts for the isolation, treatment, and cure of those diseases which their purely preventive work had not warded off. The objects and advantages of this extension of the functions of sanitary authorities are well summed up by Dr. W. H. Power, a late medical officer of the Local Government Board, in the statement:²

“ The provision of hospital accommodation for cases of infectious diseases is to be regarded primarily as a measure of sanitary defence, for the protection of the public against the spread of these diseases. It is true that such accommodation incidentally serves other useful purposes. Thus, it is frequently of value for the relief of individual sufferers from infectious disease, whose sufferings may be alleviated and recovery promoted by affording them better accommodation and attendance than they are able to obtain at their own homes. Or it may be the means of avoiding serious inconvenience and pecuniary loss, as when infectious disease breaks out in a school, lodging-house, or place of business.”

Local authorities are empowered, singly or in combination, to provide hospitals or temporary places for the reception of the sick inhabitants of their district, and may either themselves build or contract or agree with public authorities

¹ *Isolation Hospitals*, p. 2.

² Local Government Board Circular, May, 1902.

or private persons having charge of such places, and may recover the cost of maintenance of patients.¹ The Isolation Hospitals Act of 1893 went a step further by giving the lately constituted county councils power to provide or cause to be provided hospitals for the reception of patients suffering from infectious disease in any district of the county. The county council may be moved by an application from a rural or urban district council or any twenty-five ratepayers of a contributory place, or they may themselves direct the county medical officer of health to report upon the necessity for an isolation hospital in any district. The consent of the local authorities affected is required, unless it is shown that they are themselves unable or unwilling to provide the necessary accommodation. The local authorities, for the purposes of this Act, may transfer to the county council any infectious hospital provided by them under the Public Health Act, 1875, or any local Act. If satisfied, the county council must constitute a hospital district and form a committee consisting wholly or partly of members of, or persons elected by, the council, or wholly or partly of representatives of the local area or areas affected, which cannot include any county borough, or, unless the local authority consent, any borough having more than 10,000 inhabitants. The expenses incurred by the county council in providing and maintaining the hospital are chargeable upon the rates of the area served, but the county council may, in certain cases, contribute a capital or annual sum to both or either the structural and establishment expenses of such hospital; this provision has been extended to include the extension or enlargement of any hospital provided under the Public Health Act, 1875.²

The Public Health (Prevention and Treatment of Diseases) Act, 1913,³ empowered the Ministry of Health to declare a county council to be an authority to execute and enforce regulations made by the Ministry under Section 130 of the Public Health Act, 1875, with a view to the treatment of

¹ Public Health Act, 1875, ss. 131 *et seq.*

² Isolation Hospitals Acts, 1893 and 1901.

³ Section 2.

persons suffering from cholera or any other epidemic-endemic or infectious disease. It has now been made clear that this power may be extended to the provision of hospitals for the treatment of such patients, the costs being assessed on parishes on a basis of user instead of being charged generally.¹

The use of these powers throws a heavy responsibility and much onerous work upon the medical officer of health, who must not only advise his authority upon the need for such accommodation and sketch out how it is to be provided before the architect drafts the completed design, but has to support his recommendation before the inspector of the Ministry of Health, who inquires into the need for the application for a loan, and, finally, to supervise the general hospital administration, and even in many cases to treat the patients himself. In some places patients are required or permitted to provide their own medical attendant, skilled nursing being provided by the authority.

The powers to provide for the treatment of sickness are, on the whole, adequate, but unfortunately they are very far from being taken full advantage of.² Mr. and Mrs. Sidney Webb, after the exhaustive inquiries made by the Poor Law Commission, were able to write that "a majority of the rural district authorities and not a few urban district authorities have no hospital accommodation, even for the most infectious diseases,"³ and it is certain that where there has been an attempt made it is often very unsuitable and wholly inadequate. Of hospitals, as of nearly every other branch of public health work, no general statement can be made, unless it be that the variety is amazing. Where provided they range from a two- or three-roomed cottage or shed awaiting a possible case of small-pox up to the great institutions with all their specialized departments, latest scientific apparatus, and large highly-trained and skilled staffs, provided by such towns as Liverpool, Leeds and

¹ Public Health Act, 1925, s. 61. This power is extended to the provision of dwelling-houses for employees at the hospital by Public Health Act, 1925, s. 65.

² *Minority Report of the Poor Law Commission* (Fabian Society, 1909), p. 283.

³ *The State and the Doctor*, p. 208.

Sheffield. The same variation is found in the diseases treated.

Under the Isolation Hospitals Acts the provision of hospital accommodation is restricted to that for infectious diseases—a retrograde step, since the powers given by the Public Health Act, 1875, enable a local authority to provide for the reception and treatment of the sick. The latter power has been held to include a great variety of non-notifiable diseases, as at Liverpool, and urgent surgical cases and accidents, as at Barry and Widnes,¹ and, anticipating the National Insurance and Finance Acts of 1911, phthisis at Brighton, Manchester, and Liverpool. In some few cases, out-patients' departments for the treatment of ringworm, impetigo, and similar complaints have been added; in others domiciliary treatment by municipal home nurses is provided for cases of puerperal fever or erysipelas, or, where no other provision is made for treatment, of the sick poor.

Local authorities have from time to time been authorized² to give donations and subscriptions (generally of small amounts) to voluntary hospitals, but this authority is no longer necessary since they are now empowered³ to give such subscriptions or donations to the extent of the produce of a penny rate. The following statement gives some idea of the kind and amount of hospital accommodation provided or aided by various local authorities:

HOSPITALS PROVIDED BY LOCAL AUTHORITIES

	Number.	Beds.
1. For Tuberculosis	158	10,963
2. For acute infectious diseases	1,040*	37,700*
3. Maternity Hospitals (not including maternity wards in General Hospitals or Poor Law Institutions)	68	908
4. Babies' Hospitals	12	260

* Round figures. At fifty-two of these hospitals there are 2,230 beds for the treatment of tuberculosis.

¹ *Minority Report of the Poor Law Commission* (Fabian Society, 1909), p. 267. H. F. Parsons, *Isolation Hospitals*, p. 15.

² Under Local Authorities (Expenses) Act, 1887.

³ Public Health Act, 1925, s. 64.

VOLUNTARY HOSPITALS AIDED BY LOCAL AUTHORITIES

1. General Hospitals :

	Number.	Beds.
(a) Used in connection with Tuberculosis Schemes	153	†
(b) Used in connection with Venereal Diseases Schemes	139	†
(c) Maternity Sections used in connection with Maternity and Child Welfare Schemes	12	175
2. Tuberculosis Hospitals.	127	8,563
3. Maternity Hospitals (not including Maternity Sections in General Hospitals)	52	917
4. Babies' Hospitals	12	334

The figures under the above headings are exclusive of accommodation in homes for unmarried mothers and their babies, observation wards in connection with maternity and child welfare schemes, and convalescent homes.

INSTITUTIONS PROVIDED BY POOR LAW AUTHORITIES

	Number.	Beds.
1. Institutions wholly for the sick, exclusive of institutions for mental cases	64	35,250
2. Mixed institutions (with a total accommodation of some 180,000)	590	79,000†

† Available beds used as and when required.

‡ Beds for the sick.

During the year 1925, the Ministry of Health held ten public inquiries connected with the provision of isolation and small-pox hospitals, and its officers made ninety-eight inspections of hospitals and hospital sites.¹

In other places advantage is taken of the powers given by the Public Health Act, 1875,² to provide a temporary supply of medicine for the poorer inhabitants ; this, in fact, was one of the earliest efforts to prevent the spread of infectious diseases, having been employed at the time of the cholera epidemic of the early 'thirties and still persisting in the distribution of diarrhoea mixture at Manchester, and to hop-pickers in certain districts frequented by them. Two hundred and forty-eight local authorities have, with

¹ Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, pp. 186-7.

² Section 133.

the sanction of the Ministry of Health, made arrangements for home nursing of young children suffering from infectious disease. Of these 156 contracted with District Nursing Associations, others employ health visitors and, in a few populous districts, special nurses. Vaccination, although essentially a preventive measure, is provided by the Poor Law authorities, but antitoxin is in many places supplied to medical practitioners free of charge for use in cases of diphtheria.

There is, therefore, lack neither of powers nor precedents for the provision of adequate treatment for cases of preventable disease, a term which science has so extended that it is now estimated to include about two-thirds of the total. But, despite this fact, such provision is neither general in distribution nor similar in kind and amount, and, whilst in many places every effort is made to provide accommodation and to encourage all requiring treatment to enter and benefit free of charge, it is to be regretted that in some cases where hospital accommodation is provided it is so hedged with restrictions that the institutions remain empty and patients must rely upon the Poor Law and charity. The defect is due to the fact that there is no general obligation upon local authorities to provide treatment or accommodation for any particular sick person, however needy he may be, or however dangerous it is to the public for him to remain at home without proper care, treatment, or isolation.¹ Local authorities may charge for any accommodation or treatment provided, but in most cases this is freely given, the expenditure being rightly judged to be well-incurred, and justified by the improved health and greater safety of the community. The Ministry of Health favours the latter practice ; but where a charge is made it can only be charged to the patients, as not even the father of a child treated in hospital can be successfully sued for the expenses incurred.² This has led to the practice in

¹ See, however, the powers of the county council under the Isolation Hospitals Acts, 1893 and 1901, referred to earlier in chapter.

² *Hull Corporation v. Maclaren* (1898), *Local Government Chronicle*, p. 585.

some places of requiring guarantees for the costs before admitting patients, and, as previously indicated, tends to defeat the objects for which hospitals should be provided.

As an essential part of the work of the sanitary authorities as regards infectious disease, powers are given to provide disinfecting apparatus and to disinfect infected articles free of charge, a feature of their work which is frequently carried on in conjunction with the hospital,¹ vans being used to convey bedding and other things to and from the disinfecting station. For the conveyance of sick persons to or from the hospital, an ambulance may be provided,² and, where Section 50 of the Public Health Acts Amendment Act, 1907, has been adopted, this power extends to similar provision for cases of accident.³ Where the isolation hospital is provided under the provisions of the Isolation Hospitals Act, 1893, it must possess an ambulance or ambulances for the purpose of conveying patients to the hospital, which must be, as far as practicable, in connection with the system of telegraphs.⁴ This is an excellent and necessary requirement, except that the telephone is nowadays more useful.

The powers given by the Cleansing of Persons Act, 1897, to the councils of county boroughs and urban and rural districts, as well as, by an act of legislative folly, to boards of guardians, to provide the necessary apparatus and to permit verminous persons to cleanse themselves and clothing, are such as may be economically exercised in conjunction with a disinfecting station. These powers have now been replaced and strengthened where Part IV of the Public Health Act, 1925, has been adopted.⁵

It is becoming increasingly common, and, in the light of advancing knowledge, more and more necessary, for a bacteriological laboratory to be established in connection

¹ Public Health Act, 1875, s. 122.

² *Ibid.*, s. 123.

³ A charge may be made for conveying patients on discharge from an isolation hospital or for removal of non-infectious patients.—Public Health Act, 1925, s. 63.

⁴ Section 13.

⁵ Sections 45 to 50.

with the larger hospitals¹ and the time may not be long distant before every county and county borough will establish, maintain, and control a chemical and bacteriological laboratory wherein all scientific work connected with infectious disease, water, sewage, gas and foodstuffs can be rapidly and efficiently carried out.

This expectation seemed justified by the words of the Chancellor of the Exchequer, who, in introducing his Budget for 1914, stated that :

“ There is another deficiency in our health service which has been exposed by the operations of the Insurance Act. There is no provision for the scientific diagnosis of disease. In Germany, in almost every town, and I think also in France, there are pathological laboratories, which are of enormous assistance to doctors in ascertaining the real character of the disease when they are in any doubt upon the subject. There are a few boroughs in the United Kingdom where something has been done in this direction—even in London : but we propose to make a grant for the purpose of aiding the local authorities to set up laboratories throughout the United Kingdom.”²

But the War intervened and progress remains very slow.

In such a system of hospitals, incomplete in extent and with units of such varying character, it is impossible to indicate any method of administration which can be said to be generally adopted. It is perhaps the best plan to describe the characteristics of the administrative organization of a fair-sized hospital at which the essential conditions for success are practically realized. The object of a hospital is to cure disease and, by isolation, to prevent its spread amongst the members of the community ; large or small, its administration must be directed to this end, but at the same time its organization should be such as to permit of expansion with the minimum of friction and disturbance. For any hospital it is essential that the staff be adequate in number and efficient in skill and knowledge, the responsi-

¹ See Report of the Medical Officer of the Ministry of Health for 1925 for a summary of the pathological and bacteriological work done by or in connection with this department, p. 199.

² Speech by the Right Hon. D. Lloyd George, May 4, 1914.

bility of each official must be definite in amount and direction, and in the absence of any one of them another should step in automatically to undertake the same duties and carry the same responsibility. In an institution where lives are at stake discipline is a very important consideration, but it is equally necessary that in its enforcement no sense of injustice or arbitrariness should be felt by the staff. To this end it has been found advisable that in every case an appeal should be left to a higher authority, terminating, in the more serious cases, with the committee controlling the hospital.

The official control of a hospital is vested in the medical superintendent, who may be the medical officer of health, in which case, as such superintendence is not one of the duties prescribed, in the Order of the Ministry of Health an additional salary is paid. In the case of the large hospitals the office is a separate one held by a medical practitioner possessing wide clinical experience together with a high degree of administrative ability. Sometimes the officer is definitely subordinate to the medical officer of health, but the most approved plan appears to be for the medical superintendent to be directly responsible to the hospital committee for its administration, whilst the medical officer of health determines which patients are admitted, except in cases of emergency. Under such conditions the medical superintendent usually has a very free hand, although the medical officer of health may take an indirect interest in the administration of the institution. Under the medical superintendent a hierarchy of officials and servants is to be found, varying in number and kinds in the different classes of hospitals; they include medical officers, matrons, sisters, nurses, probationers, steward, clerks, ward maids, domestic servants, gardeners, porters, ambulance men, disinfectors, and others.¹

The sanitary authority invariably delegates the powers of control of hospital administration to the public health committee or a special hospital committee, a sub-committee

¹ See H. F. Parsons, *Isolation Hospitals*, Chapter XIV.

usually being formed for the purpose in the former case. To this committee all questions relating to hospital administration are referred, and all reports from the responsible chief are presented; the latter including the fortnightly or monthly reports showing cases of each disease admitted, deceased and discharged, staff cases, and existing number of patients and vacant beds, together with a requisition for the various goods and appliances ordered or required. Where an annual report is presented it summarizes the year's work, and may be accompanied by observations of any special circumstances relating to administration or treatment during the year dealt with, or by suggestions for improved methods for the future.

The medical superintendent is directly responsible for the care and treatment of the patients entering the hospital, for the discipline, training and good order of his staff, and for the general economical and efficient administration of the institution. If he is a good administrator he will exercise his control through a descending series of responsible officers, matters of sufficient importance to be dealt with by him personally reaching him at daily conferences with the departmental chiefs—the senior medical officer, the matron and the steward—official communications between whom should only pass through the medical superintendent.

The medical officers are responsible for the clinical and nursing work of the wards, of which they have charge, each ward sister being subordinate and responsible to them for these purposes. The matron, a highly-qualified and experienced nurse, controls the work of the ward sisters, except as above indicated, the general behaviour of the nurses when off duty, and the female domestic staff; in the institutions where an assistant matron or home sister is appointed she controls the female domestic staff and is herself responsible to the matron. The ward sisters—nurses who should have received a general as well as a fever training, of whom there is usually one for each division—are responsible for the general efficiency and cleanliness of the wards,

controlling the staff nurses, who are often only fever trained, and probationers, who are undergoing training, in all their work, and the ward maids for rough cleaning. The steward or headman deals with the accounts, clerical work, and stores, other than drugs, and controls the work of the lay male staff.

Local authorities are experiencing difficulties in securing a sufficient number of properly-trained and qualified nurses or of probationers of the right class. Probationers, who should be carefully selected, are received for two years, at the end of which time they are certificated if successful at an examination. These examinations were formerly set by the hospital officials, and varied so much in standard that certificates were of little value as a criterion of knowledge and ability unless the methods of the institution were known. The leading fever hospitals then took up a scheme instituted by the Fever Nurses' Association, by which a hospital of sufficient size and efficiency was recognized by the association, in which case nurses had to be trained in accordance with a scheme drafted by the association, which also approved the appointment by the Hospital Committee of an independent examiner to examine them in their practical work. The examination paper was set by the Education Committee of the association, the nurses who passed being certificated and registered. The arrangements for examination and registration were regarded by the Fever Nurses' Association as purely temporary, and every effort was made to secure examination and registration by the State, a proposal which had the support of the British Medical Association and practically all organized bodies of nurses in the United Kingdom. The need for a good system of nursing was recognized by a former Chancellor of the Exchequer when he testified to the good work being done by some voluntary associations and local authorities, and declared it to be the Government's intention "to provide a substantial annual sum to help to provide for the training of an adequate supply of nurses."¹ As State regula-

¹ Right Hon. D. Lloyd George, May 4, 1914.

tion and control is the logical outcome of State aid, the efforts of the Fever Nurses' Association were crowned with success in 1919, when the Nurses Registration Act was passed. This provided for the establishment of a General Nursing Council, amongst the duties of which were the formation and keeping of a register of nurses of various classes (including fever nurses), the making of rules regulating the formation, maintenance and publication of and admission to the Register, and the conduct of examinations. On the 31st March, 1927, there were 57,313 nurses on the Register, including 5,118 qualified by examination since June, 1925.¹

The problem of training is not the only one confronting hospital authorities. It is necessary to secure a sufficient number of applicants of the right class for training, and these will only be obtained by improving the remuneration and conditions of service. At present the hours are generally long, liberty is small, the work is arduous and the pay insufficient to attract the best class.

The first two drawbacks can only be removed by increased staffs, and as an increased supply of nurses can only be obtained by offering adequate salaries, the Fever Nurses' Association, which is particularly active, has formulated a minimum wage schedule as follows :

1. *Probationers and Junior Assistant Nurses* :
First year, £40. Second year, £45
2. *Staff Nurses* :
Those who are on *either* the General or Fever Registers :
£60 rising to £70 by £5 annually.
Those who are on *both* Registers : £75 rising to £85 by £5 annually.
3. *Sisters* :
Those who are on the General and Fever Registers : £90 rising to £120 by £10 annually.
4. *Night Superintendents and Home Sisters* :
Those who are on General and Fever Registers : £100 rising to £150 by £10 annually.

¹ Eighth Annual Report of the Ministry of Health, p. 6.

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5. *Sister Tutors* :
Without Diploma : £120 rising to £150 by £10 annually.
With Diploma : £150 rising to £190 by £10 annually.
6. *Assistant Matrons* :
Up to 100 beds : £120 to £130.
100 to 200 " £130 to £150.
200 to 300 " £150 to £175.
300 to 400 " £170 to £200.
over 400 " £200 rising.
7. *Matrons* :
Up to 50 beds : £120.
50 to 100 " £150 to £180.
100 to 200 " £200 to £250.
200 to 300 " £250 to £300.
300 to 400 " £300 to £350.
over 400 " £350 rising.

These demands, which have already been accepted by many of the more progressive authorities, are not excessive, and it is probable that economic forces will compel the most unwilling local authorities to adopt the scale in order to competently staff their institutions, especially since health visiting, school nursing, and sanatoria are rapidly increasing the demands for nurses.

CHAPTER XVIII

THE CONTROL OF TUBERCULOSIS

BEFORE the year 1911 sanitary authorities and their public health departments were not, as a general rule, specially concerned with the treatment or prevention of tuberculosis, despite the fact that the toll of deaths levied by this disease was only exceeded by those from bronchitis and pneumonia, diseases which it frequently follows. The reduction of the tuberculosis death-rate from 3.5 per 1,000 in 1851 to 1.6 in 1907 was a result of the general improved sanitary conditions, and not of any definite steps taken to combat this particular disease.¹ There were exceptions, however; several authorities, such as the Liverpool, Brighton and Blackburn Corporations, adopted systems of voluntary notification of phthisis, whilst Sheffield and Blackburn Councils early in this century obtained powers under private Acts which made notification compulsory. Administrative control, treatment and preventive effort followed as a matter of course; and by December, 1911, nearly 1,400 beds had been provided by sanitary authorities in addition to 9,000 beds in Poor Law institutions occupied by consumptives, and 400 beds rented by local authorities at some of the eighty-four sanatoria (4,200 beds) provided by private persons or voluntary associations. Besides these efforts fourteen sanitary authorities had provided tuberculosis dispensaries, and in fifty other districts tuberculosis dispensaries under voluntary management were available.² The experience thus gained, together with the growing

¹ See Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 81.

² Forty-second Report of the Local Government Board (Medical Officer's Report), p. xxxix.

public opinion, that a disease, which science showed to be amenable to control and prevention, should be controlled and prevented, resulted in the issue of a series of legislative enactments making all forms of the disease notifiable and requiring sanitary authorities to make provision for its treatment.

The Public Health (Tuberculosis) Regulations, issued in 1912, repealed the previous orders of limited application, and required the notification to the medical officer of health of all cases of tuberculosis (pulmonary and non-pulmonary) by medical practitioners within forty-eight hours after first becoming aware that any person is suffering from the disease; school medical inspectors, medical officers of Poor Law institutions and sanatoria, and tuberculosis officers are allowed to send in weekly returns of cases coming under their notice.¹ The medical officer of health must keep a register of such notifications, revising such register at least once every quarter, must transmit any received in error to the right quarter, notify the medical officers of other districts into which tuberculous patients have removed, and, if the district is a county district, he must forward to the county medical officer of health a weekly list of the notifications received.² The medical officer of health, or an officer acting under his direction, is required to make such inquiries and to take such steps as are necessary or desirable for investigating the source or preventing the spread of infection, and for removing conditions favourable to infection. For these purposes the local authority, on the advice of the medical officer of health, may supply all such facilities and articles as may reasonably be required, as well as provide and publish or distribute suitable summaries of information and instruction respecting tuberculosis and the precautions to be taken against the spread of infection.

The powers given by these regulations, supplemented

¹ See also Public Health (Notification of Infectious Disease) Regulations, 1918.

² See also Public Health (Tuberculosis) Regulations, 1918.

by the Public Health (Prevention and Treatment of Diseases) Act of 1913, were sufficiently comprehensive to include any steps that a local authority might wish to take to reduce the sickness and mortality rates from this disease. But beyond these powers the provisions of the National Insurance and Finance Acts of 1911 were far more important, and had the additional advantage of encouraging, by grants-in-aid, the authorities concerned to take effective steps to stamp out a disease which entails a heavy drain upon the public and private purses.¹

The responsibility of Insurance Committees for sanatorium treatment was terminated in 1920² and henceforth was placed upon the councils of counties and county boroughs³ which may exercise their powers through a committee or sub-committee of which a third may be co-opted persons specially qualified by training or experience,⁴ or may form with the consent of other local authorities, and by order of the Ministry of Health, joint committees for the purpose.⁵ If an authority neglects to make adequate arrangements for the treatment of tuberculosis the Ministry of Health may, after giving such authority a hearing, make the necessary arrangements and recover from the defaulting authority the costs.⁶

The medical officer of health is the centre of all schemes for the control and treatment of tuberculosis. He it is who must direct educational efforts to impress upon the public the dangerous character of the disease and the importance of utilizing facilities provided for securing early diagnosis and treatment. He also must secure the co-operation of the general practitioner and the school medical officers, and finally he has, as a rule, the administrative control of his authority's scheme, the special machinery of which must be correlated with the general work of his department.

¹ See author's "Elements in the Cost of Consumption" in the *Westminster Review*, June, 1911.

² National Health Insurance Act, 1920, s. 4.

³ See Circular 190 of the Ministry of Health, March 31, 1921.

⁴ Public Health (Tuberculosis) Act, 1921, s. 4.

⁵ *Ibid.*, s. 5.

⁶ *Ibid.*, s. 1.

The scheme set out in the Interim Report of the Departmental Committee on Tuberculosis (Cd. 6164) has been generally followed. It laid down the principles that "the tuberculosis dispensary should be the common centre for the diagnosis and for the organization of the treatment of tuberculosis in each area," and that it should act as a clearing-house for and be linked up with "a system of sanatoria, hospitals, farm colonies, open-air schools, etc."

The functions of the tuberculosis dispensary, of which there are 483, 443 of these being provided by local authorities,¹ are :

- (1) Receiving house and centre of diagnosis.
- (2) Clearing house and centre of observation.
- (3) Centre for curative treatment and supervision of domiciliary cases.
- (4) Centre for the examination of contacts.
- (5) Centre for "after care."
- (6) Information bureau and Educational Centre.

To this institution come or are sent patients in every stage of the disease as well as others whose ill-health may be only suspicious, or whose contact with infected persons makes it possible that they have contracted the disease. After examination by the tuberculosis officer, aided by specially trained nurses, the patients are either drafted off to the various institutions suitable for their particular stage of the disease, treated at the dispensary, or at home—domiciliary treatment—by their medical attendant acting in more or less close consultation with the tuberculosis officer. At the dispensary precautionary advice is given to patients and their guardians, and from it spitting cups, open-air shelters and medicines are distributed and a system of observation and "after care" of patients who have been treated at institutions or at home is organized. The work of the tuberculosis officer and of the dispensary is greatly facilitated by visits to the homes of patients by the health visitor or nurse, who investigates the home con-

¹ Seventh Annual Report of the Ministry of Health, p. i.

ditions and, where necessary, informs the medical officer of health of circumstances requiring the attention of his staff.

No hard and fast lines can be laid down for the provision of dispensary accommodation. The problem in compact urban districts, which may best be served by one or more centralized dispensaries always open, differs from that in rural areas with scattered populations, where a number of smaller institutions, periodically opened, may give the best results; but in each case the staff must include medical, nursing, and secretarial officers in order to be economical and efficient.

The whole system pivots round the tuberculosis officer, who may be the medical officer of health if he is suitably trained and has sufficient time. If not, the tuberculosis officer must be a suitably qualified and experienced medical man, not less than twenty-five years of age, who has held house appointments for at least six months in a general hospital, in addition to a similar period of service at a special institution for the treatment of tuberculosis, and be competent to supervise the necessary laboratory work. On the 31st March, 1927, there were in England 367 tuberculosis officers working under the schemes of local authorities.¹

So far as his duties are clinical and concerned with the diagnosis of the disease and the determination of the most suitable treatment the tuberculosis officer acts quite independently of control by any other medical man, but in matters of administration he "should act under the direction of the medical officer of health, who is the chief executive and organizing officer of the scheme."² It is very necessary that his relations with the general medical practitioners, the medical officers of the various institutions, and officials of other authorities and voluntary agencies should be close and friendly, as only in this way can a permanent and effective control and treatment of tuberculous patients be secured.

¹ Eighth Annual Report of the Ministry of Health, p. 34.

² Forty-second Report of the Local Government Board, Part III, p. xx.

Beyond the dispensary, and receiving cases which the tuberculosis officer has decided are suitable, are the sanatoria and hospitals. The former treat those cases in which there is a prospect of arrest of the disease. The latter (*a*) take doubtful cases for observation or for determination as to their suitability for sanatorium treatment; (*b*) treat acute cases with a possibility of subsequent transfer to a sanatorium; (*c*) take "middle" and "chronic" cases for short period treatment and education in hygiene; (*d*) isolate dangerously infective and advanced cases. General hospitals are used extensively for the treatment of non-pulmonary tuberculosis, but latterly orthopædic schemes for the treatment of tuberculosis of bones and joints are being developed in conjunction with arrangements for surgical after-cure of the patients after discharge.¹ Treatment by artificial light is as yet in an experimental stage, but installations at thirty-six residential institutions and at eleven tuberculosis dispensaries have been approved by the Ministry of Health.² The table on opposite page shows the extent of the provision of residential treatment for tuberculosis.³

"The essential element of sanatorium treatment . . . is a carefully calculated balance of rest and exercise (under the constant and watchful supervision of a skilled resident medical officer—the one predominant and essential factor) and conditions which permit of abundance of fresh air and sunshine, adequate and nutritious diet, appropriate occupation, and quiet and restful sleep."⁴

The necessity for providing appropriate occupation for mind and body is one of the most difficult problems of sanatorium administration, the needs and capacities of patients being very varied and their composition changeable. Efforts in this direction are at present experimental and in

¹ Report of the Chief Medical Officer of the Ministry of Health for 1925, p. 89.

² Eighth Annual Report of the Ministry of Health, p. 35.

³ *Ibid.*, p. 34.

⁴ Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 91.

	Institutions.		Beds.	
	Local Authorities.	Voluntary.	Local Authorities.	Voluntary.
A.—Institutions for Pulmonary Cases (mainly or entirely) :				
(1) Sanatoria	139	58	10,275	4,183
(2) Isolation Hospitals	50	1	2,351	50
(3) Children's Institutions	10	12	486	801
B.—General Hospitals :				
(1) Town	1	140	44	536
(2) Country Branches	—	15	—	140
C.—Institutions for Non-Pulmonary Cases (mainly or entirely) :				
(1) Adults only	2	5	222	139
(2) Children only	8	35	764	1,650
(3) Adults and children	1	5	23	538
	211	271	14,165	8,037
	482		22,202	

some cases, e.g. vocational training, do not appear to have given the results hoped for.¹

An important new power was given in 1925 to county councils as well as urban and rural authorities which enables them to secure the removal to hospital or an institution of any person who is suffering from pulmonary consumption and is in an infectious state and who either cannot or will not take precautions to prevent the spread of the infection. The order of a court of summary jurisdiction is necessary and the period of detention is limited to three months with powers to the authority to apply for an extension at the end of that time and to the patient to apply for a rescission of the order at any time after six weeks from its date.

¹ See *Ibid.*, pp. 104-110, for experience of Training Centres.

The costs must be borne by the authority obtaining the order, and it may be required by the justices to contribute towards the maintenance of the patient's dependants whilst the patient is detained.¹

If the benefits obtained from sanatorium treatment are to be maintained and made permanent it is necessary to safeguard the patient against those influences which may cause relapse. Village settlements² provide the necessary conditions most completely and effectively, but this method is available only to a few, hence a system of after-care, recommended by the Departmental Committee on Tuberculosis, has been authorized by the Public Health (Tuberculosis) Act of 1921³ and encouraged by the Ministry of Health, and After-Care Committees (including voluntary workers, and representatives of charitable organizations) have been set up in many places. In 85 out of 154 counties and county and metropolitan boroughs some arrangements for after-care are made. "In seventy-four instances the work is carried out by special voluntary committees, in five instances by or under the direction of the public health or other council committees, and in the remaining cases by general social welfare organizations or in other ways." The work of care committees is too variable to be generalized and their effectiveness is equally varied, depending greatly upon the capacity and enthusiasm of their individual members whose work appears, in many cases, to be crippled by lack of funds.⁴

The Chief Medical Officer of the Ministry of Health has indicated the great influences which have caused the decline of tuberculosis since 1850 as follows:⁵

- (1) The progress of sanitary reform and factory legislation and increased attention paid to child welfare and diseases predisposing to tuberculosis.

¹ Public Health Act, 1925, s. 62. See Eighth Annual Report of the Ministry of Health, p. 39.

² See Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, pp. 97-8.

³ Section 2.

⁴ Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, pp. 95-6.

⁵ *Ibid.*, p. 81.

- (2) An advance in social well-being and communal health.
- (3) The spread of knowledge of the contagiousness of the disease, particularly since 1881.
- (4) Special measures of prevention and treatment of the disease.
- (5) An increase in the immunity resistance of the population.

The mortality from all forms of the disease continues to fall, despite more accurate diagnosis and more effective notification, and, as experience widens and the full effect of other branches of hygienic effort, such as school medical inspection and maternity and child welfare work are felt, it is reasonable to expect that the decline will be greater in the future.

CHAPTER XIX

MATERNITY AND CHILD WELFARE

WITHIN the last dozen years there has been added to the vast and varied work of the Public Health Department a huge new sphere of effort—that concerned with the welfare of the mother and her infant child. The awakening of the public to the necessity for such service and its consequent recognition in enactments by Parliament was in no small measure due to the revelations of recruiting during the war,¹ supported as they were by vital statistics which showed in 1900 an infantile mortality of 154 per 1,000 births and a maternal mortality of 4·81 per 1,000 births. It is true that by 1914 these rates had been reduced to 105 and 3·56,² but the civic conscience was aroused and, supported by national fears, an administrative organization, for which voluntary effort had shown the way, was rapidly organized and built up with a view to a further reduction of these figures.

Before the end of the last century efforts at alleviating maternal and infantile suffering and reducing the mortality had been commenced in various directions, largely by or under the influence of voluntary organizations; and health visitors were authorized for the metropolis under the London County Council (General Powers) Act, 1908. But any solution of the problem involved obviously depended upon three conditions, neither of which was in existence in the early years of this century. These conditions were: (1) a prompt knowledge of all births; (2) the existence of staffs

¹ C. Porter, M.D., B.Sc., in *The Future Citizen and His Mother*, pp. 1 and 2.

² Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 119.

with adequate training ; and (3) facilities for the provision of advice, instruction, and treatment where necessary. During the past twenty years legislative and administrative activity have been directed to securing these conditions.

The Notification of Births Act, 1907, required, in the areas for which it had been adopted, the notification by the father or person in charge of the mother, of the birth of any child within thirty-six hours of such birth. Councils of counties and of county districts could adopt the Act, the former for the whole or part of the county.¹ In 1915, experience where the above Act had been adopted being favourable, the Act was put in force in every district, the central authority retaining the power to substitute the county council for the district council, or vice versa.² Two further important steps were also taken. Local authorities, i.e. county councils and urban and rural district councils, were empowered to exercise any powers under the Public Health Acts as might be required for the purpose of the care of expectant mothers, nursing mothers, and young children,³ and such powers could be exercised by a committee which had to include women and which might comprise persons who were not members of the authority.⁴

The foundations thus laid were somewhat elaborated by the Maternity and Child Welfare Act, passed in 1918. Any local authority within the meaning of the Notification of Births Act, 1907, is empowered to make such arrangements as may be sanctioned by the Ministry of Health "for attending to the health of expectant mothers and nursing mothers, and of children who have not attained the age of five years and are not being educated in schools recognized by the Board of Education."⁵ The last proviso prevents overlapping with the school medical service. To exercise these powers every council acting under this Act or the Notification of Births (Extension) Act, 1915 (Section 2),

¹ Section 1.

² Notification of Births (Extension) Act, 1915, Sect. 1.

³ *Ibid.*, Sect. 2/1.

⁴ *Ibid.*, Sect. 2/2.

⁵ Maternity and Child Welfare Act, 1918, Sect. 1.

must establish a maternity and child welfare committee, which may be an existing committee or a sub-committee of an existing committee, and, whilst at least two-thirds of its members must be members of the authority, two at least must be women, and some may be non-members specially qualified by training or experience in subjects relating to health and maternity. Obviously where there are no women on the council the "may" becomes "must" as regards non-members. To this committee all matters relating to the exercise of the powers of the council under the Act or under the Notification of Births (Extension) Act, 1915 (except raising a rate or borrowing money), must be referred, and the council, unless the matter is urgent, must receive and consider the report of the committee before taking any action.¹

There is thus no lack of power, where there is the will, for any authority to contribute to the reduction of a mortality which hygienic science shows to be far too high. It is not obligatory upon any authority to exercise these powers, but there were at the end of 1927 in England and Wales 419 authorities, comprising 60 county councils, 83 county borough councils and 276 councils of county districts administering schemes under the Maternity and Child Welfare Act.

Such schemes, to be complete, would include the following services² towards the approved net expenditure on which the Ministry of Health has power to make grants up to 50 per cent. :—

- (i) *Medical Supervision*.—This includes supervision by the medical officer of health with such medical assistance as may be necessary.
- (ii) *Health Visitors*, whose duties include attendance at centres and the visiting of children under five years of age at their homes.
- (iii) *Nurses*.—The provision of nursing under the Maternity

¹ Maternity and Child Welfare Act, 1918, Sect. 2.

² Memorandum of Evidence submitted by the Ministry of Health to the Royal Commission on Local Government, par. 191.

and Child Welfare Act is in practice limited to the following diseases and conditions :—

Maternity, puerperal fever and pre-natal cases in women, ophthalmia neonatorum, measles, whooping-cough, epidemic diarrhoea, and poliomyelitis in children.

- (iv) *Provision of Midwives.*
- (v) *Centres.*—These include :
 - (a) *Ante-Natal Centres*, providing medical supervision and advice to expectant mothers.
 - (b) *Infant Consultation Centres*, whose essential function is the supervision of healthy children rather than the treatment of the sick, although provision may be made for the individual treatment of simple ailments.
 - (c) *Treatment Centres* (including dental clinics).
- (vi) *Maternity Homes and Hospitals.*
- (vii) *Infants' Hospitals.*
- (viii) *Convalescent Homes.*
- (ix) *Homes for Mothers and Infants.*
- (x) *Homes for Children.*
- (xi) *Day Nurseries* (for the care of healthy infants and young children whose mothers are obliged to engage in daily work which takes them away from their own homes).
- (xii) *Home Helps* (for providing domestic assistance to mothers during the period of childbirth).
- (xiii) The provision of milk and food for expectant and nursing mothers and young children in necessitous cases.

As is to be expected from the permissive character of the Act and the widely differing requirements and financial standing of the various authorities, there are wide variations in the schemes as regards both their efficiency and comprehensiveness. Where a county district is in default the Ministry of Health may, on the application of the county council, transfer the powers of the former to the latter, and

since the passing of the Notification of Births Act, 1907, the powers of 616 district councils have been so transferred; and, on the other hand, seven county district councils (five borough and two urban) have had the powers transferred from the county council to them.¹ The Ministry of Health has the further power of approving or otherwise the schemes submitted by local authorities, and as such approval carries with it a grant of 50 per cent. of the cost of the approved service an effective stimulus to efficiency is provided for those local authorities who take their responsibility seriously.

On March 31st, 1927, there were in England 2,324 maternity and child welfare centres known to the Ministry of Health. Of these 1,489 were conducted by local authorities and 835 by voluntary agencies, some of the latter receiving grants indirectly through the local authorities within whose areas they operated. In addition to 52 special centres for ante-natal work, there were 720 centres in connection with which ante-natal consultations were held, and 670 where arrangements for dental treatment were made.² At the centres advice and teaching is given to mothers in regard to the care and feeding of their children and the care of their own health, and arrangements made to ensure regular medical supervision of the children's health.

An important feature of the work of the maternity and child welfare committee is the provision of maternity beds for complicated cases, and for those whose domestic circumstances are such that safe confinement at home is impossible. Over 250 authorities have made some arrangements of this nature, and there are 2,290 maternity beds in 149 institutions, 81 of the institutions being provided by voluntary associations, many of which are assisted by the local authorities. In addition, there are 105 homes for mothers (chiefly unmarried) and their babies, with accommodation for 1,490 of the former and 1,327 of the latter; and 38 homes, including residential nurseries for children under five, the

¹ Memorandum of Evidence submitted by the Ministry of Health to the Royal Commission on Local Government, par. 191.

² Eighth Annual Report of the Ministry of Health, pp. 51-2.

number of children for which accommodation is available being 965. For ailing babies there are 39 observation wards and homes containing 719 cots, whilst convalescing mothers and their babies and children under five years have 802 beds in 48 homes provided for their reception.¹

In two directions effort is as yet scarcely beyond the experimental stage. Considerable interest is being shown in the application of artificial light treatment to various forms of disease and in orthopaedic treatment for various physical defects and diseases in children under school age other than those suffering from surgical tuberculosis. Knowledge of artificial light treatment is not sufficiently advanced for its indiscriminate adoption, and the Ministry of Health is only prepared to sanction its provision, otherwise than by the light department of a hospital, in cases where there is available a medical officer and nurse with special training and experience. Forty-seven such centres, of which twenty-three are provided by voluntary agencies, have been sanctioned,² whilst in the case of orthopaedic treatment the arrangements made by 24 county councils, 19 county borough councils and 25 other maternity and child welfare authorities, with an expenditure of £29,000, have been approved.³

The importance of milk to nursing mothers and young children, and the difficulty those of the poorer classes have in securing a sufficiency of this essential food, has led to a wide development of the provision of milk at less than cost price to expectant and nursing mothers, and children under five years. This provision is not intended to relieve distress, but only for such as are certified to need it on medical grounds, a distinction difficult to maintain in practice, a fact which probably accounts for the net expenditure of £188,000 in 1925-6 by local authorities on this service.⁴

The economic circumstances of many mothers of young children are such as to oblige them to go out to work. Public opinion has not yet reached the point of making

¹ Eighth Annual Report of the Ministry of Health, p. 53.

² *Ibid.*, p. 52.

³ *Ibid.*, p. 53.

⁴ *Ibid.*, p. 54.

provision to enable such mothers to leave industry and devote themselves to their natural function—the care of their children ; but in maternity and child welfare schemes provision of day nurseries, where such children may be cared for whilst their mothers are at work, may be made. Since the war, when the need was greatest, the number of such nurseries has diminished, but there are still 100, of which 81 are provided by voluntary organizations, and these meet a very real need.¹

Of special concern in the cases of mothers and their newborn children are the diseases of puerperal fever, puerperal pyrexia and ophthalmia neonatorum, all of which are notifiable.² Notification is the precedent necessary to treatment which may be provided for in maternity and child welfare schemes.³ In the case of puerperal pyrexia such provision may take the form of consultation with an obstetric specialist, of skilled nursing, or of institutional treatment, and arrangements have been made by 162 local authorities for one form or another of these.⁴ The duty of notifying ophthalmia neonatorum now rests solely upon medical practitioners, but midwives must (1) call in medical aid in any case of inflammation or discharge from the eyes, and (2) notify the supervising authority under the Midwives Acts that such aid has been sought. Where the local sanitary authority is not the maternity and child welfare authority the medical officer of health of the county must receive such notification within twenty-four hours of its receipt,⁵ and adequate treatment of such cases by visiting and home nursing or in hospital may be provided.

The medical profession has long had a definite status, and no one may practise as a doctor unless he or she has a legally recognized medical qualification. It was not, however, until 1902 that any steps were taken to ensure that persons performing the important function of midwifery

¹ Eighth Annual Report of the Ministry of Health, p. 52.

² See Chapter XVI.

³ Ministry of Health Circulars, 617, 617A and 722 of 9/8/26.

⁴ Eighth Annual Report of the Ministry of Health, p. 50.

⁵ Public Health (Ophthalmia Neonatorum) Regulations, 1926.

were required to possess some token of training and knowledge. The Midwives Act of that year established county and county borough councils as supervisory authorities over midwives, who were thereafter to qualify by passing an examination of a Central Midwives Board. Provision was made for special training for six months of trained nurses and for twelve months of others. Centres receive grants-in-aid¹ both for ordinary courses of training and for post-certificate courses from the Ministry of Health, and, since the passing of the Act of 1918,² the local supervising authorities may aid such training and make grants for the purpose. There are 73 such institutions recognized by the Ministry, and grant was paid as regards 817 pupil midwives, and also in respect of midwives attending post-certificate courses at four approved institutions.³

A further step towards ensuring skilled treatment at childbirth was taken in 1926,⁴ when the registration of maternity homes was required and may be refused on the grounds either of unfitness of the person or of unfitness of the place. The Act also empowers local authorities to make bye-laws in respect to records to be kept at, and for the notification of any death in such homes, and provides for entry at all reasonable times to inspect the premises and examine records.

During 1925 midwives to the number of 16,282 gave notice of their intention to practise in England and Wales,⁵ but the number practising, largely owing to duplication of notification, is certainly much less. Very many of these work under the direction of District Nursing Associations, which also undertake much health work for county councils, especially in scattered and sparsely populated areas. To increase the supply of trained midwives the Ministry of Health has approved the contributions of 36 county

¹ See Memorandum 102/MCW of the Ministry of Health, February, 1925.

² Midwives Act, 1918, Sect. 11.

³ Eighth Annual Report of the Ministry of Health, p. 49.

⁴ Midwives and Maternity Homes Act, 1926.

⁵ Eighth Annual Report of the Ministry of Health, p. 47.

councils to county nursing associations in respect of such provision.¹

The importance of the legislation just outlined is evident from the fact that 59 per cent. of the births in England were notified by midwives,² and that upon them, therefore, in no small degree, devolves the responsibility for maternal mortality. Since, however, their training is not equal to that of a medical practitioner they are, in certain circumstances, required to call in medical aid, payment for which is guaranteed by the local authority, which may recover from the patient where possible.³ Such fee is often a great strain upon the resources of people with limited incomes and, recognizing this, Parliament has empowered local authorities to make arrangements whereby expectant mothers can insure against such liability,⁴ and several authorities have such schemes in operation.⁵

There are many cases of maternity where the family is in such poor circumstances that the skilful work of the midwife may be rendered nugatory and the recovery of the patient retarded by the lack of capable help in the home. To meet such necessity some authorities employ specially selected and approved women to assist in the homes of certain necessitous lying-in women. This work is closely supervised by the health visitor, and, when properly done, is of great value in facilitating the speedy recovery of the housewife and preventing the neglect of the family.⁶

The earliest official concerned in the work of maternity and child welfare was the health visitor, and these now form the most numerous and ubiquitous class. The importance of their work and the necessity for their skilled training has been emphasized by the Ministry of Health, to which the responsibility for their training has been transferred from the Board of Education. Since April 1st, 1928, the Ministry

¹ Eighth Annual Report of the Ministry of Health, pp. 48-9.

² *Ibid.*, p. 47.

³ Midwives Act, 1918, Sect. 14.

⁴ Midwives and Maternity Homes Act, 1926, Sect. 2 (3).

⁵ Eighth Annual Report of the Ministry of Health, p. 51.

⁶ See the Medical Officer of Health's Report for West Ham, 1927, for a good outline of maternity and child welfare work in a large town.

will not approve the appointment for the first time as a whole-time officer on health visiting duties of anyone who does not hold the Health Visitors' Certificate or the diploma given under the Regulations of the Board of Education. The new certificate can be obtained only by (1) trained nurses with the C.M.B. (certificate of the Midwives Board) after an approved course of training in the duties for six months; (2) women who have had an approved course of training of two years' duration, together with six months' hospital training, and who hold the C.M.B.; and (3) existing health visitors with three years' satisfactory service.¹ The financial difficulties of training are overcome either by the advance of salary during training or by employment as probationer health visitors at a salary of not more than 75 per cent. of the ordinary commencing salary. There are eight institutions approved for training, and thirty-nine of the fifty-seven students who completed training during the year 1926-7, together with fifteen existing health visitors, obtained the new certificate.²

The net expenditure of local authorities upon maternity and child welfare services in 1925-6 was £1,347,850; and during the following year the Ministry of Health paid by way of grants-in-aid £699,847 to local authorities and £209,797 to voluntary societies for the same purpose.³

During the first quarter of this century there has been a steady decline of the infantile death-rate (154 per 1,000 births in 1900; 70 in 1926), and a smaller decline in maternal mortality (4.81 per 1,000 births in 1900; 3.86 in 1925).⁴ The former is evidence of the good effect of the increasing attention devoted to the child. The latter, which shows that one out of 250 mothers died in childbirth, is "a terrible thing."⁵ The Minister of Health is very much alive to the urgency of this problem, and a Maternal Mortality Com-

¹ Ministry of Health's Circular 879 (Health Visitors), March, 1928.

² Eighth Annual Report of the Ministry of Health, p. 47.

³ Eighth Annual Report of the Ministry of Health, pp. xxvi. and 46.

⁴ Annual Report of the Chief Medical Officer to the Ministry of Health, 1925, p. 119.

⁵ The Right Hon. Neville Chamberlain, Minister of Health, in the House of Commons, May 15, 1928.

mittee has been set up to collate the results of investigations in every area by competent and experienced medical officers of all cases of puerperal fever with a view to determining actual causes leading to maternal mortality. On the other hand, believing that midwifery was "a hard and arduous profession, not well paid," and that if they could get "the class of woman wanted to enter that profession—an educated, humane, sympathetic, earnest woman—the conditions of the service must be made more attractive,"¹ the Minister of Health has, with the concurrence of the Central Midwives Board, appointed a Departmental Committee "to consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery) and the conditions under which midwives are employed."

¹ The Right Hon. Neville Chamberlain, Minister of Health, in the House of Commons, May 15, 1928.

SPECIMEN CARD USED BY HEALTH VISITORS

SURNAME..... | **ADDRESS**..... | **Date of Birth**.....

Other Names (Infant)..... **(Father)**.....

Attended by..... **Visited by**.....

Method of Feeding..... | **Advice given**.....

Digestion and Bowels..... |

Sleeping..... |

Clothing..... |

Bathing..... |

Open Air..... | **Still Birth**..... **Misc.**

Rooms Occupied..... **Rent**..... **Total Cub. Capacity**..... **Adults**..... | **Children**

under 5

5 to 15

Occupation of Father..... **Where at**..... **Of Mother ?**.....

Cleanliness of Rooms..... **Of Yard**..... **Food Store**

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CHAPTER XX

SANITARY AUTHORITIES AND THE COURTS

THE subordination of administrative authorities to statute law and the powers of the courts to enforce that subordination have been well summed up by an eminent legal authority, who says :

“ The administrative system of England is dominated throughout by the principle that no power can be exercised unless it has been conferred by law, no obligation imposed on any citizen except by law and that if the exercise of discretion has been entrusted to any officer or department of the Central Government, or to any municipal body, this discretion must be exercised strictly according to the rules of law, which law will, in cases of dispute, be interpreted by the ordinary courts, not by an administrative tribunal.”¹

We have already seen² that sanitary authorities owe their existence and powers to the action of Parliament, that some powers must be exercised and that others are discretionary, and as we have passed in review one after the other of the functions of the public health department we have repeatedly noticed that in the exercise of these powers the courts have to be appealed to in the last resort.³ On the other hand, local authorities neglecting to perform duties imposed upon them by law may be compelled to do so by a *mandamus* of the High Court,⁴ and if such neglect deprives a citizen of a right to which he is entitled he may

¹ E. Jenks, “ The Rule of Law in English Local Administration,” in *Problems of Local Government*, p. 204; compare Dicey, *The Law of the Constitution*, and Ashley, *Local and Central Government*.

² See Chapters III, IV and V.

³ See Chapters XII and XIV for particular instances.

⁴ Compare Public Health Act, 1875, s. 299; Housing Act, 1925, ss. 23, 24, 50, 51 and 73, and Milk and Dairies (Consolidation) Act, 1915, s. 13.

bring an action for damages against a local authority¹ or official, but if the duty involves the exercise of discretion malice must be proved for the action to be successful.

It is, moreover, necessary that the authority and their officials, in the performance of their duties, act strictly within their legal powers, complying with the prescribed procedure and seeking the specified remedies, for no plea of public interest will protect them if they are guilty of illegal action against individuals; they can be made liable as if they were private citizens. Any action brought against a local authority or officials in respect of any act done in pursuance or execution or intended execution of any Act of Parliament or of any public authority, or in respect of any alleged neglect or default in the execution of any such Act, duty or authority, is, however, in general, subject to the conditions that it must be instituted within six months of the alleged offence, and sufficient opportunity of offering compensation must be given to the authority or officer.² But no matter or things done or contracts entered into *bona fide* for the purpose of executing the Public Health Acts subject authorities or officers to any action, liability, claim, or demand.³

In addition to the *mandamus*, which is by far the most important of the writs issuing from the High Court, and affecting local administration, a writ of *certiorari* may be applied for by any person aggrieved by a disallowance of a district auditor⁴ or in order to remove an order of the council of a borough for the payment of money,⁵ and writs of prohibition may be obtained directing local authorities to refrain from doing particular acts which they are not empowered to do or are prohibited doing.⁶

It is, however, in the performance by the local authority of their duty to enforce the various laws that resort to the

¹ Compare Public Health Act, 1875, ss. 42 and 43.

² Public Authorities Protection Act, 1893, s. 1.

³ Public Health Act, 1875, s. 265.

⁴ *Ibid.*, s. 247.

⁵ *Ibid.*, s. 246.

⁶ Cp. Public Health Act, 1875, ss. 17 and 19 and cases thereunder.

courts is most frequent. Even in those cases where in default of the owner or occupier complying with the notice of the sanitary authority, the authority are empowered to do the necessary work and charge the defaulter with the expenses, such expenses must in the last resort be recovered by an appeal to the courts ; and where such a remedy does not lie an order of a court must be sought by the local authority.

There are, however, some rather significant tendencies developing during recent years.¹ There is, firstly, the growth of the appellate jurisdiction of the Ministry of Health,² and, secondly, the appropriation by or endowment of the local authorities with quasi-judicial functions. It is the practice of some public health committees to summon before them persons who may be charged with breaches of the law, as in cases of offence against the Food and Drugs Acts, the Diseases of Animals Acts, or the smoke nuisance clauses of the Public Health Act, and to persuade such persons to agree to be dealt with by the committee who, after hearing evidence and explanations, inflict penalties. It is by no means certain that this procedure is to be commended, although it was embodied in the Milk and Cream Regulations of 1912,³ and as regards the suspension or revocation of licences under the Milk (Special Designation) Order, 1923, the holder of the licence must be afforded an opportunity of stating his case to the licensing authority ; an appeal may be made within seven days to the Ministry of Health, whose decision is final.⁴ The obvious objections to these methods are that innocent persons may often elect to be fined by the committee as being a cheaper course than fighting the case against a powerful authority in the courts ; it destroys publicity, which is often more than half the punishment, especially in cases of food adulteration ; and finally, and perhaps

¹ On this point see *Justice and Administrative Law*, by W. A. Robson.

² See Chapter XXV.

³ Article VI, repealed by Public Health (Preservatives, etc., in Food) Amendment Regulations, 1926, article 15.

⁴ Article IX.

most important, it puts a duty upon councillors that they were never intended to fulfil, and gives opportunity for the exercise of favouritism, if not corruption, to those who may be so inclined.

A useful power, against which there is no appeal, is given to local authorities by the Rent Restriction Acts under which a certificate may be granted to tenants of houses let below certain rentals that the house is not "in a reasonable state of repair." Possession of this certificate enables the tenants to make certain deductions from the rent and is a good defence to any claim by the owner that such deductions are arrears. When the house is made fit, the owner may obtain a certificate to that effect and the deductions must cease.¹

The Housing Act, 1925,² gives local authorities distinctly judicial powers in respect to houses which appear to them to be "in a state so dangerous or injurious to health as to be unfit for human habitation." * They may make a "closing order," prohibiting the use of such house for human habitation until in their judgment it is rendered fit for such purpose, appeal lying, not to a court of law, but to the Ministry of Health within fourteen days after the order is served upon the owner. A similar appeal lies within fourteen days of the local authority refusing, on the application of the owner, to determine the "closing order." Where such an order has remained operative for three months the local authority must take into consideration the question of the demolition of the house, each owner being entitled to a month's notice of such proceeding and to be heard when the question is considered. If the house has not been rendered fit for habitation, or either cannot be so rendered or the necessary steps for the purpose are not being taken with all due diligence, the authority must make a "demolition order," the owner having the right of appeal to the Ministry of Health within twenty-one days

¹ Rent Restrictions Act, 1923, s. 5.

² Sections 11, 13, 14 and 15.

* See tabulated statements of orders, etc., at end of Chapter XIV.

from the service of the order upon him. The judicial character of these functions was well brought out in the course of a case which was ultimately taken to the House of Lords. An owner appealed to the Local Government Board against a "closing order," and the Board, after a local inquiry,¹ dismissed the appeal and confirmed the order without hearing the appellant. The local authority refused to determine the order, and the owner again appealed to the Board, who again confirmed the action of the local authority without disclosing their inspector's report to the appellant. The latter appealed to the Court of King's Bench, which upheld the decision of the Board, but the Court of Appeal, by a majority, reversed the decision and held that the Local Government Board must decide the appeal in their capacity of a statutory appellate tribunal in some more judicial way than merely reading a notice that "after an impartial and careful consideration" the Board decided to dismiss the appeal. This decision was, however, the subject of a further appeal to the House of Lords where the decision of the Court of Appeal was reversed and the order of the Divisional Court restored, the Lord Chancellor (Viscount Haldane) declaring :

"That the Act of 1909 had introduced a change of policy by transferring the jurisdiction both as regards original applications and as regards appeals from courts of justice to the local authority and the Local Government Board respectively, both of them administrative bodies, and although the Board was bound to act judicially, so long as it followed its usual procedure it was not bound either to disclose the report of its inspector or to hear the owner orally."²

Apart from these cases, when all other efforts of the local authority and its officers have failed to secure the carrying out of the requirements of the various Acts or to recover the expenses where they have themselves done the necessary work, recourse must be had to the courts of law. As a rule,

¹ See Housing and Town Planning Act, 1909, s. 39; cp. Section 14 of the Housing Act, 1925.

² *Avidge v. Local Government Board* (1913), 1 K.B. 463; (1914), 1 K.B. 160; and (1914) W.N. 328.

the court to which application must be made is a court of summary jurisdiction, from which appeal usually lies to a court of quarter sessions.¹

To this, however, there are specific exceptions, such as in the case of the Rivers Pollution Act, 1876,² in which the county court is specified, or for the recovery of penalties for the pollution of water,³ action for which may be taken in the superior courts. The persons who may take action may be either a local authority, an aggrieved party, or some one expressly authorized as required for the particular purpose ; but the last two classes are only empowered to take action in specific cases. Thus, to enforce the provision of Section 41 of the Public Health Act, 1875, action is restricted to the local authority, whilst for the purpose of dealing with polluted wells the power is extended to "any person."⁴

Any aggrieved person is empowered to institute proceedings in respect to offences under the Rivers Pollution Act, 1876,⁵ the consent of the Ministry of Health to such proceedings being necessary both for a person aggrieved or a local authority if the offence is created by Part III of the Act.⁶ In like manner proceedings to recover penalties for the pollution of water require the consent of the Attorney-General,⁷ and the authorization of a justice of the peace or of the Ministry of Health is required to enable a police officer to secure the abatement of nuisances.⁸ Wherever a local authority is of opinion that summary proceedings would afford an inadequate remedy, they may take proceedings in any superior court of law or equity to enforce the abatement or prohibition of any nuisance under the Act, or for the recovery of any penalties from or the punishment of any person offending against its provisions relating to nuisances.⁹

As a general rule the alleged offence must have arisen

¹ See Interpretations Act, 1889, for definitions.

² Section 8.

³ Public Health Act, 1875, ss. 68 and 69.

⁴ *Ibid.*, s. 70.

⁵ Section 8.

⁶ Public Health Act, 1875, ss. 68 and 69.

⁷ *Ibid.*, ss. 105 and 106.

⁸ Section 6.

⁹ *Ibid.*, s. 107.

within the district of the justices before whom it is heard, but their jurisdiction extends to cases arising within 500 yards of the boundaries of their district or within a river, lake, or arm of the sea, forming such boundary, or where the offence was either begun or finished within their district. It is, however, an invariable custom of local authorities to take proceedings at their own district courts, except in certain cases, e.g. when a nuisance arises outside their district,¹ or from an offensive trade outside their district.²

The procedure is by information which must not specify more than one offence, and which must be laid within six months of the date when the offence arose; the time is limited to twenty-eight days from the date of purchase of the alleged adulterated food for the purposes of the Food and Drugs Acts.³ The information must be written, specifying the offence, signed by an officer of the authority, and sworn to before a justice of the peace, who issues a summons to the offender to attend before the court at a specified date and time.

The proceedings of the court, which may consist of not less than two justices of the peace or a stipendiary magistrate, are regulated by the various Summary Jurisdiction Acts. It is not desirable that a member of a local authority which is a party to the proceedings should adjudicate, but certain permissions to do so are given in various Acts,⁴ and it is not necessary that a justice of the peace who has condemned food under Section 116 of the Public Health Act, 1875, should adjudicate in any subsequent proceedings.

Upon the particular officer concerned in the case falls the duty of obtaining and preparing the necessary evidence for the prosecution, which may involve the calling of witnesses by "witness summons" if otherwise unwilling, and the calling for any necessary documents by subpoena obtained from the Crown Office. The evidence, of course, varies with the case, but it must include proof of the

¹ Public Health Act, 1875, s. 108.

² *Ibid.*, s. 115.

³ Food and Drugs (Adulteration) Act, 1928, s. 27.

⁴ Public Health Act, 1875, s. 258; compare Municipal Corporations Act, 1882, s. 158, and Justice of the Peace Act, 1867, s. 2.

existence of any local Act, bye-law or regulation, or of the adoption of an adoptive Act relevant to the case, and evidence that all the necessary procedure has been carried out, including in some cases a diligent search for the owner of the property involved, notices served, and observations or inspections made. As regards the appearance of the authority at the court the practice varies: in many cases the sanitary inspector appears, in others the medical officer of health, in a few the clerk, and in some of the large county boroughs a special prosecuting solicitor is on the town clerk's staff and takes charge of all cases.

The defendant or defendants, where a nuisance is wholly or partly caused by their joint acts or defaults,¹ may appear either personally or by solicitor or counsel, the court being enabled in default to either issue a warrant, adjudicate the case in his absence, or adjourn it to a future date. It is, however, essential, if the penalty may be imprisonment without the option of a fine, that the defendant be warned before the case that he may elect to be tried by a jury, since he may not exercise the option after the case is opened, and neglect to warn him of it invalidates the proceedings.

The penalties are prescribed in the various sections of the different Acts creating the offences, the court having power to order the costs to be paid. Failure to pay the penalties inflicted may be met by imprisonment in default of distress, but a defendant cannot be committed to prison for failure to obey an order to pay the expenses incurred by an authority, except by an order made on a judgment summons on proof that he has or has had means of paying.

Any decision of a court of summary jurisdiction may be the subject of an appeal to the Court of the King's Bench on either a point of law or excess of jurisdiction.² For this purpose application for a "special case" must be made to the justices within seven days of the decision contested, accompanied by a guarantee to prosecute the

¹ Public Health Act, 1875, s. 255.

² Summary Jurisdiction Act, 1879.

appeal and for costs. If the "case" is refused the King's Bench may order the court to state the case as required; if granted, the appeal must be lodged within three days, notice to all parties being given, the decision of the King's Bench, which may make any order or remit the case back for decision, being final.

Where the penalty may not be enforced by imprisonment in default of distress, appeal may be made within twenty-one days to the next court of quarter sessions, notice being given to the other parties and to the court of summary jurisdiction within fourteen days of the decision of the court, together with the ground of appeal and security of costs. The decision of the court is final unless it thinks fit to state the facts specially for the determination of a superior court.¹

In the case where local authorities are entitled to recover expenses in a summary manner or to declare them to be private improvement expenses, any person aggrieved may object to the apportionment of the surveyor within three months of the service of the demand;² and may appeal to the Ministry of Health within twenty-one days of the final decision of the authority, stating the ground of complaint and delivering a copy to the local authority. The Ministry may make such order as seems equitable, and the order made is binding and conclusive on all parties.³

Considering the immense amount of work that sanitary authorities get through, the extent to which they resort to the courts is remarkably small. This, in the main, reflects great credit upon the officials, who perform difficult and oft-times delicate duties without friction or unpleasantness. But when such action is compelled by the stubbornness or wantonness of various persons, the penalties inflicted should be adequate and deterrent. In this respect, especially in the smaller districts, it is often a source of considerable dissatisfaction to officials that after exhausting all their powers of persuasion and patience, and being com-

¹ Public Health Act, 1875, s. 269.

² *Ibid.*, s. 257.

³ *Ibid.*, s. 268.

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pelled at last to come to the court to secure the enforcement of the law, the court treats the matter lightly and either makes a simple order or imposes such an insignificant penalty as to encourage rather than deter opposition to administrative action and requirements.

CHAPTER XXI

REGISTERS, RECORDS AND REPORTS

THE performance of so many duties of such diverse kinds necessarily involves an enormous amount of clerical work. Not only have notices to be served and correspondence carried on, but records and registers must be kept up-to-date either in fulfilment of statutory duties or to enable the officials to make periodical reports to their authority and to the departments of the Central Government. Of course, every increase in official activity entails a corresponding increase in clerical work, and this is made more burdensome by the many reports now required by the Ministry of Health. An amusing illustration of this difficulty occurred some years ago at a meeting of the Bulkington Rural District Council, where in reply to a question in reference to complaints that he had not made any returns under the Housing Regulations of 1910, the inspector stated that "it would take him centuries" to fill up the book provided for the purpose.¹ The burden is specially felt in the many rural and small urban districts where the sanitary inspector is the only whole-time sanitary officer and has little or no aid in his office work; and many complain that they must either greatly extend their working hours or neglect inspectorial duties which they feel demand more attention than they can possibly give. Where, as is often the case, the inspector's home is also his office, and his salary is anything under £4 per week, particularly bad cases of official "sweating" arise without public knowledge or protest. Such a condition of things undoubtedly results in many insanitary conditions remaining undealt with,

¹ *Coventry Herald*, May 5, 1914.

and they will remain so until a definite standard of inspectorial staffing, based upon area to be covered, population to be dealt with, and the amount of clerical assistance provided, is insisted upon.¹ Some knowledge of the effect of the demands for information made by the Central Government upon the work and hours of sanitary officials found its way into Parliament just before the War, but the President of the Local Government Board declined to consider the question of a grant to local authorities to meet the cost of providing the information ;² since then circumstances have not been propitious for again raising the matter.

The clerical work of a public health département, like that of a business, should be simple and adequate without any duplication ; but, as similar work is being carried on in every sanitary district in the country, there should be a great measure of uniformity in the methods adopted. Unfortunately these desirable points cannot be said to be achieved. In the effort to attain simplicity much duplication arises, and many books, not really necessary if an efficient system of cross-reference is adopted, find place on the office shelves, whilst uniformity is almost unthought of, still less attained.

Referring to lack of uniformity in records of local administration, Mr. G. M. Harris wrote :

“ Each authority thinks its own fashion the best, and consequently anyone who has to study the documents of a number of authorities has to deal with papers of every size and shape, with minutes and reports of councils, committees and sub-committees, sometimes printed one after the other in chronological or other order, sometimes interspersed with the resolutions of the various bodies who consider them . . . it might well be worth while for those concerned to consider whether the public convenience and the interests of knowledge might not be served by some more scientific and more uniform system of documentation than exists at present.”³

¹ See Memorandum of Evidence submitted on behalf of the Minister of Health to the Royal Commission on Local Government, pp. 63 *et seq.*

² Reply to question in the House of Commons, May 25, 1914.

³ *Problems of Local Government*, pp. 154-5.

These remarks are as applicable to public health officers as to the other departments of a local authority, and indicate a problem which might well be dealt with at some of the congresses of sanitary authorities and officials.

Certain persons following specified occupations and various premises at which business of a special nature is carried on are required by statute to be registered, such registration being, as a rule, a condition preliminary to carrying on or sheltering such business. All dairymen and cowkeepers and all farms and other premises used as dairies must be registered;¹ and no one may produce or sell milk under a "special designation" unless licensed by the appropriate authority.² Every midwife must notify to the local authority her intention to practise within their district and repeat the notification in January of each year, the authority being required to keep a roll of such midwives and to send a copy to the Central Midwives Board every January, reporting every change due to death or removal.³ Persons who employ outworkers in certain trades specified in Special Orders of the Home Secretary are required to send before February 1 and August 1 in each year a list of the names and addresses of such persons to the council of the district in which his business premises are situated. The list thus obtained is examined, addresses in other administrative areas being forwarded to the councils of those districts, and form the basis of a register for the purpose of inspection and supervision.⁴

Before any person may open premises as a common lodging-house it is necessary that he be registered as well as the premises, and it is an offence to carry on such a business unless this has been done by the local authority, which has power to refuse.⁵ The local authority has similar powers, but only as regards the premises, in the case of slaughter-

¹ Milk and Dairies Order, 1926, article 6.

² Milk and Dairies (Amendment) Act, 1922, s. 3; and Milk (Special Designations) Order, 1923.

³ Midwives Act, 1902.

⁴ Factory and Workshop Act, 1901, s. 107.

⁵ Public Health Act, 1875, ss. 76 *et seq.*

houses,¹ offensive trades,² and canal-boats ;³ but in the first case the license to use may be an annual one if the Public Health Act Amendment Acts, 1890,⁴ has been adopted, and the requirements as regards offensive trades are not in force in rural districts unless the council has obtained urban powers for the purpose.

Premises used for the manufacture of margarine, margarine cheese, milk-blended butter and butter, as well as those in which the business of wholesale dealer in the first three commodities is carried on, must be registered with the local authority, and the registration, which cannot be refused, must be reported to the Ministry of Agriculture ;⁵ the same conditions are applicable to the businesses of milk importers.⁶ The local authority is also required to keep a register of all workshops within their district, the factory inspector supplementing the efforts of the local officials by forwarding notice of the occupation of such premises to the local authority.⁷

For the purpose of the Public Health (Tuberculosis) Regulations, 1912, the duty of keeping a register of notifications of tuberculosis is placed upon the medical officer of health, in whose custody it is to be kept inaccessible to all except persons specially authorized by resolution of the local authority, the county medical officer of health, a local school medical officer, or an official of any Government department authorized for the purpose ; the information contained therein is to be regarded as strictly confidential.⁸ This register must be revised at least once per quarter and the medical officers of districts into which any registered persons have removed must be notified ;⁹ and every district

¹ Public Health Act, 1875, ss. 169 and 170, and Rural District Councils (Slaughter Houses) Order, 1924.

² *Ibid.*, s. 112, and Public Health Act, 1925, s. 44.

³ Canal Boats Act, 1877, s. 1.

⁴ Section 29.

⁵ Food and Drugs (Adulteration) Act, 1928, s. 8.

⁶ Public Health (Imported Milk) Regulations, 1926, s. 3.

⁷ Factory and Workshop Act, 1901, ss. 127 and 131.

⁸ Public Health (Tuberculosis) Regulations, 1912, article XI.

⁹ *Ibid.*, 1921.

medical officer of health must furnish the county medical officer with a quarterly statement showing ¹—

- (a) The number of cases on his register at the commencement of the quarter.
- (b) The number of cases notified for the first time during the quarter.
- (c) The number of cases removed from the register during the quarter, giving name, address and reason for removal.
- (d) The number of cases remaining on the register at the end of the quarter.

Separate figures being given for males and females and for pulmonary and non-pulmonary cases.

As will be seen from the few specimen headings of registers appended to this chapter, the information recorded varies considerably, a register of margarine or similar factories or wholesale warehouses or of dairies and cowsheds containing four heads, whilst those of common lodging-houses or canal-boats gives much detailed information. As a rule a separate book is kept for each subject, the result being that the vast majority of the pages in each are blank and likely to remain so for ever. A much more economical method is to have a few loose leaves ruled for each subject and kept in one volume by one of the "loose-leaved ledger" devices; such a volume would cost less, occupy less room, and save time in reference or in writing-up, since all or any registrable premises could be at once turned up without moving.

Both medical officers of health and sanitary inspectors are required to keep records of their official activities, and the reports upon various branches of their work which are specifically demanded of them necessitate such a course; but the methods to be adopted are seldom designated and are determined in general by imitation and habit. In the case of houses inspected for the purposes of Section 8 of the Housing Act of 1925, however, the Ministry of Health have specifically and fully enumerated the information to be contained in the records which must be kept by every

¹ Public Health (Tuberculosis) Regulations, 1924.

local authority.¹ Such records are for a limited purpose, but they could and should be extended to include all premises within the district, and would in that case form the basis upon which a sanitary survey of the whole area might be built. The records may be kept in a book or books or on separate sheets or cards. Each system has its advocates, but the last two methods have the merit of elasticity, a great advantage in all districts where building operations are still going on, as every new house can be entered upon a sheet or card and placed in its correct position relative to other premises. A specimen page or card for this purpose is given, together with a page of what may be termed an inspection index. The latter may not comply strictly with the regulations, since it does not directly give all the information asked for ; but this can be found by reference to the inspector's inspection book, the book in which reports are made to the authority to obtain its sanction to the service of statutory notices, and the books in which copies of letters and notices are kept, and it has the great advantage of enabling anyone to determine, almost at a glance, the particular portions of the district which have, for good or bad reasons, lacked inspection over a series of years.

FORM OF CARD RECORD

Address :

Description :

Water Supply :

Drainage :

Closet Accommodation :

Paving, etc., Yard.

Provision for refuse :

Date of Inspection.	Inspected by	Reason for Inspection.	Defects Found.	Action Taken.	Rent and Tenancy.	Remarks.
		Sketch Plan	of Drainage	on Back		

¹ Housing (Consolidating) Regulations, 1925.

FORM OF INSPECTION INDEX

Road, Street or Lane					
No.	Description, etc.	1928.	1929.	1930.	1931.
1	6 and retail shop (Grocer's) M.; w.c.	$\frac{1}{2}$ D.			
2	5 S.L. (1) C.; w.c.	$\frac{2}{5}$ C. (7/6)			
3	5 P. W.; E.C.	$\frac{2}{4}$ S.F. (7/-)			
4	6 T. (2) C.; w.c.'s (2)	$\frac{5}{4}$ S.F. (4/6 each) $\frac{2}{8}$ C.			

Abbreviations.—Figure = No. of rooms. Tenancy—P = private; S.L. = sub-let; T. (1 or 2 etc.) = tenements. Water Supply—M. = from main; C. = from cistern; W = from well. Closet Accommodation—w.c. = water-closet; E.C. = earth closet. Reason for particular inspection—C. = complaint; D. = after diphtheria; S.F. = after scarlet fever, etc. The fractions indicate day and month of inspection; in red ink if a notice is served, in black ink if not.

Such a system saves much time in entering up, enables speedy reference to sources of further information, and adequately serves the purpose for which such a record is required; and the rents, inserted in parenthesis will ultimately form a valuable index of rent movements.

At the periodical meetings of the committee having charge of sanitary administration reports of the work performed during the intervening periods are presented by the medical officer of health, sanitary inspector, medical superintendent of the hospital, and the public analyst, sanction is asked for action needing it, and matters upon which instructions are required are presented. The information contained in these reports forms the basis of the annual reports which must be made by the various officers.¹ Towards the end of each year the Ministry of Health issues a circular to local authorities indicating the lines upon which the report of the medical officer of health must be drawn. For 1926 the minimum was prescribed as follows: ²

¹ Sanitary Officers Order, 1926, articles 14 (3) and 19 (15).

² Circular 743, December 20, 1926.

- (1) Information under the following heads :
- (a) Statistics and Social Conditions of the Area.
 - (b) General Provision of Health Services for the Area.
 - (c) Sanitary Circumstances of the Area.
 - (d) Housing.
 - (e) Inspection and Supervision of Food.
 - (f) Prevalence of, and Control over, Infectious Disease.
- (2) A statement of any noteworthy conditions prejudicial to the health of the area . . . Observations in regard to the character and results of any important measures affecting the public health taken in the area, or recommended, but not so far carried out.
- (3) A statement of any important change made during the year in the public health services which cannot be conveniently dealt with under headings given in appendix to circular.
- (4) A statement of any special action taken during the year in the area to arouse public interest in the prevention of ill-health.
- (5) A summary of important special reports, if any, made during the year.

In the Appendix to the Circular the headings under (1) above are extended thus :

- (a) *Statistics and Social Conditions :*
 Area, population (at last census and estimated for year), inhabited houses, number of families or separate occupiers, rateable value and sum represented by a penny rate ; social conditions, including chief occupations, of people and influence on public health. Extracts from vital statistics (births and deaths) in form given.
- (b) *Health Services :*
 Number, situation, nature, extent and sufficiency of hospitals for fever, small-pox, tuberculosis, maternity, children, and others.

Institutional provision for unmarried mothers, illegitimate and homeless children.

Ambulance facilities for infectious and non-infectious and accident cases.

Clinics and treatment centres.—Maternity and child welfare centres; day nurseries, school clinics; tuberculosis dispensaries, treatment centres for venereal diseases.

List of public health officers indicating whole- and part-time officers, and noting special diplomas or certificates of qualification and other public offices held by them.

Professional nursing in the home for general and for infectious disease.

Number of midwives practising in area; and employment of, or subsidy to, practising midwives by the local authority.

Arrangements for chemical work; and reports by public analyst if deemed desirable.

A list of local Acts, special local Orders, general adoptive Acts and bye-laws relating to public health, in force, and the dates at which they became operative.

'c) *Sanitary Circumstances*.—Water. Pollution of rivers and streams. Drainage and sewerage. Closet accommodation—conversion from conservancy to water-carriage system. Scavenging. Sanitary inspection of area¹—a classified statement of the number of premises visited, defects or nuisances discovered and action and the result of action taken. Smoke abatement. Number and character of premises which can be controlled by Bye-laws or Regulations and action taken or needed in regard thereto.

(d) *Housing*.—A statement showing number of new houses erected with and without State assistance, number of inspections under Housing Act and

¹ This includes the report of the sanitary inspector.

results, and proceedings taken under various powers.

- (e) *Inspection and Supervision of Food.*—Milk supply. Meat and other foods. Action taken under Food and Drugs and kindred Acts and regulations.
- (f) *Prevalence of and Control over Infectious Diseases.*—A review of the prevalence of notifiable and other infectious diseases and statement of use made of various methods of prevention. Particulars of use made of facilities for cleansing and disinfection of verminous persons and things and disinfection of premises and articles exposed to infection. Tabulated statements of (1) cases of disease notified, showing number admitted to hospital, and deaths, classified in age-groups; (2) cases of ophthalmia neonatorum notified, with indication of place of treatment, effects on vision and deaths; and (3) new cases and deaths from tuberculosis (pulmonary and non-pulmonary), distinguishing the sexes and age-periods. Information as to any action taken under the Public Health (Prevention of Tuberculosis) Regulations, 1925, and Public Health Act, 1925, section 62.

The sanitary inspector is required ¹ as soon as practicable after the 31st day of December in each year, to furnish the medical officer of health with a tabular statement containing the following particulars:

- (a) The number and nature of inspections made by him during the year.
- (b) The number of notices served during the year, distinguishing statutory from informal notices.
- (c) The result of the service of such notices.

The like duty of officers of a port sanitary authority are similarly prescribed, but are necessarily more circumscribed in the conditions and things to which they relate.

The content of these annual reports is considerably extended by the provisions of Acts imposing special sanitary

¹ Sanitary Officers Order, 1926, article 19 (15).

duties. The medical officer of health not only has to notify the factory inspector of any case where a woman, young person or child is employed in a workshop in which no abstract of the Act is affixed,¹ and to report to him whatever action has been taken as regards any complaint forwarded by him to the medical officer of health,² but he is required to report specifically, in his annual report, on the administration of the Act in workshops and workplaces, and to send a copy of such report to the factory inspector.³ This is usually summarized in five tabular statements as follows :

- (1) Number of inspections made, notices served, and prosecutions undertaken in reference to each class of premises.
- (2) Number and nature of defects found and remedied, or referred to the factory inspector.
- (3) Number of outworkers in the specified trades, and administrative action and results.
- (4) Number of workshops on the register, important classes being specially enumerated.
- (5) A summary of miscellaneous administrative matters.

All sanitary authorities are required to furnish the Ministry of Health with an annual report of their administration of the Canal Boats Acts, 1877 and 1884, and the regulations thereunder within twenty-eight days of December 31st of each year,⁴ the information required being prescribed as follows :⁵

- (1) Arrangements for inspection, and name, address and remuneration of inspector.
- (2) Number and condition of boats inspected, and their occupants.
- (3) Infringements of the law as regards registration, notification of change of master, certificates, marking, overcrowding, separation of sexes, cleanliness,

¹ Factory and Workshop Act, 1901, s. 133.

² *Ibid.*, s. 5.

³ *Ibid.*, s. 132.

⁴ Canal Boats Act, 1884, s. 3.

⁵ Local Government Board Circular, December 17, 1909.

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ventilation, painting, provision of water cask, removal of bilge water, notification of infectious disease, admittance of inspector.

- (4) Legal proceedings and results.
 - (5) Other steps taken to secure compliance with the law.
 - (6) Infectious diseases dealt with and measures of isolation adopted.
 - (7) Detention of boats for cleansing and disinfection.
- In case of registration authorities :
- (8) Number of boats on register, showing—
 - (a) Number believed to be in use or available.
 - (b) Number not traced.
 - (c) Number registered and re-registered on account of structural alterations.

The regulations as to unsound food require a record to be kept by the sanitary authority of any articles of food destroyed or disposed of under their provisions, and the medical officer of health's report contains an abstract of such records, together with an account of the proceedings taken to give effect to the regulations.¹

Each public analyst is required to furnish quarterly reports to the local authority appointing him, specifying the number of articles analysed by him and the results of all such examinations, preferably in a tabular form as under : ²

ANALYSES.

Article.	Number Examined.				Number Adulterated, etc.			
	Formal.	Informal.	Private.	Total.	Formal.	Informal.	Private.	Total.
Total								

¹ Public Health (Unsound Food : First Series) Regulations, 1908, Article VII, and Local Government Board Circular thereon, September 16, 1908.

² Memorandum (36/Foods) issued by the Ministry of Health, January, 1927, on Procedure under the Sale of Food and Drugs Acts, etc.

ADULTERATED SAMPLES, ETC.

Serial No.	Article.	Whether Formal, Informal or Private.	Nature of Adulteration or Irregularity.	Observations.

The sum paid in respect of each analysis was :—

These reports must be transmitted to the Ministry of Health, with information under other heads of which the following are the most important :

- (1) Administrative action in regard to samples reported against.
- (2) Administrative action in regard to offences other than adulteration.
- (3) Action under Acts other than the Food and Drugs Acts.
- (4) Information as to " appeal to the cow " samples.
- (5) Preservatives.
- (6) Comparison of milk samples.
- (7) Action under Milk (Special Designations) Order.

Some medical officers of health content themselves with a bald statement of fact sufficient to comply with the requirements of the Ministry of Health, but others, grasping the advantages which their position gives them, not only illumine their reports with detailed explanations, but by the collection and comparison of data are able to suggest theories of the greatest value. Such reports often serve a useful purpose by focussing public attention upon some insanitary conditions, and on this account some local authorities have endeavoured, generally unsuccessfully, to alter or amend reports which reflected unfavourably upon their use of the powers they possess. The reports are carefully considered by officers of the Ministry of Health, and frequently form the starting-point of efforts of the

Department to persuade or compel the local authority to carry out works required to improve the sanitary condition of the district. The Ministry has not yet attempted, except in the case of vital statistics and one or two other matters,¹ to summarize the general work of sanitary officials throughout the country. Some years ago a President of the Local Government Board stated that "he had been struck by the fact that hitherto there had been no adequate means of collating and diffusing information on the many questions with which the Board was concerned. In fact, there was no intelligence department."² He expressed his intention of setting up an intelligence department which should have made it possible to formulate under a few significant headings the main activities of the health department of each local authority. Such a statement would be useful in several ways, particularly by affording an approximate test of the activity of each authority in enforcing the provisions of sanitary legislation, and by giving an incentive,

REGISTER OF SLAUGHTER-HOUSES

Date of Registration.	Date of Licence.	No. of Licence.	Christian and Surname and Address of Owner of Premises.	Christian and Surname and Address of Occupier of Premises.	Sanitation of Slaughter-house	No. of Animals for which Accommodation is provided on the Premises.				General Condition of Premises.	Remarks.
						Oxen.	Calves.	Sheep.	Swine.		

¹ Administration of the Canal Boats and Food and Drugs Acts are two exceptions.

² The Right Hon. H. Samuel in the House of Commons, June 18, 1914.

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through shame or emulation, to the more backward authorities to increase their efforts.¹

REGISTER OF COMMON LODGING-HOUSES

No.	Date of Registration.	Name of Keeper of Lodging-house.	Name of Deputy-Keeper.	Residence of Keeper.	Situation of Lodging-house.	No. of Rooms set apart as Bedrooms.	Cubical Contents of Bedrooms.	No. of Lodgers allowed in each Bedroom.	Whether whole or part of such House (and what part) is used as Common Lodging-house.	Name of Officer by whom House was Inspected.	Date of Inspection.	Date of Approval.	Date of Certificate of Character	Names of Ratepayers by whom Certificate was signed.	Condition.	Remarks.

REGISTER OF WHOLESALE DEALERS IN MARGARINE AND MARGARINE CHEESE AND MILK BLENDED BUTTER

No.	Date of Registration.	Name and Address of Applicant for Registration.	Situation of Premises on which business of Wholesale Dealer is carried on.	Name and Address of Owner or Occupier carrying on Business.

¹ For more detailed information on this subject, see Public Health section of *Municipal Office Organisation and Management*, W. Bateson (Ed.), and *Organisation and Administration of the Public Health Department*, by W. A. Leonard.

CHAPTER XXII

TOWN PLANNING AND IMPROVEMENT

As a unit of the local administration the public health department is engaged in the discovery and abatement of nuisances, the regulation of particular trades and premises, the investigation into and isolation and treatment of infectious disease, the provision of various services for the welfare of mothers and children, and the protection of the food supply. These functions are, as a rule, peculiarly personal; they bring the department into relation, not with the community as a whole, but with individuals or small groups of individuals. It is for this reason that the possession of courtesy, tact and a wide knowledge of men and affairs is particularly essential for officials of the department.

The sanitary authority is, however, endowed with other powers and duties which involve complex engineering and architectural questions, the construction of various works and buildings, and often the establishment of special departments with officials equipped with experience, knowledge and skill peculiar to the service in which they are engaged. Such subjects of sanitary administration as the regulation of streets and buildings, the provision of houses for the working classes, town planning, sewerage and sewage and refuse disposal works, water supply, and the provision of public abattoirs, markets, baths and washhouses, burial grounds and crematoria, are, as a rule, matters with which the surveyor or engineer has to deal, at least until they are handed over to the special department into the care of which some of them are usually placed. But all of them affect the public health, and several are, either by order of the

Ministry of Health or on the initiative of the medical officer of health, dealt with in his annual report ; and, in the case of many of them, proposals for the performance of the duties or the establishment of the services or institutions, usually originate in the public health department. Upon the medical officer of health falls the duty of advising his authority when such duties and works are necessary for the public health, and by his staff are gathered the data upon which his advice is based. Hence, although the work, service or institution generally passes out of the domain of the public health department, the responsibility of the medical officer of health in the initial stages is very onerous.

In the early years of the nineteenth century the new towns which arose as a result of the concentration of population due to the industrial revolution were constructed without plan, streets were made without regulation and houses were built without supervision ; out of these circumstances developed many of the sanitary difficulties and problems with which later generations had to grapple. That day is passed, and local authorities now possess extensive powers for regulating the development of estates, defining conditions with which new streets and buildings must comply, and improving conditions which have developed in the absence of supervision and control.

The Public Health Act, 1875,¹ vested all streets repairable by the inhabitants at large of urban districts in the local authorities, who were empowered to make up, repair, or alter them at their discretion. They were also given powers,² extended some years later,³ to compel owners or occupiers of premises fronting, adjoining, or abutting on private streets, to sewer, level, pave, metal, flag, channel, make good, or light such streets to the satisfaction of the authority, after which they might be declared to be public highways repairable by the inhabitants at large. Failure to comply with the notice can be met by the authority

¹ Section 149.

² Public Health Act, 1875, ss. 150 to 152.

³ Private Street Works Act, 1892.

carrying out the necessary work and recovering the expenses incurred. An urban authority may also deal with the naming of streets and the numbering of houses, take steps to improve the line of streets, remove obstructions, deal with ruinous or dangerous buildings, and prescribe precautions to be taken during the construction or repair of sewers, streets and houses.¹ It is also empowered to purchase any premises for improving any street, or, with the sanction of the Ministry of Health, for making any new street,² and may regulate the building line where the whole or front of any house or building has been taken down.³

As regards new streets and buildings, the important power of making bye-laws has been placed in the hands of urban authorities.⁴ These may be made in respect of the level, width, sewerage and construction of new streets, the structure, drainage and sanitary arrangements of and air space about new buildings, and for closing and prohibiting the habitation of buildings unfit for human habitation. These powers were extended fifteen years later, and rural authorities were empowered to make similar bye-laws, but for buildings only.⁵ Building bye-laws are, in the larger districts, administered from the surveyor's or engineer's department, building inspectors being employed for the purpose, but in many of the smaller areas the duties are added to those of the sanitary inspector.

County councils and other highway authorities are empowered to prescribe building lines along highways repairable by them, provision for compensation or betterment being made.⁶ They may control height and character of walls, hedges, etc., and restrict the erection of new buildings at corners or bends,⁷ and may plant and maintain trees, shrubs and grass margins along the highway.⁸ The

¹ Public Health Act, 1875, s. 160.

² *Ibid.*, s. 154.

³ *Ibid.*, s. 155. See also Public Health Acts Amendment Act, 1890, ss. 33 to 43.

⁴ *Ibid.*, s. 157.

⁵ Public Health Acts Amendment Act, 1890, s. 23; see also Public Health Acts Amendment Act, 1907, ss. 13 to 33.

⁶ Roads Improvement Act, 1925, s. 5.

⁷ *Ibid.*, s. 4.

⁸ *Ibid.*, s. 1.

Public Health Act, 1925 (Part II), which is adoptive,¹ enables the same authorities to prescribe "improvement lines" preventing the erection of buildings upon land which may be required for street widening,² and gives other powers in enlargement or addition to those already possessed for the regulation of highways.

Previous to 1909, although local authorities could regulate the construction of new streets and buildings and take action to remove certain obstacles or dangers to the use of such places, they had no power to take a broad survey of the general conditions of their area with a view to its development on lines at once healthy, artistic and convenient. The Housing and Town Planning Act of 1909, which altered this condition of affairs, was followed by several other Acts, the bulk of the provisions of which have been consolidated in the Town Planning Act of 1925. By this Act the London County Council and borough and urban and rural district councils may make town-planning schemes in respect to any land which is in course of development or appears likely to be used for building purposes, with the general object of securing proper sanitary conditions, amenity, and convenience in connection with the laying out and use of the land, and of any neighbouring lands ;³ and the council of every borough or urban district having a population of more than 20,000 at the census of 1921, must prepare and submit to the Minister of Health such a scheme before January 1, 1929.⁴ In the performance of this function they are subject to a rigorous control by the Ministry who have issued regulations prescribing the procedure necessary to secure their consent to the schemes and for carrying them out. The Ministry's decision is final, but, permission obtained, the next step is to prepare the scheme, which may include land already built upon, and submit it, together with all the necessary plans and information, to the Ministry of Health, who may subject it to modifications and conditions. A scheme may be

¹ Applicable to county councils without adoption.

² Sections 33-4.

³ Sections 1 and 2.

⁴ Sections 3.

revoked or varied by similar procedure,¹ but otherwise it may be enforced against a defaulting authority by an order of the Ministry of Health, made after inquiry and enforceable by *mandamus*.² The Ministry may, in a similar way, compel a local authority to prepare and submit a scheme, to adopt any scheme proposed and presented by the owners of any land, or to consent to any modifications or conditions imposed by the Ministry in respect of a scheme prepared by the authority.³ Provision is made for compensation either by the authority to owners of property injuriously affected by such a scheme or to the authority by owners of property which is increased in value by the scheme, the expenses incurred being considered as expenses under the Public Health Act, but money borrowed is not subject to the limitations imposed by that Act.⁴ In the metropolis the expenses are defrayed out of the county rate, and loans are raised in the same manner as for general county expenses.⁵

The preparation of town-planning schemes needs very careful consideration and the collection of a great deal of data, so that, having in mind the unprecedented nature of the work, it may be considered satisfactory to find that at March 31, 1926, 324 local authorities had submitted 498 schemes covering an area of 2,181,266 acres.⁶ At the same date there were thirty-four joint Town Planning Committees, formed under the provisions of Section 2 (3) of the Act, which included 537 local authorities, covering a total area of 5½ million acres, with a population of 17 millions, and a combined rateable value of £88 millions.⁷

For the improvement of areas already built upon powers are given in the Housing Act, 1925, which repealed a whole series of previous Acts and consolidated and amended their provisions. Part II deals with unhealthy areas which are represented to the local authority by the medical officer of health as needing an improvement scheme for the

¹ Town Planning Act, 1925, s. 2.

² *Ibid.*, s. 14 (2-3).

³ *Ibid.*, s. 14 (1).

⁴ *Ibid.*, s. 20 (2).

⁵ *Ibid.*, s. 20 (3-4).

⁶ Seventh Annual Report of the Ministry of Health, pp. 181-5.

⁷ *Ibid.*, p. 75.

rearrangement and reconstruction of the streets and houses within such area, or of some such streets and houses. It is the duty of a medical officer of health to make such representation when he discovers such an area, if his attention is drawn to it by a local justice of the peace or four or more local ratepayers. If on receipt of such a complaint the medical officer of health fails to inspect the area an appeal may be made to the Ministry of Health, who may send an inspector, and, if satisfied that the area is unhealthy, must make a representation to that effect to the local authority. As a rule the preparation of an improvement scheme as well as schemes of town-planning and reconstruction become matters for the surveyor or engineer, who consults with the medical officer of health. In the county or city of London the scheme must include the provision of dwelling accommodation for at least half the number of persons displaced, although this need not always be upon the same site; in the provinces the Ministry of Health may require the provision of such accommodation as the local inquiry shows to be necessary. After complying with the preliminary procedure, which includes the publication of the scheme in a local newspaper and the service of notices upon every owner or reputed owner, lessee or reputed lessee, and occupier of lands proposed to be compulsorily taken, the Ministry of Health must be petitioned for an order confirming the scheme. The Ministry may first direct a local inquiry, but their order when made has effect as if enacted in the Act and is enforceable upon a neglectful authority by *mandamus*.¹

Many notoriously unhealthy areas in different parts of the country have been improved by the use of these powers, by virtue of which seventy-three local authorities submitted ninety-five improvement schemes between 1919 and the 31st of March, 1926, fifteen of such schemes, involving the demolition of 1,597 houses and other buildings, being confirmed during the year then current.²

¹ Housing Act, 1925, ss. 50-1.

² Seventh Annual Report of the Ministry of Health, p. 62.

Part I of the Act of 1925 relates to unhealthy dwelling-houses or obstructive buildings of which complaint may be made to the local authority by any four or more local government electors or a justice of the peace.¹ The medical officer of health is required to represent such houses and buildings to his authority.² If the authority fail to exercise their powers where necessary, complaint may be made to the Ministry of Health as respects a rural district council by the county council, the parish council or meeting of any parish within the district, by a justice of the peace or by four local government electors; as respects county boroughs by a justice or four electors and as respects other urban districts by the county council, a justice or four electors.³ The Ministry, after inquiry, may order the local authority to take the necessary proceedings and may enforce their order by *mandamus*, but in the case of county districts they have the alternative, if the county council consents, of issuing the order to the county council. The power of local authorities to make closing orders in respect of houses certified as unfit for human habitation, and demolition orders where they have not been rendered fit has been already referred to,⁴ but the local authority, upon the representation of the medical officer of health or county council, may deal with buildings which, whilst not themselves being unfit for habitation, are so obstructive as to render others unfit. Such a building may be ordered to be demolished, failure to do which may be met by the local authority acquiring the property and doing the necessary work, compensation to the owner, in case of difference, being settled by arbitration.

For dealing with cases intermediate between single houses and large insanitary areas the local authority is empowered to purchase by agreement or compulsorily, subject in both cases to the consent of the Ministry of Health, any property required for a reconstruction scheme. The object of such a scheme may be either to dedicate the land

¹ Housing Act, 1925, ss. 10 and 19 (2).

² *Ibid.*, ss. 9 and 19.

³ See Chapter XX.

⁴ *Ibid.*, s. 23.

as a highway or open space, use it or exchange it for land to be used for the erection of houses for the working classes, or to remedy the bad arrangement or condition or the sanitary defects of any buildings where the site is too small to be dealt with by an improvement scheme.¹ After the usual resolution of the council and notices to owners and occupiers, the Ministry of Health must be petitioned to make an order sanctioning the scheme, a local inquiry-being held if the Ministry think fit, the usual means of compulsion being available in case of default. This power is a very useful one, and the objects of an improvement scheme may often be attained by its judicious use without the great expenditure involved in such a scheme.

It had long been felt before the War intervened that the crux of the housing problem is the provision of adequate and healthy housing accommodation; it is not sufficient to pull down insanitary houses—healthy houses must be provided. The War placed a rigorous check upon the building of houses—privately and by public authorities—and housing accommodation became not only more defective in quality but deficient in quantity. As so often happens, economic considerations enter here; it is a truism that so long as we have the poor they will be poorly housed unless low or irregular wages are supplemented by the provision of houses at rents which fail to be sufficient to cover cost of construction and maintenance. To the objection that such a policy creates a privileged and pauperized class it may well be urged as a valid argument that the considerations of public health are worth the expense incurred, and that the effect of decent housing will be to raise the standard of life of those housed, especially the children, improve their economic value as productive agents, and ultimately result in an increase of their remuneration. This is not intended to beg the question against proposals to directly increase or regularize earnings, which is by far the superior method of dealing with the problem, but until this is generally

¹ Housing Act, 1925, s. 37.

achieved the health of the people must not be sacrificed to the exigencies of economic theory.

Post-war conditions converted all shades of political opinion to the recognition of the fact that without public assistance housing conditions would go from bad to worse. A series of Acts provided such assistance in the form of subsidies to local authorities, public utility societies and private builders to encourage the building of houses of an approved type, and from the Armistice to March 31, 1926, over £45½ millions had been paid by the Exchequer as subsidies in respect of housing,¹ and two years later the Minister of Health could boast that no less than 1,102,000 houses had been built, 412,000 by local authorities.²

Local authorities are, to an increasing extent, utilizing their powers of acquiring land within or without their districts, and providing thereon "housing accommodation," a term which includes "lodging-houses and separate houses or cottages containing one or several tenements," and a cottage may include a garden not exceeding an acre in extent.³ Land may be acquired by agreement or leased, with the consent of the Ministry of Health, and houses may also be acquired, roads may be laid out and part of the land may be used for all purposes for the convenience of persons belonging to the working classes and other persons.⁴ Complaint of default may be made in the same way and the Ministry have the same powers of compulsion as in the case of Part I, but they must take into consideration the necessity for further accommodation for the housing of the working classes, the probability that such accommodation will not be otherwise provided, and the prudence of placing increased liability upon the rates.⁵ In the case of rural districts, the county council, if satisfied that a complaint of default is justified, may resolve that the powers of the district council be transferred to them, notice of such intention being given to the council concerned, after which

¹ Seventh Annual Report of the Ministry of Health, p. 60.

² House of Commons, May 15, 1928.

³ Housing Act, 1925, s. 57.

⁴ *Ibid.*, s. 58.

⁵ *Ibid.*, s. 73.

application must be made to the Ministry of Health for an order transferring the necessary powers.¹

The lack of housing accommodation has hampered the closing and demolition of houses very considerably, but a reference to the figures of work done in this direction shows that where opportunity offers many local authorities are alert to their responsibilities.² Mention must be made of the Housing (Rural Workers) Act of 1926, which enabled, within limits, rural authorities to aid the owners of dilapidated cottages to recondition them, without an increase of rent. Progress has been "disappointingly slow,"³ but when the possibilities of the Act are better realized much useful remedial work will probably be done.

Although not properly within the province of the public health department, the powers given by the Small Dwellings Acquisition Acts of 1899 and 1923 are important as being a useful factor in the solution of the housing problem. By these Acts local authorities are empowered to lend on mortgage to the occupiers of small houses up to 90 per cent. of the approved purchase price to enable them to own the house in which they dwell. It was the latter Act which extended the amount which might be advanced; and its popularity and value may be gauged by the fact that since its passing local authorities have advanced £54½ millions whilst building societies have contributed to the solution of the problem £172 millions in aid of the purchase of small houses.⁴

Progress in housing still appears to many to be painfully slow; all public health officials are alive to its urgency, but considering the complex economic and social factors involved the advance made must appear to the unprejudiced observer to be a very remarkable testimony to the value of the co-operation of national and local authorities, co-operative enterprise and private effort.

¹ Housing Act, 1925, s. 77.

² See page 149.

³ The Minister of Health in the House of Commons, May 15, 1928.

⁴ The Right Hon. Neville Chamberlain in the House of Commons, May 15, 1928.

CHAPTER XXIII

SANITARY SUPPLIES AND SERVICES

THE Royal Sanitary Commission, in their second report (1871) includes, amongst other things comprising "the ordinary supply of what is necessary for civilized social life," a supply of wholesome and sufficient water for drinking and washing, provision of sewerage, and the utilization of sewage, removal of refuse, provision of burial for the dead without injury to the living, and regulation of markets. In so doing, they rightly recognized that the subdivision of local government which was referred to them was "generally designated in recent legislation as sanitary though it might be, in a wider sense, called economical."

It is important to press this point when considering public health efforts of all kinds. Looked at from a financial point of view, these efforts result on the whole, and usually in detail, in a loss; the balance is usually on the debit side. But, viewed as benefiting the community, as a provision of "collective goods"¹ which are enjoyed by all, and often to the greatest extent by the poorest members, the financial outlay is amply justified. It is these facts that have deterred private enterprise from any general attempt to provide the supplies and services enumerated above. The public interest and private interests clash; and to the growing recognition that, in matters of health at least, the interests of the community cannot be left to the mercies of private individuals, we owe the increasing extension of the public provision of these supplies and services.²

¹ Marshall, *Economics of Industry* (1893), p. 54.

² Compare Mill, *Representative Government*, Chapter XV.

As water is one of the prime necessities of life, it was inevitable that local authorities should be given the power to provide a supply proper and sufficient for public and private purposes. In order to do this, an authority may construct and maintain waterworks, dig wells, and do any other necessary acts, lease, hire, or purchase any waterworks or sources of supply, or contract with any person for such supply, and has various powers for regulating the supply and use of and making charges for water.¹ Although from the text of the section (51) this is a power, not a duty, of the local authority, a later section enables the Local Government Board (now Ministry of Health), upon complaint that a local authority has made default, to make an order, enforceable by *mandamus* or executed by a person named in a further order at the expense of the authority, requiring the authority to perform their duty within a stated time.² The duty and powers of a rural district council under the Public Health (Water) Act, 1878, to provide or require the provision of a sufficient and wholesome supply of water for every occupied dwelling-house and to ascertain the condition of the water supply within their district, may be granted to any urban authority by order of the Ministry of Health.³ The fact that parish councils may utilize any spring, well, or stream within their district⁴ does not relieve the rural district council of its duties as regards water supply, the parish council being enabled to complain to the county council where they think the rural district council ought to have provided a water supply and could have done so at a reasonable cost. If satisfied, the county council may thereupon resolve that such duties be transferred to them, or may make an order appointing some one to perform the duty and recover the costs from the defaulting authority.⁵

There were no complete statistics as to water supplies

¹ Public Health Act, 1875, ss. 51 to 67.

² *Ibid.*, s. 299.

³ Public Health (Water) Act, 1878, s. 11.

⁴ Local Government Act, 1894, s. 8.

⁵ *Ibid.*, s. 16. Public Health Act, 1875, s. 299.

available, but by arrangement with the Ministry of Health the collection and publication of statistical information was undertaken by the British Waterworks Association, by which much useful inquiry has already been made.¹

A Select Committee which inquired into water power resources recommended a Water Commission to conserve water resources in general interests, readjust conflicting interests and generally to assist the Public and Parliament in questions affecting water supply, and an advisory Committee has been set up by the Ministry of Health to review the situation with the object of formulating a national policy. The tendency is for water supplies to be put into the hands of *ad hoc* authorities—e.g. the Durham and Staffordshire Potteries Water Boards—and the establishment of regional committees with the primary function of advising neighbouring authorities with common interest in source or supply of water and securing co-operation, whilst leaving ultimate decisions with water authorities themselves.²

Methods of acquisition of the supply or its source and of charging for the water, vary considerably. Whilst efficiency, not profits, has in general been the aim of the local authorities, many have realized useful surpluses.³ The returns which must be looked for, however, is not financial but vital; in public health, not pecuniary profits.

The provision of means of quickly and cleanly removing and disposing of waste waters and excremental matters is almost as essential as an abundant supply of pure water; in practice the latter frequently depends upon the efficiency of the former, and also makes its provision more necessary. There are numerous instances of the good effects of the construction of efficient sewerage and sewage disposal works, and the general reduction of the disease and death rates from typhoid fever, as well as the practical elimination of cholera, are due in no small measure to the increasing

¹ See *British Waterworks Year Book and Directory with Statistical Tables*, 1926.

² Seventh Annual Report of the Ministry of Health, pp. 44-5.

³ See *Municipal Year Book*, 1926, pp. 691 *et seq.*, for list of authorities and financial particulars.

efficiency of this public health service. There are still many towns in England and Wales whose sanitary conveniences are not on the water-carriage system. The Central Government are, however, continuing to press upon local authorities the necessity for a speedy conversion from the conservancy methods to the water-carriage system, and their efforts are meeting with success.

With certain exceptions the Public Health Act vested all existing and future sewers within the district of a local authority together with all buildings, works, materials, and things belonging thereto, in that local authority, who may improve or abolish such sewers, where it is deemed necessary, must maintain them, so as not to be a nuisance or injurious to health, and must not pollute any streams or other water by discharging sewage into them. The sewage becomes the property of the authority immediately it has gone through the drains into the sewer. For the purpose of receiving, storing, disinfecting, distributing or otherwise disposing of sewage any local authority may construct works within or without their district, contract for the use of, purchase or lease lands, buildings, engines, or other things necessary for their purpose, and may contract to supply upon terms, for a period of less than twenty-five years, any person with sewage.¹ Whilst it is generally agreed that the water-carriage system is by far the better method, great and increasing difficulties are met with when seeking an efficient method of disposing of the sewage. The methods that have been adopted are very numerous,² and the Royal Commission appointed in 1898 to inquire into the matter issued their ninth and final report in 1915, having surveyed a vast field of effort and formulated recommendations the value of which progressive investigation constantly modifies. The amount of loans outstanding in 1924-5 for the purposes of sewerage and sewage disposal works totalled £49,241,397, the amount raised during the year reaching

¹ Public Health Act, 1875, ss. 13 *et seq.*; definitions of "drain" and "sewer," s. 4, and Public Health Acts Amendment Act, 1890, s. 19. See also Public Health (Support of Sewers) Act, 1883.

² See *Municipal Year Book*, 1926, p. 831 *et seq.*

£5,039,587, the expenditure, including loan charges, reached £8,710,545, the working expenses being £4,773,119; whilst the receipts amounted to only £755,317.¹ This is a more important instance of a return for expenditure being received in improved public health.

A cognate service with similar objects—i.e. the speedy and cleanly removal and disposal of matters which are offensive or dangerous to health—is the removal and disposal of house refuse and the contents of sanitary conveniences on the conservancy system. Local authorities may, and if required by the Ministry of Health must, undertake or contract for the removal of these matters for the whole or part of their district and may sell or otherwise dispose of them, a daily penalty being recoverable if, when they undertake or are required to do so, they make default after the expiration of seven days from the receipt of notice in writing from the occupier of any house within their district.² The Local Government Board frequently exercised their powers in this respect, and in 1912 went so far as to apply for a *mandamus* to compel the Windsor Rural District Council to comply with their order. The council, however, gave an undertaking in the High Court that they would take the necessary steps within a month and the case was removed from the list.³

This service is frequently performed by the public health department, the sanitary inspector or a special officer being put in charge of the staff necessary for the purpose. The methods of disposal, in contrast to those for sewage, are very few, resolving themselves, as a rule, into two—incineration in a destructor, or dumping on waste land, occasionally with a view to its reclamation. The former is the more sanitary method, and is almost imperative for urban districts, where it is often united with various industrial activities such as the manufacture of paving-slabs from the slag, or disinfectant powder from the ash, or the genera-

¹ Eighth Annual Report of the Ministry of Health, pp. 226-7.

² Public Health Act, 1875, ss. 42 and 43.

³ Forty-second Report of the Local Government Board, Part III, p. xlix.

tion of steam or electricity. The expenditure during 1924-5, inclusive of loan charges, was £6,597,455, the receipts being a negligible quantity.¹ There is evidence that this department of public health activity is often defective in organization and costly in working. To avoid this and to ensure comparative data a report on the methods of keeping costing accounts in relation to public cleansing services was printed and sold in large numbers, a fact which gives hope for improvement in the future.²

In their Eighth Annual Report the Ministry tabulate and comment upon returns of costs of public cleansing made by seventy-nine of the councils of county boroughs. These show wide variations in the quantity of refuse per 1,000 of the population per day (from under 10 cwt. to over 22 cwt.; average 16.6 cwt.), cost per ton of refuse collected (from under 6s. to over 12s.; average 9s. 1d.) and cost per 1,000 of population per year (from under £90 to over £180; average £130).³ A further return from all urban areas with populations exceeding 30,000 has been asked for and it is hoped that comparisons of costs may lead to local scrutiny and material economics.

The advantages of public abattoirs for the purpose of supervision of slaughtering, prevention of cruelty, cleanliness, and the inspection of the meat supply have been already referred to.⁴ Any urban district⁵ and, with the consent of the Ministry of Health, any rural district,⁶ may provide slaughter-houses and make bye-laws for their use and management, and a number of local authorities have already done so,⁷ but few of them yield a profit. In twenty-nine districts public slaughter-houses are combined with markets, all but three showing a profit on the financial transactions.⁸ Where a public slaughter-house or market has been provided by a local authority they may, with the

¹ Eighth Annual Report of the Ministry of Health, pp. 206-7.

² See Seventh Annual Report of the Ministry of Health, pp. 51-2.

³ See Eighth Annual Report of the Ministry of Health, pp. 14 *et seq.*, and 206 *et seq.*

⁴ Chapter XV.

⁵ *Ibid.*, s. 262.

⁶ Public Health Act, 1875, s. 169.

⁷ *Municipal Year Book*, 1926, pp. 749-52.

⁸ *Ibid.*, p. 749.

consent of the Ministry of Health, provide a cold-air store or refrigerator, together with all apparatus necessary for the storage and preservation of meat or other foodstuffs, and may make reasonable charges for use.¹

Borough councils, with the approval of two-thirds of their members, and urban district councils, with the consent of the owners and ratepayers in the district, may provide and maintain a market-place or house and the necessary appendages, making charges and tolls for its use, and bye-laws for its regulation.² Rural district councils, with the consent of the Ministry of Health, are enabled to do the same by the Public Health Act, 1908. A fair number of authorities have taken advantage of their powers and provided these institutions which, besides facilitating the supervision of the quality of foodstuffs and the veracity of weights and measures, as a rule show a financial profit.³ In 1924-5 the outstanding loans for this purpose amounted to £6,093,140, of which £67,006 were expended during the year; the expenditure reached £1,553,820, including loan charges amounting to £375,350, against which there was a revenue of £1,983,687.⁴

By a series of adoptive Acts, the first dating from 1846, borough and urban district councils⁵ and parish councils (on the adoption of the Acts by the Parish Meeting),⁶ may establish baths and washhouses, adapt them for the purposes of gymnasia, music and dancing, and make bye-laws for the regulation of their use. A large number of local authorities have availed themselves of this power, no district now being considered up-to-date unless facilities for learning and practising swimming are provided. The amount of loans for these purposes outstanding in 1924-5 was £2,856,186, £378,216 being expended during that year, the expenditure of £1,418,107 being raised to £1,699,289

¹ Public Health Act, 1925, s. 71.

² *Ibid.*, 1875, ss. 106 and 107, incorporating the Markets and Fairs Clauses Act, 1847.

³ *Municipal Year Book*, 1926, pp. 827-36.

⁴ Eighth Annual Report of the Ministry of Health, pp. 226-7.

⁵ Public Health Act, 1875, s. 10.

⁶ Local Government Act, 1894, s. 7.

by loan charges, to meet which a revenue of £770,359 was received.¹ The maximum charges prescribed by the Baths and Washhouses Acts were abolished by the Public Health Act, 1925, and powers were also given enabling local authorities to make a fuller use of swimming baths which are often closed during winter months.² The removal of such restrictions will enable some local authorities to reduce the annual losses falling upon the rates.

The provision of adequate and proper accommodation for the disposal of the dead is one of the most urgent and essential branches of sanitary administration, a long series of Burial Acts, extending from 1852 to 1906, in addition to the Cemeteries Clauses Act, 1847, which was incorporated in the Public Health (Interments) Act, 1879, giving powers to various authorities for the purpose. The majority of the *ad hoc* burial boards have now been abolished in favour of the sanitary authorities, and the distinction between a burial-ground and cemetery (chiefly one as to the distance from a dwelling within which burial was prohibited) has now been removed by the Burial Act of 1900, which gave the Local Government Board (now the Ministry of Health) powers and duties relating to their use and sanitation, and left the Home Office with jurisdiction in ecclesiastical matters. The Cremation Act, 1902, extended the above powers to include provision and maintenance of crematoria, the plans and site for which must be approved by the Ministry of Health, a certificate of a Secretary of State being required before it may be used.³ Very few of the local authorities who provide public cemeteries have added crematoria. The amount of outstanding loans for these purposes in 1924-5 was £2,435,698, of which £168,272 was expended during that year, the expenditure of £1,142,552 being increased to £1,378,410 by loan charges, which was partly met by a receipt of £965,544.⁴

¹ Eighth Annual Report of the Ministry of Health, pp. 226-7.

² Part IX, ss. 85-6-7.

³ Regulations as to use issued March 31, 1903.

⁴ Eighth Annual Report of the Ministry of Health, pp. 226-7.

Most of these supplies and services have the common characteristic of involving a charge upon the rates, and have often been quoted by unthinking or irresponsible persons as being instances of unsuccessful public enterprise. This is quite erroneous. The primary reason for their provision is the improvement and maintenance of the public health. That they should be conducted as economically as the object to be attained permits must be admitted, but their success is not to be measured in *£ s. d.*; but in the far more elusive standard of vitality and health.

CHAPTER XXIV

PUBLIC HEALTH FINANCE

FROM the financial point of view one fact about the public health department stands out prominently ; it is essentially a spending, not an earning, department. Its revenue from charges, fees, tolls, fines, and subventions is far below its expenditure. This, to a large extent, explains the inability of the department to attract and keep a large number of the best class of public men closely interested in its work ; it also explains, in part, its unpopularity with ratepayers' associations, and accounts for much of the difficulty of securing adequate remuneration for its officials. The absence of sufficient revenue from other sources necessarily entails recourse to local taxation, ample powers being given to sanitary authorities for the purpose.

As early as 1538 the levy of a distinctly sanitary rate is recorded at Ipswich where constables were " assigned to several wards to remove nuisances and to levy money to pay carts for their carriage of the filth away." ¹ It is probable that levies for such purposes were common in the mediæval towns, for in the previous century at Coventry, by orders of leet, " the sergeants collected every quarter a penny from each citizen dwelling in a house with a hall door, and a halfpenny from every shop to provide a cart which carried away the filth from the streets." ² These were the forerunners of the present sanitary rates, those levied by improvement commissioners for various purposes under local Acts being intermediate forms.

The Public Health Act, 1875, which established the

¹ Cannan, *History of Local Rates*, p. 20.

² Miss M. D. Harris, *Life in an Old English Town*, pp. 291-2.

present system of sanitary authorities, also defined their powers of raising money to meet the expenditure involved in performing these functions. With a few exceptions the expenses incurred by urban authorities are defrayed out of the general district fund and the general district rate.¹ The general district rate is levied on occupiers of property assessable to the relief of the poor at the full net annual value, except that, as the extent of area is not regarded as a measure of the degree of benefit derived from local sanitary expenditure, agricultural land, railways, canals, and land used for certain horticultural and pastoral purposes were rated on only one-fourth of their value.² Under the Agricultural Rates Act, 1923, an additional exemption (making three-quarters in all) was given to occupiers of agricultural land; and, if proposals now before Parliament mature,³ not only will agricultural land and buildings cease to be rated, but industrial and freight transport hereditaments will be rated at one-fourth of the net annual value as defined by the Rating and Valuation Act, 1925. The resulting deficiency is to be made good by grants from the National Exchequer.

The expenses of rural district councils are divided into general, including establishment expenses, salaries, cost of disinfection, conveyance of infected persons, and all other expenses not designated as special, and special expenses⁴ incurred in the provision and maintenance of various services and works in contributory places within the districts. Both are met by rates levied and collected by the rural district councils, but the former are paid out of a common fund to which all contribute in proportion to their rateable value, whilst the special expenses are defrayed by sums raised from each contributory place benefiting from the service for which the expenses are incurred.⁵

¹ Public Health Act, 1875, ss. 207 *et seq.*

² *Ibid.*, s. 211.

³ See Proposals for Reform in Local Government and in the Financial Relations between the Exchequer and Local Authorities (Cd. 3134, June, 1928).

⁴ Public Health Act, 1875, s. 229.

⁵ See Rating and Valuation Act, 1925.

There are a number of cases where the owners or occupiers of property have neglected to do certain works required by the local authority, and the latter having done the work, is entitled to recover the costs.¹ They may elect to do so by declaring the expenses to be private improvement expenses and levying upon the occupier a private improvement rate sufficient to redeem the debt, with interest not exceeding 5 per cent. per annum, within a period less than thirty years. The occupier may deduct three-fourths of the amount from the rent, and either he or the owner is empowered to redeem the debt at any time.² Among the purposes for which such rates may be levied are the drainage of undrained houses,³ the provision of privy accommodation⁴ or water supply,⁵ the repair of drains and sanitary fittings,⁶ and the making up of private streets.⁷

Out of the general district fund of urban district councils and the common fund of rural district councils are paid the expenses incurred not only in administering the Public Health Acts, but in the performance of many kindred duties imposed by other Acts. Thus, the expenses of administering the Baths and Washhouses Acts,⁸ the Canal Boats Acts,⁹ the Factory and Workshop Acts,¹⁰ the Alkali Works, etc., Regulation Act, 1906,¹¹ and the Milk and Dairies (Consolidation) Act, 1915 and Orders,¹² and any excess expenditure over the agreed amount repaid by the county council to district councils for carrying out the delegated duties under the Midwives Acts¹³ are chargeable to general district and common funds, except that in rural districts the expenses incurred by the adoption of the Baths and Washhouses

¹ See Table at end of Chapter XIV.

² Public Health Act, 1875, ss. 213 to 215 and 232.

³ *Ibid.*, s. 23.

⁴ *Ibid.*, s. 36; Public Health Acts Amendment Act, 1907, s. 39.

⁵ *Ibid.*, s. 62; Public Health (Water) Act, 1878, s. 3.

⁶ *Ibid.*, s. 41; Public Health Acts Amendment Act, 1890, s. 19.

⁷ *Ibid.*, s. 150; Public Street Works Act, 1892, s. 12.

⁸ Baths and Washhouses Act, 1846, s. 16.

⁹ Canal Boats Act, 1877, s. 8.

¹⁰ Factory and Workshop Act, 1901, s. 14.

¹¹ Section 24.

¹² Milk and Dairies (Consolidation) Act, 1915, s. 17.

¹³ Midwives Act, 1902, s. 9.

Act, or in the administration of the Factory and Workshop Acts are special expenses chargeable upon the contributory place in which the baths or factories or workshops are situated.

In several cases, however, the expenses incurred in administering Acts, the duty of which usually falls upon the public health department, are chargeable upon the county funds of the county councils or the borough funds of the borough councils. This occurs where the rural authorities have been ruled out as administrative bodies, and includes expenses incurred for the purposes of the Contagious Diseases of Animals Acts,¹ the Sale of Food and Drugs Acts,² Shops Acts³ and the Midwives Acts,⁴ as well as the Explosives and Weights and Measures Acts, which are often administered from the same department.

Local rates agree with national taxes in being compulsory contributions from the private individual for the public service; but since the benefit from their expenditure is supposed to be more limited they are leviable over a more restricted area. There is a distinction usually noticed between rates and taxes, which, however, is not of great practical importance—"in the case of Imperial taxation of commodities a duty is imposed upon each unit of consumption. Local taxation reverses this process; it starts with the gross amount required; the ratio of the assessed value of the rateable property in the district to this sum gives the rate per £ to be levied, and each occupier pays at this rate on the assessed value of his holding."⁵ Far more important is the fact that the amount of the rate is subject to no legal limitation, except in the comparatively unimportant case of parish councils, the rating powers of which are restricted to 3*d.* in the £, or, with the consent of the parish meeting, to 6*d.*, plus a further amount to meet expenses incurred through the adoption of various Acts.⁶

¹ Diseases of Animals Act, 1894, s. 40.

² Food and Drugs (Adulteration) Act, 1928, s. 26.

³ Shops Act, 1912, s. 13.

⁴ Midwives Act, 1902, s. 15.

⁵ G. Armitage Smith, *Principles and Methods of Taxation*, p. 159.

⁶ Local Government Act, 1894, s. 11.

It is extremely difficult, if not impossible, to arrive at any figures in respect to public health finance in bulk; the authorities and rates and the expenses charged upon them are so various as to defy elucidation. In 1924-5 in England and Wales the sum of £141,977,060 was raised by means of rates, averaging 11s. 8½d. in the £ of rateable value, and £3 13s. 3½d. per head of population. In addition, local authorities received grants equivalent to 6s. 9d. in the £, and £2 2s. 2½d. per head of the population. Of such rates approximately 21·4 per cent. was to meet expenditure upon health services, including housing and town planning, distributed as follows: ¹

	Per cent.
Sewers, Refuse, Water Supply, Baths, Cemeteries, Hospitals, Salaries, etc.	15·6
Maternity and Child Welfare, Tuberculosis, Venereal Disease	1·3
Lunacy and Mental Deficiency	3·7
Housing and Town Planning	·8
	21·4

To receipts from rates must be added revenue derived from various institutions and undertakings, such as markets, slaughter-houses, cemeteries, and water supplies, amounting to some £14 millions, and lastly exchequer grants which, including grants made in connection with schemes of work for the unemployed, amounted in 1924-5 to about £11 millions.² As being the only instance prior to the National Insurance and Finance Acts of 1911, of the sanitary authorities receiving grants-in-aid, the following figures, showing the salaries of sanitary officers in respect of which such grants were paid, are interesting: ³

1875-6	£57,536	1899-1900	£259,000
1885-6	71,321	1905-6	325,000
1889-90	75,000	1909-10	358,000
1895-6	221,000	1911-12	372,000

¹ Eighth Annual Report of the Ministry of Health, pp. 108-9.

² See Table on page 274.

³ Figures for 1875-6 and 1885-6 from *National and Local Finance*, J. Watson Grice, p. 364; remainder from Report of the Departmental Committee on Local Taxation, 1914 (Cd. 7315). Salaries of county medical officers and officers of many county boroughs are not included.

Nowadays the grant for the above purposes forms but a small proportion of the total, the growth of which upon services more recently developed is indicated in the following tables :¹

	Maternity and Child Welfare.	Institutional Treatment of Tuberculosis.	Treatment of Venereal Diseases.
	£	£	£
1919-20 .	526,217	500,238	224,716
1920-1 .	833,850	777,006	327,595
1921-2 .	1,168,920	1,176,556	491,127
1922-3 .	829,520	1,481,846	326,634
1923-4 .	791,201	1,580,651	303,431
1924-5 .	814,519	1,599,402	297,798
1925-6 .	897,100	1,624,311	306,816
1926-7 .	962,476	1,644,098	308,662

(Part of these grants was paid to various voluntary societies.)

As we have already seen in the last two chapters, many of the functions of sanitary authorities involve the execution of costly and enduring buildings and works. It would be manifestly unfair, even if it were possible, to pay for these out of current income ; rates would be subject to violent fluctuations, and posterity would reap undue benefit from the burden borne by the present generation. To meet this difficulty sanitary authorities have been empowered to borrow money on the security of the rates for these purposes, spreading the repayments over a period tending towards, but seldom reaching, the " life " of the building or works for which the money is borrowed. In this way the burden is borne by those who benefit, at least in the earlier years.

From 1848 to the passing of the Local Government Act of 1858, the General Board of Health sanctioned loans under the Public Health Act, 1848, to the extent of £2,956,178. From this date up to the constitution of the Local Government Board in 1871, the Secretary of State sanctioned, under the Local Government Act of 1858, and the Sewage

¹ For fuller details, see Eighth Annual Report of the Ministry of Health, pp. xxvi *et seq.*

Utilisation Act, 1865, loans amounting to £7,363,366, and the Local Government Board, between 1871 and 1913, sanctioned loans to urban and rural authorities which totalled £211,007,163.¹ Of course, by no means all of this last amount, or of that outstanding in 1925 (£864,882,330), is connected with public health; lighting (gas and electric), fire-stations and appliances, and works of sea defence are included, but the fact that the total sanctioned during the year ending March 31, 1927 (£27,338,932, about £10½ millions of which were for sanitary purposes), was nine times as much as was sanctioned during the ten years 1848-1858, indicates the tremendous advance made in the provision of works of enduring utility.²

A careful observer³ has stated that "the mere fact of interference of the Legislature in such matters of mainly local concern, as e.g. public health, argues a strong *prima facie* general interest, and the implied obligation has been met in some measure by subventions, but for the most part by the advances of public credit for the improvement of local sanitation." This was done by empowering local authorities to borrow money from the Public Works Loan Commissioners, who were constituted in 1817, the Public Works Loans Act, 1875, consolidating previous statutes on the subject of the powers of local authorities for obtaining money from the central authority at cheaper rates than it could be obtained in the open market.⁴ Since then a long series of local Loans and Public Works Loans Acts have dealt with the question, but judging from the fact that the Ministry of Health issued during the year 1926-7 twenty-one Orders sanctioning the issue of stock under the Stock Regulations, 1891-1921, to the amount of £17,204,418 (exclusive of expenses), the Public Works Loans Commissioners are not favoured by the authorities whose credit is

¹ Forty-second Report of the Local Government Board, Part III, p. lxxxii.

² See Eighth Annual Report of the Ministry of Health, pp. 90-1, for analysis and details.

³ J. Watson Grice, *National and Local Finance*, p. 6.

⁴ See Public Health Act, 1875, s. 243; Public Works Loans Act, 1898.

good.¹ In the early days of public health legislation the central authority had great difficulty in persuading local authorities to borrow money ; nowadays it imposed greater restrictions upon borrowing, and the check to borrowing from the Public Works Loans Commissioners is probably due to these restrictions.

Local authorities can acquire borrowing powers in two ways—(a) by means of local Acts, which, at the instigation of the Ministry of Health, frequently contain certain checks upon the expenditure of money so raised and provision for the submission to the Ministry of annual returns showing the manner in which the authority are complying with the statutory requirements as regards the repayment of the money ; and (b) by clauses in general Acts.

For sanitary purposes the chief powers are contained in the Public Health Act, 1875,² which empowers local authorities to borrow money on the credit of the fund or rates out of which they are authorized to defray expenses. This may be done by borrowing the money for definite periods from the Public Works Loans Commissioners, or private persons, companies or associations, or the issue of stock.

Apart from loans raised under private Acts, which may be subject to various conditions imposed therein, there are many limitations placed upon borrowing. A copy of the resolution of the local authority, together with any provisional agreements, plans, estimates, and particulars of the existing debt and assessable value of the district, must be forwarded to the Ministry of Health, whose sanction is not, as a rule, given until after a local inquiry by one of their engineering or medical inspectors.³ The sanction of the Ministry must be obtained before the expenditure is incurred, otherwise the expenses may have to be met out of the current rate, as without sanction a loan is void ; and

¹ Eighth Annual Report of the Ministry of Health, p. 91.

² Sections 233 *et seq.* See also Public Health Acts Amendment Act, 1890, s. 52, for powers to issue stock.

³ See Public Health Act, 1875, s. 134, and the Epidemic and other Diseases (Prevention) Act, 1883, for possible exceptions.

the Ministry will not give their sanction to borrow for any purpose for which the local authority possesses powers under a local Act, except when the local Act requires such sanction as a condition precedent to borrowing.

The chief statutory limitations to the exercise of borrowing powers are : ¹

- (a) The works must be permanent ;
- (b) The total loans for the purposes of the Public Health Act must not exceed two years' assessable value of the premises assessable in respect of the money borrowed ;
- (c) Sanction cannot be given to any loan without a local inquiry, when the loan, with loans outstanding, is in excess of one year's assessable value ;
- (d) Loans must be repaid by instalments or by the accumulation of a sinking fund in not more than sixty years ; and
- (e) Any loans raised to pay off existing loans must not extend beyond the unexpired period of the period for which the original loan was sanctioned unless the Ministry of Health consent, the period not to exceed sixty years in any case.

The limitation on the total amount of loans is, however, subject to some exceptions in more recent legislation ; loans for the purposes of the Small Dwellings Acquisition Act, 1899,² the Housing Acts³ and for town planning⁴ are not to be reckoned as part of the debt for the purpose of calculating outstanding loans when a proposal to borrow for the purposes either of those Acts or the Public Health Acts is made ; and loans raised by mortgaging sewage-land or plant are considered an addition to borrowing powers under the Act where they do not exceed three-fourths of the purchase money of the lands.⁵

The time limits for repayment vary according to the

¹ Public Health Act, 1875, s. 234.

² Section 9.

³ Housing Act, 1925, s. 88.

⁴ Town Planning Act, 1925, s. 20.

⁵ Public Health Act, 1875, s. 235.

purpose of the loan, the general practice being to allow sixty years for land, about thirty years for brick or stone buildings, sewers, water mains and reservoirs, and about fifteen years for the furniture of buildings, refuse destructors and machinery.¹ Previous to 1898 loans from the Public Works Loan Commissioners had to be repaid within some period less than twenty years unless the Treasury, on the recommendation of the Commissioners, sanctioned an extension.² In this year, however, the period was extended to thirty years,³ a recommendation from the Local Government Board (now Ministry of Health) being required for a longer period.⁴ In the Housing Act, 1925, the period for any purposes of the Housing Acts may be extended to eighty years, and if borrowed from the Public Works Loan Commissioners the interest is fixed at the minimum rate fixed for the time being irrespective of the duration of the loan.⁵ In local Acts various times, within limits, are allowed, but the Select Committee on the Repayment of Loans by Local Authorities reported in 1902 that they were "quite unable to discover any general principle by which the periods allowed by local Acts have been found."⁶ The rates of interest paid for loans varies according to fluctuations in the money market and the credit of the local authority, but loans from the Public Works Loan Commissioners are at present subject to a rate of about 5 per cent.

The power of the Ministry of Health to control the borrowing of money by local authorities is a very real one. By local inquiries, to which ratepayers are invited by public notice and allowed to state their views, the Ministry satisfy themselves that the public works are necessary and adapted to the requirements of the locality, that they will last good for at least as long a time as that limited for the

¹ See Lumley's *Public Health* (9th Ed.), p. 529.

² Public Works Loans Act, 1875, s. 11.

³ *Ibid.*, 1898, s. 5.

⁴ Public Health Act, 1875, s. 243.

⁵ Section 89.

⁶ Grice, *National and Local Taxation*, p. 347.

repayment of the loan, and that the estimates are not excessive. They also take into consideration the records of the authority as regards previous loans; and when a loan is permitted they satisfy themselves that it is properly applied, being empowered to enforce this by *mandamus*.¹

In order to prevent illegal expenditure and malversation of the public funds provision is made for the audit of the accounts of local authorities.² These must be kept in prescribed forms and made up as required by the Ministry of Health. The accounts of borough councils acting as sanitary authorities are exempt from examination and audit by the district auditors of the Ministry, but provision may be made for such audit in local Acts or by provisional order, made under Section 303 of the Public Health Act, 1875, amending local Acts and clauses in the Act of Parliament confirming the orders.³ In several towns the audit is carried out by the district auditor, but in the remainder the borough auditors examine the accounts, except in those boroughs where professional auditors are employed under powers given by local Acts. The accounts of other authorities are examined and audited by district auditors with full powers of calling for all necessary documents, papers, and information, and of publicly hearing objections which may be made by ratepayers or owners of the district. The auditors may disallow any expenditure which has no legal sanction and may surcharge the persons making or authorizing such expenditure. The persons surcharged have the right of appeal to the Ministry of Health, who may disallow or remit the surcharges at discretion. Local authorities are, however, permitted to anticipate disallowance by the district auditor by obtaining beforehand the sanction of the Ministry to any expenditure,⁴ in which case the district auditor cannot disallow the item. Such sanction was given in 3,352 cases out of 3,677 applications made

¹ Public Works Loans Acts, 1875, s. 36, and 1878, s. 4.

² Public Health Act, 1875, ss. 245 *et seq.*

³ See Eighth Annual Report of the Ministry of Health, pp. 113 *et seq.*

⁴ Local Authorities (Expenses) Act, 1887.

during the year 1926-7.¹ The fact that the accounts of a local authority have been audited does not, however, bar any interested person from applying to the Attorney-General to obtain an injunction restraining the payment of money under an order of the council for which there is no legal warrant; similar orders of an urban authority may be removed into the High Court by a writ of *certiorari* at the instance of any interested person, and if invalid may be quashed.² During the year 1926-7 over 3,250 reports were made by district auditors and 517 disallowances and surcharges amounting to £111,974, were made.³

It is so difficult in many cases to determine definitely what are purely matters of public health, and those which may be so determined are so inextricably mixed up with other matters in the financial transactions of local authorities that it is impossible to decide with certainty what the annual cost of the public health service is, or to give figures as to the expenditure, income and loans which may with certainty be said to completely cover the ground. The following figures, extracted from the Local Taxation Returns for the year 1924-5 indicate, with some approximation to accuracy, the cost to the community of the various services, showing how this is affected by expenditure upon works of a more or less permanent nature. On the side of receipts it is noticeable that only in the case of waterworks do fees, tolls, rents, etc., approximate to expenditure; in every other case there is a burden upon the rates despite Exchequer grants (see page 274 for table).

These figures are ample justification of the designation of the public health department as a spending department, the burden upon the ratepayers amounting to some £30 millions per annum.

As we have seen, Parliament has yearly increased the powers and duties and, consequently, the expenditure of sanitary authorities, and that the Ministry of Health is

¹ Eighth Annual Report of the Ministry of Health, p. 112.

² Public Health Act, 1875, s. 246.

³ Eighth Annual Report of the Ministry of Health, pp. 110-11.

Services.	Expenditure other than out of Loans.		Receipts other than from Loans and Rates.	
	Loan Charges.	Total.	Fees, Tolls, Rents, etc.	Exchequer Grants.*
	£	£	£	£
Sewers and Sewage Disposal	3,937,426	8,710,545	755,317	280,401
Collection and Disposal of House Refuse Hospitals, Sanatoria, Dispensaries, etc. :	355,758	6,597,455	485,929	17,270
For Tuberculosis	204,540	2,870,351	133,350	1,577,088
" Venereal Diseases	1,843	393,386	6,778	276,280
" Other Diseases (Fever, etc.)	298,530	3,194,127	182,648	3,112
Salaries of Medical Officers of Health, Sanitary Inspectors and Health Visitors (so far as not allocated to other services)	—	1,250,768	2,849	393,108
Maternity and Child Welfare	41,027	1,713,941	367,461	645,192
Baths, Washhouses, etc.	281,182	1,999,289	770,359	13,919
Parks, Pleasure Grounds and Open Spaces	830,856	4,168,960	1,011,458	176,325
Vaccination	—	182,077	—	3,050
Port Sanitary Service	1,356	90,966	5,047	36,112
Other Health Services	226,240	1,954,413	479,691	7,477
Housing and Town Planning	13,387,739	18,083,062	9,306,950	7,490,017
Cemeteries	235,858	1,378,410	965,544	11,617
Waterworks	7,684,925	13,839,483	15,203,381	62,455
Totals	£27,487,280	£69,127,233	£29,677,762	£10,993,423

* Includes grants made in connection with schemes of work for the unemployed.

constantly endeavouring to obtain a higher standard of efficiency. Until 1911 the central department lacked the best weapon—grants-in-aid—for this purpose, this being justified on the ground that the public health service is essentially "beneficial," it "tends to make the locality in which these services are administered a more attractive place, both for business and residential purposes." This being so, it was urged that "it is only reasonable that the owners and occupiers of property thus benefited should pay the rates necessary to defray the local authority's expenses on these services," and that "any grants-in-aid would have the effect of relieving them of this equitable obligation."¹ This was the position adopted in the Report of the Royal Commission on Local Taxation in 1901. Public

¹ *Reservation to Report of the Departmental Committee on Local Taxation*, by Messrs. Barstow, Harper and Murray, pp. 106-7.

health expenses were not considered to be "onerous," i.e. they were not incurred locally for national purposes, and therefore were not entitled to national assistance.

Public opinion, however, has been changing from this position, which, as the means of transport improve, and the mobility of population becomes greater both in possibility and in reality, becomes less tenable; and the demand for a more effective supervision of local authorities by the Central Government is due to the growing recognition of the national importance of their services, and is an argument in favour of grants-in-aid as a help to the local authorities and a means of control for the central authority. This view was adopted by the Departmental Committee on Local Taxation, who devised a new classification of public services which included an intermediate class of "semi-national services" administered by local authorities, but in which "the State has at the same time so marked an interest in their efficiency as to justify a claim to the supervision of their administration," and the expenses of which should be a joint burden on the local and national exchequers.¹

In this class the Committee, three members dissenting, included public health services. They stated that—

"the considerations that may be held to justify grants are not absent from this branch of local government. While the bulk of the benefit conferred by these services is enjoyed by the immediate locality, it is clear that the maintenance of a good standard of public health is no less important to the nation as a whole than the education of its children or the upkeep of its main roads."

And as a lever for improving local administration they considered encouragement by grants-in-aid as "likely to be more effective than the somewhat cumbersome method of default and *mandamus*."²

The European War intervened and put an end to the scheme of grants-in-aid introduced by the Chancellor of the Exchequer in his Budget of 1914,³ but, as we have seen,

¹ Report, p. 15.

² *Ibid.*, p. 48.

³ The Right Hon. Lloyd George, May 5, 1914.

such grants have since the Peace been used to encourage and develop new public health services. Now once more the country is considering a new attempt to readjust the financial relations between the Exchequer and local authorities consequent upon the derating of agricultural land and industrial and freight transport hereditaments.¹ These proposals involve reforms in the Poor Law Administration by which the functions of the present Boards of Guardians will be distributed between county and county borough councils, a change which will add very considerably to the work of the public health department.²

Public Health authorities receive percentage grants in aid of such services as tuberculosis, maternity and child welfare, welfare of the blind, venereal diseases and mental deficiency which involve "close supervision by the central department of the work of the local authorities to whom they are paid." They have the great defect that "as they are not related closely to needs, but to expenditure, their effect is that those areas which are poorest, and can least afford to maintain an adequate standard, are just those which receive the least assistance from national funds."³

The Government (June, 1928) take the view that a proper system of national aid should—

- (1) recognize that a fair contribution should be made from the Exchequer towards the cost of local services ;
- (2) ensure that local authorities have complete financial interest in their administration ;
- (3) be adapted in its working to the needs of the areas ;
- (4) permit the greatest freedom of local administration and initiative ;
- (5) provide for sufficient general control and advice from the central departments to ensure a reasonable standard of performance.

¹ See page 263.

² Proposals for Reform in Local Government and in the Financial relations between the Exchequer and Local Authorities (Cd. 3134, June, 1928), pp. 6 *et seq.*

³ *Ibid.*, p. 12. Remainder of proposals from same source.

To this end they propose to abolish as from April 1, 1930, the Assigned Revenue Grants, the grants under the Agricultural Rates Acts, 1896 and 1923, the percentage grants in aid of public health services and various grants towards highway expenses, and in place thereof to substitute an annual block grant, fixed in total and for each authority for periods of five years, to county and county borough councils. From the former grants will be distributed to the councils of county districts.

Apportionment is to be ultimately made according to a formula based on general characteristics, independent of actual expenditure, in which the population, proportion of children under five years of age and rateable value per head of population are the primary factors. Secondary factors allow for the additional burden thrown upon certain areas by abnormal unemployment and for variations in the cost of local government services due to differing density of the population. For the former the proportion of unemployed insured men to the total population is adopted as the standard, in the latter case the population per mile of public road is adopted.

To introduce this system at once would cause too great a disturbance of local finance, so that for three quinquennial periods various adjustments are proposed until by 1945 the total grant will be distributed on the basis of the full formula as follows :

- (1) For each county and county borough a figure of weighted population is arrived at by increasing the population in the standard year as estimated by the Registrar-General—
 - (a) by the percentage by which, at the last previous Census, the number of children under 5 years of age per 1,000 of the population of the area exceeded 50, and
 - (b) by the percentage by which, according to the Valuation List in force on the 1st October, 1929, or on subsequent revisions of the grant in the year prior to the

revision, the rateable value per head of estimated population of the area is below £10.

The population so increased is further weighted—

(c) for unemployment; the number of unemployed insured men is expressed as a percentage of total estimated population, and where this percentage, averaged over three years, exceeds $1\frac{1}{2}$ per cent., the population is increased by a percentage equal to ten times the excess over $1\frac{1}{2}$ per cent. ;

and in administrative counties other than London

(d) for low density of population; where the estimated population per mile of roads is less than 100 persons, the population increased by (a) and (b) is further increased by the percentage by which the estimated population per mile of roads is less than 200 persons, and, where the estimated population per mile of roads is 100 persons or more, by the percentage which 50 persons bears to the estimated population per mile of roads.

Each non-county borough and urban district council will receive from the county council a grant at a uniform figure per head of actual population, and each rural district council at one-fifth of that uniform figure per head of actual population; the uniform figure being one-half the result of dividing the total grant to all administrative counties by their aggregate actual population.

The Parliamentary Paper (Cd. 3134) from which the foregoing information has been obtained contains elaborate explanations and statistical charts showing the effect of the proposals upon local finance, but as to how far the financial advisers to the various local authorities will agree

will ultimately emerge from the cauldron of Parliamentary debate. The proposals vary very considerably from those made in 1914 based upon the Report of the Departmental Committee on Local Taxation and appear *prima facie* to be open to the criticism that an effective method to encourage or even coerce local authorities may be removed from the hands of the Ministry of Health, and that some local authorities may utilize the grants to reduce rates rather than to improve their health services.

CHAPTER XXV

CENTRAL CONTROL

THE purpose of administrative control by the Central Government of the activities of local authorities is to secure a high general level of efficiency, by advising and encouraging the more willing authorities, and by exhorting and, in the last resort, compelling neglectful councils to perform their duties and exercise their powers. The source of all such control lies in the various legislative measures constituting the controlling departments and the local authorities, or endowing them with their diverse powers and duties. Its extent and effect consequently vary with different authorities and for different purposes; and if the three greatest spheres of local government be considered—education, poor relief, and public health—it will be found that central control is slightest and weakest in the case of last-mentioned. The chief reason for this is to be sought in the fact that the foundations of public health service were being laid at a time when the excessive centralization of Poor Law administration and the somewhat tactless zeal of Chadwick in trying to force sanitation upon the country by the same method had provoked a strong reaction in favour of local autonomy. A secondary but not unimportant cause is to be found in the general belief that public health effort was for the benefit of the locality rather than for that of the country as a whole, and consequently the expenditure incurred was not considered “onerous” and therefore was not shared by the National Exchequer. This opinion was not authoritatively changed until the Departmental Committee on Local Taxation

ment was without the best weapon for exercising efficient control, the power of withholding grants-in-aid. The consequence has been that legislation conferred many powers and placed few duties upon local authorities, and that control by the Central Government has been neither wide in its application nor very drastic in its effects. The maternity and child welfare service, which is heavily financed from national funds, is a significant instance of an advance in method of control.

The importance of central control has been exaggerated. Maltbie states that "nearly every system that could be thought of was tried, but not until a logical plan of central control was instituted and made to apply to all of England by the Acts of 1866, 1872 and subsequent years was there any noticeable decrease in the death-rate either relatively or absolutely, or great improvement in sanitation."¹ It is not true that a logical plan of central control was instituted; there neither was nor is such a system. To suggest it is almost an insult to Englishmen who pride themselves upon the possession of common sense and the absence of logic in public affairs. The decreased death-rate is rather the result of the institution of a general system of local authorities endowed with wide powers in place of the "desperate state of confusion in which valuable principles are affirmed, but the necessary organization and authorities are absent."² To local initiative and local effort must by far the greater amount of credit be given for the improved public health.

It is true that the Royal Sanitary Commission of 1871 found similar complexity and overlapping of the six central departments acting in respect of public health,³ and that there was a great waste of power in consequence. They reported that they found "a general consent in the minds of persons of every class that it is not so much lack of

¹ *English Local Government of To-day*, p. 114-15.

² Second Report of the Royal Sanitary Commission, 1871, Vol. II, p. 183.

³ These were the Home Secretary, Privy Council, Poor Law Board, Board of Trade, Registrar-General and the Lunacy Commission.

science nor lack of machinery, but rather a proper arrangement of the machinery which is needed for taking due care of the public health." ¹ The Report was immediately acted upon. In 1871 the Local Government Board was constituted, and remained until 1919 the chief department of the Central Government concerned with the control of the local sanitary authorities.

In 1848 the General Board of Health was established, but, after enduring a series of bitter attacks, was abolished ten years later, when its powers were shared between the Privy Council, a branch of the Home Office called the Local Government Acts Office, and the Poor Law Board. Such a confused and complex jurisdiction was bound to be inefficient, and the Local Government Board Act of 1871 transferred all such powers to a new department called the Local Government Board, stating in the preamble that it was "expedient to concentrate in one department of the Government the supervision of the laws relating to the public health, the relief of the poor and local government."

By the Ministry of Health Act, 1919, the Local Government Board, which like the Board of Trade was only a phantom body which never met, was replaced by a Minister of Health, the general duties of whom were "to take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people, including measures for the prevention and cure of diseases, the avoidance of fraud in connection with alleged remedies therefor, the treatment of physical and mental defects, the treatment and care of the blind, the initiation and direction of research, the collection, preparation, publication, and dissemination of information and statistics relating thereto, and the training of persons for health service." ² To him were transferred all the powers and duties of the defunct Local Government Board and of the Insurance Commissioner of England and Wales, of the Board of Education as regards expectant and

nursing mothers and children under five not at school and the medical inspection and treatment of school children, and of the Privy Council and Lord President as regards midwives.¹ Other duties may be transferred to the Minister by Order in Council, and work in connection with lunacy and mental deficiency and under the Rats and Mice Destruction Act has been so transferred as well as certain powers of the Secretary of State under the Factory and Workshop Act, 1901.² To advise and assist the Minister consultative councils, including women, of persons having practical experience may be set up,³ and travelling expenses, subsistence allowance and reasonable compensation for loss of remunerative time may be paid to them.

The Minister, a member of the Cabinet, submits the departmental estimates to the Chancellor of the Exchequer and, with the aid of the Parliamentary Secretary, explains and defends the actions and policy of the Ministry before Parliament. His staff is large and includes men and women who are highly skilled in engineering, medical and preventive science and finance, the Permanent Secretary exercising control with the assistance of a chief medical officer, a solicitor and legal adviser, an assistant secretary for finance, a director of establishments, and a controller of health insurance. The control of public health administration, including all those activities having for their object the prevention and treatment of disease, is divided among nine different divisions of the department, each with a separate staff having special administrative experiences and policies and superintended by a chief responsible through the Permanent Secretary to the Minister.

Of these divisions the one dealing with Poor Law administration is only indirectly connected with the public health service⁴ through its dealings with Poor Law infirmaries,

¹ *Ibid.*, s. 3.

² The Ministry of Health (Factories and Workshops Transfer of Powers) Order, 1921. Powers under Factory and Workshop Act, 1901, sections 61, 97 to 100, 109 and 110 transferred.

³ Ministry of Health Act, 1919, s. 4.

⁴ If proposals now before the country materialize, all Poor Law functions will be distributed between the councils of counties and county boroughs.

district sick asylums and the establishment under the Metropolitan Asylums Board, and cognate matters. The other divisions, most of which are subdivided into departments for administrative convenience, have extensive and varied functions, the common ignorance of which justifies them being set out *seriatim* as far as they are concerned with public health.

I. LOCAL GOVERNMENT ADMINISTRATION

A.—Constitution and alteration of Local Government and other areas; and Charters of Incorporation. Loans for Aerodromes; Allotments; County and Municipal Buildings; Public Offices and Halls; Education; Ferries; Fire Stations and Appliances; Gas and Public Lighting; Highways (other than Private Streets); Inebriates' Reformatories; Markets and Refrigerators; Military Lands Acts; Parking Places; Police Buildings (except erection of dwellings); Public Libraries; Sale, Letting; Appropriation, etc., of Land (including Provisional Orders for Compulsory Purchase) in relation to above matters; Sea Defences; Small Holdings, and certain other purposes. Provisional Orders for extending borrowing powers of County Councils. Transactions with respect to Corporate Lands under Municipal Corporation Act, 1882. Schemes for Unemployment Grants. Urban Powers (except as to Private Streets). "Special" Expenses. Adoption of Public Health Act, 1925 (except consents under Section 3), and conferring powers on Rural District Councils. Application of adjustment moneys. Examination of Public Health Act debt, and suspension of Sinking Fund payments and Local Authorities (Financial Provisions) Act, 1921. Loans under Section 3 of the Local Authorities (Financial Provisions) Act, 1921. Advising on Applications for loans from local authorities of heavily rated areas. Financial and Loans Records.

B.—Sewerage and Sewage Disposal; Surface and Storm Water Drainage, and Land Drainage. Culverting Streams. Refuse Disposal, and Scavenging and Public Cleansing.

including salvage of waste. Street Bins. Recreation Grounds, Parks, Open Spaces, and Playing Fields. Seats, Drinking Troughs, and Fountains. Public Conveniences. Baths and Washhouses. Provisional Orders for compulsory purchase of Land for above purposes. Privy Conversions. Private Streets (including loans, urban powers, etc.). Loans for above matters. Alkali, etc. Works Regulation Act, Smoke Abatement, and Nuisances under the Public Health Acts. Appeals under Section 268, Public Health Act, 1875, referred from Legal Branch. Canal Boats.

C.—Provisional Orders altering Local Acts. Reporting on Bills for Local Acts. Approval of promotion of or opposition to Bills. Examination of draft Provisional Orders of the Ministry of Transport under the Pier and Harbour Acts and the Light Railways Acts. Issue of Stock by Local Authorities. Approval of equation schemes under Local Acts for repayment of debt. Adjustments between County Councils and County Boroughs. Miscellaneous work in connection with local finance.

D.—Water Supply (including loans and formation of special water districts) and Water Charges. Provisional Orders relating to Water Undertakings. River Pollution. Burial Grounds and Burials (other than fees and bye-laws).

E.—Correspondence generally, not allocated to another Division or Branch, and in particular as to the following matters :— Qualification and disqualification of members of, and proceedings at meetings of, local authorities. Examination of bye-laws, tables of fees or tolls, rules, regulations, etc., submitted to the Minister under Act of Parliament and preparation of model series. Bye-laws, requisitions, etc., under Sections 100 and 101 of the Housing Act, 1925. Appeals under Section 99 of the Housing Act, 1925, and Section 25 of the Housing, Town Planning, etc., Act, 1919. Investing urban authorities with certain powers of parish councils under Section 33, Local Government Act, 1894, and urban and rural authorities with powers of Public Health Acts Amendment Act, 1907; consents under Section 3 of the Public Health Act, 1925, and miscellaneous

inquiries as to the effect of that Act. Modification of local Acts under the Public Health Acts Amendment Act, 1907 ; and the Public Health Act, 1925. Confirmation of orders as to offensive trades made by local authorities under Section 51 of the Public Health Acts Amendment Act, 1907. Regulations of the Minister under the Burial Acts. Rating and assessment (other than matters arising under the Rating and Valuation Act, 1925). Legality of expenditure by Local Authorities (except when belonging to Division VII).

II. FOODS, APPOINTMENT OF MEDICAL OFFICERS OF HEALTH, ETC.

A.—Appointment of M.O.H.'s and Sanitary Officers. Miscellaneous health and sanitary questions not specifically allocated to other Divisions.

B.—Food (including all matters relating to Milk and Dairies, the Sale of Food and Drugs Acts, the Public Health (Regulations as to Food) Act, 1907, and the Provision and control of Slaughter-houses.

III. INFECTIOUS DISEASES, TUBERCULOSIS, VENEREAL DISEASE, MATERNITY AND CHILD WELFARE, BLIND, ETC.

A.—*Tuberculosis* : Schemes of local authorities for treatment ; payment of capital and maintenance grants ; arrangements with Ministry of Pensions for treatment of ex-Service men ; regulations for the notification and prevention of tuberculosis ; arrangements for the after-care ; provision of extra nourishment, domiciliary treatment of insured persons, etc.

B.—*Venereal Disease* : Schemes of local authorities for the provision of facilities for diagnosis and treatment, and propaganda work in connection therewith ; paying of exchequer grants ; approval of arsenobenzol compounds ; arrangements with National Council for combating Venereal Diseases for propaganda work ; international arrangements.

C.—*Infectious Disease* prevention (including provision for

Port Sanitary administration, medical inspection of aliens, International Sanitary Conventions, and Vaccination).

D.—*Maternity and Child Welfare*: Approval of arrangements of Local Authorities under the Maternity and Child Welfare Act, 1918, and general administration of that Act, the Notification of Births Acts, 1907 and 1915, Part I of the Children Act, 1908, the Midwives Acts, 1902 and 1918, and the Midwives and Maternity Homes Act, 1926; arrangements in connection with the training and provision of Midwives and the training and certification of Health Visitors; examination of applications for grant of Local Authorities and Voluntary Agencies.

E.—*Welfare of the Blind*: Approval of arrangements of Local Authorities under the Blind Persons Act, 1920, and general administration of that Act, examination of applications for grant of Local Authorities and Voluntary Agencies.

V. HEALTH QUESTIONS AND GENERAL PRACTITIONER SERVICES

A.—Dentists' Registration. Nurses' Registration. Hospitals and hospital provision (other than Isolation, Poor Law and Maternity). Lunacy and Mental Deficiency Acts and relation of the Ministry to the Board of Control. Powers under the Anatomy Acts. Patent Medicines. Medical Research. Deaths from Anæsthetics. International Health arrangements and Foreign Correspondence (except that shown in Division III). Therapeutic Substances Act. Post-graduate Education.

B.—Medical Benefit under National Health Insurance Acts. Terms and conditions of service of medical practitioners and chemists under the National Health Insurance Acts. Constitution and personnel of Insurance Committees. Miscellaneous questions affecting general practitioners and supplies of drugs (other than those arising directly under the Sales of Food and Drugs Acts) and of medical and surgical appliances.

C. — Insurance Committees' Administration. General

administrative machinery and financial arrangements of Insurance Committees.

VI. ESTABLISHMENT AND INTELLIGENCE

A.—Control of office organization as a whole. Appointment, promotion, transfer, retirement, discipline and leave of the whole of the staff. Provision, allocation and upkeep of office accommodation and equipment (including provincial offices); correspondence with Stationery Office and Office of Works. Correspondence with Treasury relating to personnel and office organization.

Registry.—Receipt, registration, distribution and custody of all letters and papers.

Printing.—Provision of all printing, neostyling, stationery, and other stores for all branches of the Department.

Copying.—Typing and Shorthand Writing.

B.—*Intelligence.*

(i) *General Intelligence.*—Special inquiries and reports. Editing Annual Reports of Ministry. Selection and Distribution of Press Cuttings. Noting suggestions for legislation. Provision of information to Press.

(ii) *Foreign Intelligence.*—Special inquiries and reports on health and local government questions abroad. Replying to inquiries from abroad. Examination of foreign newspapers and periodicals.

(iii) *Library.*—Care and custody of books, pamphlets, Government publications, and maps.

VII. AUDIT, ACCOUNTS AND STATISTICS OF LOCAL AUTHORITIES

A.—Decision of appeals against allowances, disallowances and surcharges by District Auditors. Correspondence relating to recovery of sums disallowed or surcharged by the District Auditors. Applications for sanction under Local Authorities (Expenses) Act, 1887, to expenditure liable to be disallowed. Applications for approval to expenditure.

Powers) Act, 1923. Extending time for payment of accounts which are out of date.

B.—General supervision of work of District Audit. Reports by District Auditors upon accounts to Local Authorities and their officers. Correspondence with Local Authorities as to finance accounts and other matters arising out of audit. Prescribing forms of accounts of financial statements. Supervision of arrangements for rate collection and assent to departure from Regulations in special cases. Examination of Audit Stamp Duties paid by Local Authorities. Supervision of repayment of Loans.

C.—(i) Administration of the grants under the Local Government Act, 1888, the Agricultural Rates Act, 1896, the Agricultural Rates Act, 1923, and other grants paid out of the Local Taxation Account.

(ii) Financial and other Statistics of Local Authorities (except infectious disease and vaccination); Preparation of Local Taxation Returns and Returns of the number of persons in receipt of Poor Law Relief and other periodical and special Returns.

IX. HOUSE PRODUCTION AND SLUM CLEARANCE

Schemes for the provision of new houses. Clearance of slum areas and unfit houses. Appeals, closing orders, etc. (except appeals under Section 25 (3), Housing, Town Planning, etc., Act, 1919, and Section 99 (2) Housing Act, 1925). Increase of Rent, etc., Acts.

XI. TOWN PLANNING

Approval of Town Planning Schemes for securing proper sanitary conditions, amenity and convenience, in connection with the lay-out and use of land for building purposes, including the allocation of land for industrial, residential or other uses, or for open spaces, the planning of roads, and the determination of density and height of buildings. Determination of appeals against decisions of Local Authorities upon application for permission to develop pending

the preparation and approval of Schemes. Correspondence and approval of indexes to registers in connection with the registration of local land charges under the Land Charges Act, 1925.

XII. POOR LAW AND OLD AGE PENSIONS

A.—General administration of Poor Law, including questions relating to parish property and certain parish officers. Superannuation of employees of all local authorities.

B.—Old Age Pensions Appeals.

Legal Branch.

General advice to the Ministry on all legal questions. Preparation and issue of Provisional Orders, Regulations, Orders and Certificates under Seal. Preliminary work on the preparation of Government Bills affecting the Ministry. Assisting in the preparation of notes on amendments on Public Bills affecting the Ministry. Preparation of cases for opinion of Law Officers. Conduct of civil and criminal proceedings in which the Ministry is concerned. Conduct of appeals to the Minister against decisions of Local Authorities and in Insurance matters. Legal questions and appeals arising under Widows', etc., Pensions Act, 1925.

Parliamentary.

Watching all parliamentary proceedings; making the detailed arrangements for answering Parliamentary questions; presentation of documents to Parliament. Supply of Parliamentary Papers and Stationery Office publications. Examinations of all Public Bills.

The medical staff, at the head of which is the chief medical officer, is organized at head-quarters into six divisions as follows:

(1) Medical intelligence and epidemiology: international

- (3) Tuberculosis and venereal disease.
- (4) Milk and other Food Acts and Regulations.
- (5) Insurance; Drugs; Poor Law; General Hospital Questions.
- (6) Port sanitary and infectious diseases administration; vaccination, etc.,

and there are regional medical staffs for each of four divisions of England and for Wales.

In the offices of the Ministry public Bills dealing with local government are prepared, and all private Bills promoted by local authorities or private associations have to run the gauntlet of criticism, and frequently the opposition, of its expert advisers. In fact, unless the demands of the Ministry are conceded, or it is in some other respect placated, the promotion of such legislation is seldom successful.

The administration of the Factory and Workshop Acts and kindred legislation by local authorities is supervised and controlled from the Home Office, at the head of which is the Secretary of State, a lineal descendant of one of the oldest officers of the Crown.¹ On the other hand, one of the newest of the departments of the Central Government, the Ministry of Agriculture, is endowed with certain powers of control and supervision as respects the local administration of the Contagious Diseases of Animals Acts, and the *quasi* public health legislation affecting fertilizers and feeding-stuffs and destructive insects and pests.

In theory and by law there are few powers or duties conferred upon local authorities in the exercise of which they are not subject to some measure of supervision or control. The practice varies from time to time, and as regards different matters, very divergent opinions being expressed as to the wisdom, efficiency, and advantage of such interference. On the one hand, it is denounced as the mischievous meddling of bureaucratic busybodies, whilst on the other, demands are made for a more stringent exercise by the central authorities of those powers they possess to compel reluctant authorities to exercise the

¹ See R. H. Gretton, *The King's Government*.

powers they are by law endowed with. It is not safe in this case to assume that the middle course is the right one. The issue is to a certain extent the old one between the centralizing and decentralizing tendencies, and local government becomes a myth if the central authority is empowered to step in and forcibly compel local authorities to do everything which, having the power, they neglect to do. It remains true that the population of a local area, like that of a country, gets the kind of government which it deserves ; a neglectful local authority can be replaced by one more energetic when the local electors are desirous of so doing. Striking examples of the paralysing effects on local administration of indifferent or even interested electorates were brought before the Royal Sanitary Commission in 1871,¹ and more recently the position was summed up in a report of the medical officer to the Local Government Board in the statement that "the responsibility for failure to secure sanitary conditions of life in a district must be shared between the sanitary authority, their officers and the inhabitants of the district. In a restricted sense it may be said that the inhabitants of a district secure such sanitary conditions as they deserve, the members of the local councils having been elected by them."² Nevertheless, the complaints of those who wish for a more progressive exertion of central control in the direction of a general levelling up of local administrative effort are not without justification, but, as will be seen, the fault probably rests less with the central departments than with the methods at their disposal for the purpose.

The various methods by which the Central Government is enabled to aid, supervise and control local authorities are susceptible to classification. But they are not all as equally applicable in the case of public health administration as they are to other branches of local government ; and the defect is most important. In the case of police, Poor Law,

¹ Second Report, 1871, Minutes of Evidence.

and education, enterprise is stimulated and efficiency is rewarded by a system of grants-in-aid. Until comparatively recently public health administration was entirely without this very important factor for promoting a progressive development of the service, unless the payment, out of the Exchequer contribution accounts of the county councils, of a moiety of the salaries of district medical officers of health and sanitary inspectors whose appointments have been approved by the central department be considered as such a grant. A new departure was made by the National Insurance and Finance Acts of 1911, by which local authorities are receiving grants-in-aid to enable them to deal effectively with tuberculosis. It was not unreasonable that, having the beneficial effects of grants-in-aid in the case of such services as police and education before them, enthusiasts for sanitary progress viewed this step as a move in the right direction, and urged with greater force the need for similar treatment of other public health problems. And with success, as, since 1919, liberal grants have been made towards the cost of maternity and child welfare services and for the treatment of venereal diseases as well as heavy subsidies in aid of the provision of housing accommodation.¹

Apart from this method, at present undeveloped as regards the general sanitary work of local authorities, the methods of central control fall under one or the other of the following heads :²

- (1) *Sub-legislative*.—Discretionary grants of powers, provisional orders, etc. The issue of orders, rules and regulations dealing with affairs administered locally.
- (2) *Approval*.—The sanction of acts of local authorities in order to render them lawful.
- (3) *Appellate*.—The power of decision in cases where local authorities are one or both parties in a matter of dispute.

¹ See Chapter XXIV.

² Compare Maltbie, *English Local Government of To-day*, p. 260, and Ashley's *Local Government*, pp. 49 et seq.

- (4) *Inspection and Direction.*—Including the audit of accounts.
- (5) *Executive.*—The administration of local affairs or the execution of local Acts where the local authority is negligent.
- (6) *Advisory.*—The preparation, publication, and distribution of reports and information upon matters of importance to sanitary authorities.

There is no doubt that the work of the Ministry of Health in these directions is steadily increasing, particularly that generalized under the heading "Sub-legislative." One of the tendencies of modern legislation is to define generally the powers and duties of a local authority in an Act of Parliament and to delegate to the Ministry of Health the power of elaborating the details of administration in orders and regulations.¹ On the other hand, by the device of provisional orders, the Ministry sanctions the details of local legislation and is responsible for piloting the confirmation Acts through Parliament. By these means some of the legislative congestion of Parliament is relieved and some of the heavy expense of promoting private Bills is saved to local authorities, but it has been alleged, with some show of reason, that the result was to over-burden the department with work and to cause delay in dealing with many matters of importance.²

It is these conditions that have given added strength to the demand for some measure of decentralization, especially in the direction of transferring some of the Ministry of Health's power of control over the county sanitary districts to the county councils. For this purpose ample powers are given by the Local Government Act, 1888,³ which authorizes the Ministry to make a provisional order transferring to county councils any powers, duties, and liabilities of the Privy Council, a Secretary of State or any of the Government Departments as are conferred

by or in pursuance of any statute, and appear to relate to matters of an administrative character arising within the county. The power thus transferable include those of the Ministry of Health under the Public Health, Baths and Washhouses, Artisans' Dwellings, Highway and Rivers Pollution Acts. The year after the Act was passed Mr. Ritchie, then President of the Local Government Board, brought forward a Bill to confirm a provisional order made to effect some transfers originally intended to be effected by the Act itself, but the opposition from the councils of the county districts, on the ground that the county council would not be so impartial as a central department, and that the Board possessed more expert knowledge and could give more valuable advice was too strong and the Bill was dropped.¹ A later Act² permit such powers to be transferred to any particular county council or county borough council if they make application, but notice of such intention must be given to all local authorities likely to be affected, and the result has been that matters have remained as they were. It remains to be seen how far such decentralization will result from the reforms in local government of which at the moment only the broad lines are indicated.

Another way of relieving the strain upon the capacity of the controlling authority, viz. by an increase in the size and a reduction in the number of local authorities, is now under consideration by the Royal Commission on Local Government. On the whole it is probably true that the larger the authority the better the Public Health Acts are administered and the less supervision is required, whilst it is certain that such authorities, being better able to bear the burdens, are more amenable to the pressure of the central authority and are less likely to be dominated by sinister interests than the smaller authorities. In addition, a reduction of the number or of the functions of the lesser authorities would entail a large decrease in cor-

¹ See Simon, *English Sanitary Institutions*, pp. 422-3, and Ashley, *Local Government*, pp. 55-6.

² Local Government (Transfer of Powers) Act, 1903.

responsidence and other business of the Ministry of Health, leaving it free to devote more attention to greater matters. Against these suggestions local sentiment is, of course, arrayed; people who take little or no interest in local government are aroused by the proposal that their council should be abolished or stripped of some of its powers. And it is urged that a reduction of the powers, duties and responsibilities of a local authority results in a failure to attract the best men, and that it is essential that local autonomy should prevail, inasmuch as each locality has special circumstances which are more efficiently dealt with by men elected and appointed for the immediate district than by those acting over a large area of which it forms only a minor part.

These questions are not special to public health administration; they form part of the greater one which is concerned with the discovery of the best area and authority for the administration of local affairs. But for the present purpose it suffices to point out that recent legislation shows a tendency to increase the powers of the larger authorities, leaving the smaller with subordinate powers, and that, whatever may be said of other branches of local government, there is no reason to think that such powers as those pertaining to housing and sanitary inspection could not be better administered by a larger than by a smaller local authority. On the contrary; it is easy to find reasons in favour of such a course. The housing problem is never confined to the area of one district council, neither need its solution be similarly restricted; and, in these days of mobile labour and quick transit which enables people working in one district to live in another, sometimes quite distant, the problem appearing in one area often has its origin elsewhere. It is only a strong authority elected for a large area that can adequately face these facts. As regards sanitary inspection, the disadvantages of small and poor districts are equally obvious; ¹ such districts are not

only unable to obtain and keep the most efficient officials, but their small councils are frequently dominated by local people whose interest it is that sanitary inspection should not be too thorough and effective, and who use their powers to prevent it being so. Upon the officials of such authorities there is often a constant and not always noticed pressure which could not be exerted without public protest by the members of a larger authority.

CHAPTER XXVI

METHODS OF CENTRAL CONTROL

IN the last chapter the powers of the Central Government, exercised chiefly by the Ministry of Health, to supervise and control the activities of local authorities, were classified under six heads, viz. : (1) Sub-legislative ; (2) Approval ; (3) Appellate ; (4) Inspection and Direction ; (5) Executive ; and (6) Advisory. It is now necessary to enter into fuller details of each of these methods as applied to the administration of the Public Health and kindred Acts.

Sub-legislation.—Almost every Act of Parliament affecting the powers and duties of local authorities contains some clauses enabling one of the departments of the Central Government to extend and amplify its provisions. This is done by means of provisional orders, orders and regulations, the first of which requires the sanction of Parliament to the confirmation Act, and the last two are liable, like all other matters of departmental activity, to be discussed by Parliament, even in those cases where they are not definitely required to be laid before Parliament.¹ All such orders and regulations must be sent to the King's printers to be numbered, printed, and sold according to regulations issued by the Treasury ;² and must be published in the *London Gazette*, such publication being conclusive evidence of their existence.³ All such orders are binding and conclusive,⁴ and the courts have refused to grant a writ of

¹ Ilbert, *Legislative Methods and Forms*, p. 41 ; Anson, *Law and Custom of the Constitution*, Vol. II, Part II, p. 48.

² Rules Publication Act, 1893.

³ See Public Health Act, 1875, ss. 135 and 295 ; Canal Boats Act, 1877, s. 9 ; and Documentary Evidence Acts, 1868 and 1882.

⁴ Public Health Act, 1875, s. 295.

certiorari to remove a provisional order for the purpose of being quashed, inasmuch as to do so would be to usurp functions which do not belong to courts by stepping in between the provisional order and the exercise of the parliamentary will.¹

By provisional order the Ministry of Health may constitute port sanitary authorities and endow them with all necessary powers and duties and may dissolve, divide, or unite other districts, part of the latter power, together with others, being concurrently held by county councils, whose order is in the more important cases subject to the consent of the Ministry of Health.² By this means also the Ministry may, on the application of the local authority, wholly or partially repeal any local Act except such as deal with the conservancy of sewers,³ and may authorize the compulsory purchase of lands for various purposes.⁴ During the period 1926-7 the Ministry issued and secured the confirmation of twenty-two Provisional Orders for the repeal, alteration or amendment of local Acts.⁵

The issue of orders under the various Acts is an important part of the work of the Ministry. The range of this power is very extensive; by it rural authorities may be endowed with various urban powers, local authorities may be required to undertake the collection and removal of house refuse, the construction of sewerage and water supply works outside a district may be allowed, improvement schemes under the Housing Acts sanctioned, the adoption of the whole or parts of the Public Health Acts Amendment Act, 1907, permitted, and the list of noxious and offensive gases, coming under the operation of the Alkali, etc., Works Regulation Act, 1906 (section 27),⁶ may be extended.

Under the Factory and Workshops Act, 1901, the Home Secretary has made orders extending the provisions of the

¹ *Reg. v. Hastings Local Board*, 6 B. & S. 401.

² Local Government Act, 1888, ss. 54 *et seq.*

³ Public Health Act, 1875, s. 303.

⁴ Lands required for purposes of the Baths and Washhouses, Burial, Public Libraries, and Open Spaces Acts are exceptions.

⁵ Eighth Annual Report of the Ministry of Health, pp. 88-9.

⁶ Public Health (Smoke Abatement Act), 1926, s. 4.

Act to specified classes of homework,¹ and may in a similar way modify the prescribed amount of air space in cases where artificial light other than electricity is used, where a workshop or workplace is occupied by night as a sleeping apartment, and as regards any particular manufacturing process,² make exceptions to the application of requirements as to limewashing of walls,³ and prescribe the amount of sanitary accommodation for factories and workshops.⁴ Such orders must be laid before both Houses of Parliament, and may be annulled by resolution of either of them within forty days.⁵

The powers previously exercised by the Privy Council of issuing orders as regards diseases of animals were transferred to the Ministry of Agriculture,⁶ who have issued orders dealing specially and generally with all kinds of matters concerning the importation, transport, and keeping of animals, very important examples being the Tuberculosis Orders, 1925. The Ministry also exercises similar powers under the Destructive Insects and Pests Acts, 1877 and 1907. The power to make regulations extends to a similar variety of subjects, many of which have been already enumerated or explained.⁷

By these methods almost as much as by direct parliamentary legislation do the duties and powers of local authorities and their officers increase, and the laws they administer become more complex. In fact, it becomes increasingly difficult to find any matter dealt with by Act of Parliament that is not in some way or another affected by orders or regulations of one of the departments of the Central Government, and this growing and complicated mass of law is one of the strongest arguments in favour of a consolidation and simplification of its provisions.

Approval.—For many acts of local authorities the consent or approval of one of the central departments is

¹ Sections 107, 108 and 110.

² Section 3.

³ Section 1.

⁴ Section 9.

⁵ Sections 3-107 and 126.

⁶ Board of Agriculture Act, 1889, and Diseases of Animals Act, 1894.

⁷ See list of recent orders and regulations at end of Chapter III.

necessary. In many cases, as indicated in the preceding section, this consent is given by the issue of a provisional or an ordinary order ; in other cases simple sanction is all that is necessary. The adoption of certain Acts and the enactment of bye-laws and some regulations require the consent of the Ministry of Health,¹ which is also necessary for the purchase by agreement, of waterworks, the right to take or convey water, and property needed for the cleansing of streets. Consent is also required before a local authority can take proceedings under the Rivers Pollution Act, 1876, and to orders made by county councils under the Isolation Hospitals and other Acts, a similar condition limiting the transfer of hospitals from a district authority to the county council. For the appointment of all medical officers of health and sanitary inspectors, a moiety of whose salary is expected from the Exchequer contribution account of the county council, the approval of the Ministry of Health is required, and in this, as in other cases, such approval, as the annual reports of the Ministry disclose, is no mere formality, although in the case of these appointments its value has been greatly overestimated. No one who is well acquainted with public health administration will agree with the opinion that " the Legislature by prescribing for these local officers certain conditions of dependence upon the central authority, has given the latter a potent leverage on the work of local government . . . This peculiar device powerfully assists the Local Government Board (now Ministry of Health) and serves as a bulwark to the control which it exerts on behalf of the State over the local administration of sanitary law." ² Sanitary officials have long been aware, and the Government has begun to realize, that these ideas are erroneous ; there is little security either for the official in his office or for the efficient administration of the law.

The powers of the Ministry of Health in this direction are strongly reinforced by the necessity for local authorities

¹ See Chapter V.

² Redlich and Hirst, *English Local Government*, Vol. II, pp. 292-3.

to obtain its sanction to the borrowing of money or the issue of stock for various purposes requiring large capital outlay. During the year 1926-7 borrowing by local authorities to the extent of £27,338,720 was sanctioned for public works, exclusive of Poor Law and housing works and loans for providing temporarily for current expenses.¹

The *appellate jurisdiction* of the Ministry of Health is very considerable and appears to be increasing. As a rule the right of appeal lies with the individual against the decision of the local authority, and the decision of the Ministry is final and conclusive, but there are a few exceptions. Any person aggrieved by a decision of a local authority in cases where the authority is empowered to recover expenses incurred by them or to declare such expenses to be "private improvement expenses," may appeal to the Ministry,² and a similar right exists against the requirement by a rural district council that the owner provide a water supply for his premises,³ and against the refusal of a local authority to grant a licence under the Milk (Special Designations) Order, 1923. Any individual aggrieved by the grant or refusal of a certificate that the means adopted to render harmless any polluting matter flowing into a stream are the best or only practicable and available means under the circumstances has the right of appeal to the Ministry of Health,⁴ who may also be asked to determine the reasonable cost at which water may be required to be furnished to houses without a supply,⁵ or to fix a general scale of charges for a water supply.⁶ In the last two cases the initiative rests with the local authority.

The Housing and Town Planning Act, 1909, since consolidated with succeeding Acts in the Housing and Town

¹ See Eighth Annual Report of the Ministry of Health, pp. 88 *et seq.* for detailed statement of amount and purposes of loans for 1925-6 and 1926-7.

² Public Health Act, 1875, s. 268.

³ Public Health (Water) Act, 1878, ss. 3 and 4.

⁴ Rivers Pollution Act, 1876, s. 12.

⁵ Public Health Act, 1875, s. 62.

⁶ Public Health (Water) Act, 1878, s. 8.

Planning Acts, 1925, gave local authorities much stronger powers than they previously possessed, but it also extends the appellate jurisdiction of the Ministry of Health, to which a landlord can appeal against a notice from the local authority or a demand for expenses incurred by them in carrying out the requirements of the notice.¹ A similar appeal lies against closing and demolition orders made by the local authority, or their refusal to determine a closing order.² Appeals against the action of local authorities under these Acts have been numerous, but on the decisions of the Ministry, which in general is final, not very successful.

The Public Health Act gives general powers to the Ministry of Health to settle any differences arising out of the transfer of powers or property to any local authority,³ and local authorities aggrieved may appeal against the decision of the county council to include its area within a proposed hospital district or against the mode of constituting a joint committee for such a district, the decision of the Ministry being final.⁴ Compulsion is introduced in the case of disputes and differences between medical officers of health of county districts and the county medical officer of health with reference to their duties under the Housing Act, which requires that such differences shall be referred to the Ministry of Health, whose decision is final and binding.⁵ Differences arising in relation to matters under the regulations dealing with unsound food and milk and cream may be referred to the Ministry, but only on the application of all the affected parties; the Ministry, however, may choose to determine the differences as arbitrators, in which case the provisions of the Regulation of Railways Act, 1868, apply; otherwise their decision is final and conclusive.⁶

¹ Housing Act, 1925, s. 3.

² *Ibid.*, ss. 11, 14 and 19.

³ Section 304.

⁴ Isolation Hospitals Act, 1893, ss. 8 and 10. See also Public Health (Prevention and Treatment of Diseases) Act, 1913, and Public Health Act, 1925, s. 61.

⁵ Housing and Town Planning Act, 1909, s. 69.

⁶ Public Health (First Series: Unsound Food) Regulations, 1908, art. XIII, and Public Health (Milk and Cream) Regulations, 1912, art. X.

Inspection and Inquiry.—Before making the special orders, giving their consent to various proposals of local authorities, deciding appeals or requiring local authorities to perform specific duties, it is necessary that the Ministry of Health be fully informed upon the matter in question. For this purpose they have very full and extensive powers of inquiry and inspection, some of which are expressly provided for, whilst the remainder are exercised under powers given by the Local Government Board Act, 1871,¹ and the Public Health Act, 1875.² The former transferred to the Board (now the Ministry of Health) the powers of the Privy Council to “from time to time cause to be made such inquiries as they might see fit in relation to any matters concerning the public health in any place or places, and to the observation of the regulations and directions issued by them under this Act.”³ The latter gives the Ministry power to make such inquiries as are directed by the Act, and such inquiries as they see fit in relation to any matters concerning the public health in any place, or any matters with respect to which their sanction, approval, or consent is required. For this purpose the inspectors of the Ministry have powers not only to attend meetings of the local authorities,⁴ but to call for and examine all persons, books, documents, and other matters relevant to the subject of inquiry; they may summon witnesses to attend and administer oaths, refusal to attend or give evidence, giving false evidence or destroying or altering documents being punishable as a misdemeanour.⁵ The Ministry, whose decision is final, may make orders fixing costs and determining by whom they are to be borne. Similar powers are given to the Ministry’s inspectors for the purposes of the Canal Boats Acts.⁶

Inquiries are expressly directed in cases where objection

¹ Section 2.

Sections 293 *et seq.*

² Public Health Act, 1848, s. 3.

³ *Ibid.* 1875, s. 205.

⁴ *Ibid.*, s. 296; Poor Law Boards Act, 1847, ss. 21 and 26.

⁵ Canal Boats Act, 1884, s. 4.

is made to the construction of sewage works outside the district of the local authority,¹ or to the construction of a large reservoir for water,² as well as in cases where it is proposed to purchase land otherwise than by agreement,³ or borrow money in excess of a certain amount.⁴ A local inquiry must be held by the Ministry before making an order requiring the local authority to prepare and submit a town-planning scheme,⁵ and such inquiries are usually made when complaints are received alleging neglect of the local authority's to enforce the provisions of the Housing Act, 1925,⁶ or that a medical officer of health has failed in his duty to inspect and represent to his authority any area complained of as unhealthy.⁷ For the purpose of deciding whether or not any powers under the Housing Act should be put in force in a district the Ministry may require the local authority to make a report to them upon the density of population and such other matters as they may direct.⁸ The information thus obtained enables the Ministry to exercise a certain amount of pressure and persuasion which may be successful without entailing the expense of a public inquiry.

Inquiries and inspections by the officers of the Ministry are not always public; many are informal, being frequently suggested by observations or statements in the annual reports of medical officers of health and sanitary inspectors, but where an inquiry is specified as a necessary part of the procedure preliminary to action by the Ministry, public announcement must be made of its time, place, and purpose.

It is the practice of the Ministry in the case of public inquiries in respect of housing, sewerage, and, where the county council desires it, water supply, to notify the county council of the district concerned of the time and place of inquiry, but this practice is not extended to the cases of informal inspections, which might lose some of their efficacy

¹ Public Health Act, 1875, s. 34.

² *Ibid.*, s. 176.

³ Town Planning Act, 1925, s. 13.

⁴ Housing Act, 1925, s. 116.

⁵ *Ibid.*, s. 52.

⁶ *Ibid.*, s. 234.

⁷ *Ibid.*, s. 48.

⁸ *Ibid.*, s. 117.

if they were announced beforehand. These inquiries form a valuable means of obtaining first-hand information as to the sanitary circumstances of any particular district and of enabling the Ministry of Health to determine where an exertion of their most drastic powers of executing or compelling the local authority to perform their duties is called for.

The audit of the accounts of local authorities by the district auditors of the Ministry of Health is a function which rightly comes under this class-heading, but has been sufficiently dealt with elsewhere.¹

Executive and Compulsory Powers.—Being satisfied of the necessity for intervention in the sanitary administration of any district, the Ministry seldom proceeds to the full limit of its powers before endeavouring to secure its ends by persuasion. The records of such efforts and their results cannot be tabulated; they are, if mentioned, stated in general terms.

When, however, advice and persuasion fail to awaken a local authority to a sense of its duties, and it neglects to obey the order issued by the Ministry, the latter is endowed with powers either to compel the authority to perform its duties or to themselves appoint persons or authorities to carry out the duties.² The exercise by a local authority of its discretionary powers cannot be so enforced, but there are optional powers, such as those dealing with the cleansing of streets and removal of house refuse,³ and the provision of mortuaries⁴ which the Ministry of Health is enabled to transform into duties. The general power of the Ministry to enforce the performance of a duty by a defaulting local authority is contained in Section 299 of the Public Health Act, 1875, which specifies several cases in which it may be exercised, such as neglect to provide sufficient sewers, or water supply, or to maintain existing sewers, as well as default in enforcing any provisions of the Act which it is their duty to enforce. The Ministry

¹ See Chapter XXIV.

² Public Health Act, 1875, s. 299. ³ *Ibid.*, s. 42. ⁴ *Ibid.*, s. 141.

of Health must make inquiry and, if satisfied that the alleged default exists, must make an order limiting the time for the performance of the duty by the authority. In case the order is not obeyed, the Ministry have the option of appealing to the High Court for a *mandamus*, in which case the dispute is no longer between the Ministry and the authority, but between the latter and the Court; or the Ministry may appoint some person to perform the duty at the expense of the local authority, from whom the costs may be recovered. As previously noted,¹ however, the default of the local authority as regards its duty in relation to nuisances may be met by the Ministry authorizing a local police officer to act as a sanitary inspector and institute any proceedings which the authority might institute in respect of such nuisances.²

Similar powers are contained in other Acts for the purpose of enforcing the performance of duties thereunder. The Home Secretary may authorize a factory inspector to use the powers of a neglectful local authority to enforce the provisions of the Factory and Workshop Acts and to recover the expenses thereby incurred.³ The Minister of Agriculture may empower any person named in its order to execute and enforce any of the provisions of the Diseases of Animals Act, 1894, or orders made thereunder, which the local authority has failed to execute and enforce.⁴ And both the Ministry and the Minister of Agriculture may, after warning a negligent authority, empower an officer to execute and enforce or procure the execution and enforcement of the provisions of the Food and Drugs Acts within the district.⁵

Resort to the High Court for a *mandamus* is provided to enforce orders upon local authorities to exercise their

¹ Chapter XII.

² Public Health Act, 1875, s. 106. See also Public Health (Imported Food) Regulations, 1925, s. 4 (2), for similar powers to empower some person to execute provisions of Regulations in case of default.

³ Factory and Workshop Act, 1901, s. 4.

⁴ Diseases of Animals Act, 1894, s. 34. Compare for similar powers the Rats and Mice Destruction Act, 1919.

⁵ Food and Drugs Act (Adulteration), 1928, s. 14

powers under Parts I, II, and III of the Housing Act, 1925 ;¹ but as regards the last part an order to execute the necessary works may be addressed, with its consent, to the county council.² An order of the Ministry requiring a local authority to prepare a town-planning scheme or to consent to modifications or conditions imposed by the Ministry is enforceable by *mandamus*, but neglect to carry out an order requiring them to adopt a scheme proposed by landowners may be met by the Ministry's approval of such scheme, which then has the same effect as if it had been adopted by the local authority.³

Careful observers have expressed doubts as to the efficacy of these methods of control,⁴ and even a high official of the State has stated that "for various reasons central compulsion of defaulting authorities is not generally successful ; and the only provision—apart from an educated and responsible public opinion—likely successfully to replace compulsion would be the institution of grants in aid of definite execution of sanitary administration, the grants depending on the work actually accomplished."⁵ These opinions were at last adopted by the Government, and just before the outbreak of war, the Chancellor of the Exchequer, in outlining his proposals for a system of grants in aid of housing efforts of local authorities, referred to present methods of compulsion in the following terms :⁶

"As to the housing problem, we are on the eve of proposing great changes to deal with it. The first thing is to put local authorities in a position to enable them to carry out these proposals without being crippled and handicapped by rates. Now, the only pressure you can bring to bear upon public authorities to deal with public health is through the obsolete, antiquated,

¹ Housing Act, 1925, ss. 24, 50, 51 and 73.

² *Ibid.*, s. 73.

³ Town Planning Act, 1925, ss. 13, 14, 15.

⁴ Ashley, *Local Government*, pp. 53 *et seq.* Compare Webb, *The State and the Doctor and Grants in Aid*.

⁵ Thirty-ninth Report of the Local Government Board, Medical Officer's Report, p. xv. Compare Annual Report of the Medical Officer of the Ministry of Health, 1924, p. 251.

⁶ The Right Hon. D. Lloyd George in introducing the Budget, May 14, 1914. Compare Webb, *Grants in Aid*, p. 18.

and futile method of the *mandamus*. You may as well go into action armed with a flint-axe as a *mandamus*. The idea that you could march off the whole of the members of a municipal corporation that is levying rates of nine, ten, or eleven shillings in the pound because they cannot face the problem of finding another *2d.* or *3d.* is a thing that no Local Government Board has ever been able to bring itself up to the point of doing."

But because few cases occur in which either remedy is sought by the Ministry of Health it does not follow that the latent power is quite useless ; such power always lies at the back of orders, as the latter lie at the back of the advice and persuasion which are incessantly given and used with good effect by the Ministry. Like all ultimate penalties, the potency of such powers is not to be judged merely by the number of times they are exercised.¹

Advisory.—The central departments of the Government act as reservoirs into which flow from all parts of the country and from many parts of the world much information and statistics bearing upon the work they, and the local authorities they supervise, have to perform. From such reservoirs might be distributed the essence of this information for the guidance and advice of local authorities. In addition, the various departments employ a large number of experts in different branches of knowledge who undertake research work, and whose skill and experience are placed generally and specially at the disposal of authorities desirous of utilizing them. The mass of this information is contained in the annual report of the Ministry, the report of the chief medical officer being issued separately.

Almost every Act of Parliament and general order or regulation of a central department which affects the duties of an authority or its officials is introduced to their notice, explained and commented upon in circulars and memoranda, and information dealing with such matters as the extermination of rats, prevention of tuberculosis, construction of sanatoria, and education in public health is issued as occasion arises. This literature forms a voluminous but

¹ An instance of the effect of applying for a *mandamus* is given in the Forty-second Report of the Local Government Board, Part III, p. xlix.

incomplete and unorganized mass of information upon the powers, duties, activities, and technique of sanitary authorities and administration. But surprisingly little was known even to the Ministry of Health of what the various local authorities were doing or leaving undone in the domain of public health until the Ministry asked every Medical Officer of Health to make for 1925 a comprehensive report¹ upon :

(a) The measure of progress made in the area during the preceding five years in the improvement of the public health.

(b) The extent and character of the changes made during that period in the public health services of the area (e.g. housing, water supply, sewerage, scavenging, or refuse disposal, food inspection, or other services affecting the environment of the inhabitants ; and maternity and child welfare schemes, schemes for the treatment of tuberculosis and venereal diseases, provision of isolation hospitals, or other services directed to the prevention or cure of disease in individuals).

(c) Any further action of importance in the organization or development of public health services contemplated by the Local Authority or considered desirable by the Medical Officer of Health.

In another respect the Ministry is behind the Board of Trade and Ministry of Agriculture ; it does not issue a gazette or journal dealing periodically with matters which concern its sphere of administration. This is an omission which could be made good with considerable advantage, affording, as it would, not only immediate information to officials, but, by being placed upon library tables, bringing clearly before the public matters with which it is closely concerned—those pertaining to the public health.

¹ Circular 684.

CHAPTER XXVII

THE NEED FOR REFORM

AT the conclusion of a survey of the machinery by which it is sought to promote the public health the questions inevitably arise: How does it work? Does it achieve its object with a minimum of friction and waste? and does the action of the national and local officials stimulate the individuals for whom they work to efforts on their own behalf?

Judged by the national vital statistics, there can be no question that it has been effective. The general death-rates for England and Wales were 19.9 per 1,000 in 1850, 19.3 in 1890, 15 in 1907,¹ and 12.3 in 1927; and the infantile mortality, which was 146 per 1,000 births in 1850, 151 in 1890, 118 in 1907,² has been reduced to 70 in 1927. During the same period typhus and cholera have been practically wiped out, typhoid fever has been diminished by four-fifths, and deaths from tuberculosis have undergone a 70 per cent. reduction. Small-pox, unfortunately, has of recent years shown a decided upward tendency and, although the mortality therefrom remains very low, the case-rate mars the picture of progress. These facts and figures disclose positive gains, and it may be that they have been cheaply purchased, indicating as they do general improved health and longer life. But they do not afford any answer to the question as to whether or not we are justified in thinking that they could not have been gained by a less expenditure of effort and wealth or that the same expenditure could not be expected to have given

¹ *Public Health and Social Conditions* (Cd. 4671), p. 25.

² *Ibid.*, p. 27.

better results. They indicate progress, but give no data for its comparison with efforts.

Unfortunately such data are impossible to obtain. If it is desired to answer the question involved, the only method available is to critically examine the machinery. Is it as simple as possible having regard to the work it has to perform? Does it cover the whole field of efforts without overlapping? Does it combine with other non-governmental agencies so as to prevent duplication of public efforts by voluntary endeavour? To attempt to answer these questions involves critical and constructive work of far too great a magnitude to be attempted here. The whole subject of local government is under the consideration of a Royal Commission and the domain of public health has been surveyed, from the view-point of the Central Government, in a comprehensive and instructive memorandum by the Ministry of Health; and the views of local authorities of various kinds will no doubt be fully weighed ere the final report is presented. But already there is enough information available to enable a negative reply to be given to these questions.

It is, however, impossible to close this book without in some measure amplifying criticism which has been made, *en passant*, in the preceding chapters. It cannot have escaped notice that the basis of public health legislation is fifty-three years old, and that upon this has been reared a complex mass of statutes, orders and regulations which are made more complicated and various by adopted and private Acts, bye-laws and regulations differing in each locality. A glance at such a small volume as Knight's *Public Health Acts* (1925 edition) discloses the fact that out of ninety-two Acts given therein sixteen may be quoted as Public Health Acts. The standard legal work, Lumley's *Public Health* (9th edition) runs to 2,967 closely printed pages of Acts, orders, etc., there is a table of statutes taking up 122 pages and a table of relevant statutes covers 78 pages with the addition of 620 pages of orders and 274 pages of decided cases.

With such a superabundance of statutory, sub-statutory and judicial law it is not surprising that there is often a great difference between what Parliament meant, what ordinary people believe it meant, and what judges decide it meant. Despite this, no one can exactly define the difference between a drain and a sewer, or what constitutes a nuisance, or the standard of fitness for human habitation of a dwelling-house; and because of it the methods of adopting Acts, the powers of entry, and the means of securing the abatement of nuisances are bewildering in their variety. Such conditions as these gave point to the assertion of an expert publicist: ¹

“ That our existing codes of health laws are neither practically efficient nor sufficient for the purpose originally intended and still expected by the public. The methods of administration are too intricate and confused, the wide differences of opinion as to scope and definition are fatal to direct and speedy action, and in the result we get the maximum of cost and effort to the minimum of result, a comparatively low standard of administrative efficiency, and a money cost to the ratepayer out of all proportion to the improvement effected.”

This may err somewhat on the side of rhetorical exaggeration, but fourteen years of legislative effort has done, on balance, little to make matters better.

The necessity for a general overhauling and consolidation of laws was never greater than it is to-day in connection with public health legislation. Three years ago we were told that “ the consolidation of the Public Health Acts was in hand ”; ² and there it remains. It seems as if the work involved is so arduous, the fear that, in seeking to improve, much that is good might be lost is so great, and the fact that such a task, even if successfully achieved, is not very likely to be an asset in party politics, makes such a consummation almost too remote to be hoped for.

The confusion which the Royal Commission found in

¹ *Municipal Journal*, May 29, 1914, p. 653.

² The Right Hon. Neville Chamberlain, M.P., Minister of Health. See *Municipal Journal*, June 12, 1925, p. 862.

1870 amongst the authorities dealing with the discovery and suppression of nuisances is fortunately no longer in existence. In this branch of the service there is completeness of organization and a separation of jurisdiction which permits of no overlapping or lacunæ, but the efficiency of inspection and the enforcement of the law exhibits a very wide range of difference. In some areas special inspectors are so numerous that the public are said to be "inspected to death," in others inspection is so slight that the people may be said "to die without inspection." And efficient and energetic officers may meet with a blank wall of opposition in the form of a council reluctant to sanction the legal proceedings necessary for the enforcement of the law. Add to this the obvious unwillingness or even antagonism of many magisterial benches when asked to punish those who refuse to carry out the legal demands of local authorities, and it is easy to see that there are numerous factors creating friction and waste in the administration of the law.

When, however, we turn from the efforts aimed at the prevention of disease to those occupied with its treatment we reach a realm of the greatest confusion, overlapping and gap-leaving that it is possible to imagine. Here the efforts of public institutions and authorities and voluntary institutions and agencies are made with little regard to co-ordination and economy; and the National Insurance Act, extending the public treatment of disease, increased the confusion. It is possible in some districts to have members of the same household undergoing treatment in the institutions or at the hands of the officers of the sanitary authority, the education authority, the guardians of the poor, the insurance committee, and some one or more of the voluntary hospitals or nursing associations. On the other hand, there are districts where, unless a person is destitute or insured, there is practically no treatment provided, however necessary it may be. It is needless to labour this very serious defect; it was scathingly exposed in the Minority Report of the Poor Law Commission, and

persists despite efforts by the Ministry of Health to rectify it in various directions. The existence of two authorities, one of which welcomes and treats all suffering from certain diseases without regard to economic circumstances, whilst the other avoids giving any aid or treatment unless the person is destitute, is too absurd an anomaly to be tolerated much longer. For this reason, if for no other, the proposals now being made for the distribution of the functions of the Poor Law authorities between the councils of counties and county boroughs is to be welcomed. It is a step in the direction of one authority for all health purposes, and it is to be hoped will be the foundation upon which will be established a public medical service available for all persons of all ages and both sexes for all purposes, centring upon and directed from the public health department of the local authority.

Avoiding the objection that a general provision of treatment for ill-health is likely to sap independence and pauperize the recipients, involving all the evil consequences that the Poor Law Commission reported upon in 1834, the question is largely a financial one. It is not difficult to provide against possible pauperization ; administrative co-ordination can be achieved without great difficulty, but the financial burden is one that many, perhaps most, authorities could not possibly undertake at the present time without some measure of equalization. This, in the main, can only be done by a reorganization of the financial relations between the Central Government and local authorities, for which proposals have been recently submitted to Parliament.¹ But the fact remains that the major part of the local sanitary authorities are too small and too poor either to properly administer or to adequately finance an efficient system of prevention, treatment and cure of disease.² The following tables are as eloquent as figures can be in favour of larger and wealthier areas.

¹ See *Proposals for Reform in Local Government and in the Financial Relations between the Exchequer and Local Authorities* (Cd. 3134).

² See Memorandum submitted by the Ministry of Health to the Royal Commission on Local Government.

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DISTRIBUTION OF POPULATION—COUNTY DISTRICTS

Population.	N.C. Boroughs. 255	Urban Districts. 785	Rural Districts. 658
5,000 or less	66	302	126
5,000—10,000	40	222	216
10,000—20,000	53	178	229
20,000 or less (Total 1,432)	159	702	571
20,000—30,000	33	45	67
30,000 or less (Total 1,577)	192	747	638
30,000—50,000	50	28	15
50,000 or less (Total 1,670)	242	775	653
50,000 to 100,000	12	6	5
Over 100,000	1	4	—
Total over 30,000 (121)	63	38	20
Total over 50,000 (28) (Grand Total 1,698)	13	10	5

RATEABLE VALUES

Values.	1d. Rate produces	N.C. Boroughs. 253	Urban Districts. 782	Rural Districts. 663	Total. 1,698
Under £10,000 . . . £40		19	83	9	111
£10,000—£20,000 . . £81		34	150	27	211
£20,000—£30,000 . . £122		26	125	40	191
£30,000 or under . . (£122 or under)		79	358	76	513
£30,000—£40,000 . . £162		16	91	58	165
£40,000—£50,000 . . £203		13	70	47	130
£50,000—£60,000 . . £243		17	47	49	113
£60,000 or under . . (£244)		125	566	230	921
£60,000—£100,000 . . £405		38	116	207	361
£100,000 or under . . (£405)		163	682	437	1,282

Here, again, it is to be hoped that the labours of the Royal Commission on Local Government may be fruitful in reforms which will improve public health administration, but it may be laid down as a general rule that the fewer and more powerful the authorities the more efficient and consistent will be the general administration.

Enough has been said in this and the preceding chapters to afford a general answer to the question whether the machinery for the promotion of the public health works with a minimum of friction and waste. It may be confidently asserted that it is more efficient than it was, but that its imperfections are still very great. Its intricacies and complexities require simplification; it covers the field of efforts too unevenly, leaving parts quite untouched; it meets opposition where it ought to get assistance, and efforts are but partially co-ordinated; and in many directions it lacks the motive power of an enlightened and vigorous public opinion. Fortunately the defects are being recognized and questions of public health are coming to the front in every department of social and political life, thanks in large measure to increasing education and propaganda in health matters by local authorities.¹ Public discussion is a necessary preliminary to reform, and when once it is realized that no branch of administration more closely affects the lives of the people than that concerned with public health the demand for its efficient organization will rapidly follow and as surely be conceded.

It may therefore be affirmed without fear of contradiction that the time is ripe for a national survey of the institutions for and the methods of promoting the public health. Nearly sixty years have elapsed since the Royal Sanitary Commission reported upon the sanitary administration of the country and provided the information and impetus for its reorganization and a consolidation of the law. The interval has been filled by scores of legislative enactments and by

¹ See *Public Education in Health*, by Sir G. Newman, K.C.B., M.D., F.R.C.P., Chief Medical Officer of the Ministry of Health and of the Board of Education.

hundreds of administrative experiments of which we have no complete and consistent records available for guidance. Local authorities muddle along, happy to avoid glaring failure, seldom achieving brilliant success. It is of good omen that the Ministry of Health has awakened to these facts and in its circular ¹ to medical officers of health asked for information in their reports for 1925 which was to be the basis of the first of a series of survey reports. The report is compulsory upon medical officers of health and it does not speak too highly of the attachment to duty of those of sixty-nine out of 1,686 sanitary areas when the Ministry can report that on March 31, 1927, no reports had been received from them.² The information so collected, although not intended for that purpose, was used by the Ministry as the basis of its evidence to the Royal Commission on Local Government. At present the central authority is without that comprehensive knowledge of the extent and ways in which local authorities have performed their duties and used their powers which is an essential condition to action for a general levelling up of administrative efficiency. There is an imperative call for a statesman with the strength to demand and the genius to direct a broad survey of public health law and administration with a view to its reform and improvement. Perhaps it is not too much to hope that the statesman is there, and to believe that we may already discern the foundations of reform.

¹ Circular 648.

² Memorandum of Evidence submitted by the Ministry of Health to the Royal Commission on Local Government.

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