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I BELIEVE that my subject is one of interest to all, as well as one of practical politics, so that I do not hesitate to introduce it. I will deal with it as follows:—

1. The evolution of our organisation in State Medicine up to the present day in this country.
2. The constitution and role of the proposed Health Ministry and the co-ordination of the public medical services, whereby our system may be extended and strengthened.
3. An outline of the problems which would confront a Minister of Public Health.

I need not apologise for the dryness of the bones of sanitary history, as I hope to clothe them with vital substance. Its progress, as you are aware, has been always allied to that of the British medical profession. I should say that the classic in which one must study English sanitary history is the work of the late Sir John Simon, "English Sanitary Institutions."

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From this we learn that up to the reign of William IV., 1830–1837, the Statute Book contained *no general law* of sanitary intention if one excepts a Quarantine Act and an annual vote of £2,000 to the National Vaccine Board. What national wave of feeling gave the impetus to sanitation in this land? Pure panic, which this country shared with others when *Cholera Asiatica* appeared in Europe, and still more so when it entered England in 1831. Such an unreasoning motive power is still, it is feared (at least, up to 1884, when cholera last threatened us), the most effective, if temporary, stimulus to progress. It resulted in 1831 in the formation of a Consultative Board of Health, consisting of the President and four Fellows of the College of Physicians, the Superintendent-General of

Quarantine, the Director-General of the Army Medical Department, the Medical Commissioner of the Victualling Office, two Civil Servants, and a paid Medical Secretary. This Board worked with activity and good sense.

The year 1834 was marked by the passing of the Poor Law Amendment Act, notable because it gave occasion a few years later to the beginning of a public sanitary inquiry.

Mr., afterwards Sir, Edwin Chadwick became Secretary of the new Poor Law Board, and his efforts in the cause of hygiene were monumental.

In 1837 the Act for Registering Births, Deaths, and Marriages became law, whereby the statistics of life and death became possible; the necessity of which is now recognised.

With Queen Victoria's reign began a new era. The demand for sanitary reform may be said to have begun in this country in 1838; the Poor Law Commissioners drawing attention to preventable disease as a cause of pauperism. Mr. Chadwick issued his general report on the sanitary condition of the labouring population of Great Britain in 1842, and this was supplemented by a special report on the practice of interment in towns.

This was followed by the Royal Commission of 1843–5, whose report resulted in legislation on sewerage and drainage, on removal of nuisances, and on prevention of epidemic diseases. I can only sketch to you the broad effect of the later legislation of 1848. A General Board of Health was established for control and regulation of local improvements and the prevention of disease. Health nuisances could be dealt with by local justices on complaint by a local authority. Modes of procedure were provided by which the larger powers required for purposes of local sanitary regulation were provided. In epidemic periods the Privy Council could bring into force by order certain provisions of the Nuisances Removal and Diseases Prevention Act, by which the General Board was to have certain powers of imperative direction, and the local authorities were to have special powers of local action. The General Board consisted of three persons, with a medical member for particular times, but its obvious disadvantage was that its proceedings were not controlled by a Minister responsible to Parliament.

Various voluntary associations of the period diffused and popularised the sort of knowledge which had been before Parliament. The Board, as originally constituted, terminated in 1854, but was renewed annually until 1858. It was assisted by a Medical Council. In 1858 its medical duties were assigned by the Public Health Act of 1858 to the Privy

Council, to which department the medical officer of the Board was transferred, and by the Local Act, 1858 (amending the Public Health Act 1848) the other duties were assigned to the Home Secretary.

An appointment of note was that which initiated medical officerships; the first medical officer of Liverpool was Mr. Duncan, in 1847, and of London, Sir John Simon, in 1848. The central medical officer was created in 1855, and the post was held by the late Sir John Simon for nearly twenty-one years. He was attached, from 1855 to 1858, to the General Board of Health; from 1858 to 1871, to the Lords of the Privy Council; and from 1871 to 1876, chiefly to the Local Government Board, established in 1871. Since 1876 the central medical officer has been the principal medical officer of the Local Government Board, with ill-defined duties. About 1858, the first public health lectures were given by Dr. Greenhow at St Thomas's Hospital, and to Dr. Greenhow was due the reduction of the data of deaths from the General Register Office to a standard death-rate *per 100,000 living*. The records and publications of the General Register Office had now begun to exert an important influence on sanitary progress; and improvements had already begun to be initiated in sanitary apparatus of drainage, etc.

A year of mark for sanitary progress was that of 1858, when the Medical Act of that year controlled the British medical profession, and established the medical register. The Medical Department under the Privy Council steadily developed, and its machinery was perfected. It promoted an efficient system of vaccination; valuable statistics were collected as to fatal diseases, the distribution of phthisis, and deaths of infants.

Later the great Sanitary Act of 1866 was passed, which really began a new epoch of hygiene at the instigation of the Medical Department of the Privy Council. This Act introduced the obligatory nature of certain duties of local authorities and largely increased their powers; gave power to provide water supply; regulated tenement dwellings; made enactments in relation to contagious diseases; gave power to provide hospital accommodation, mortuaries, disinfection; extended the term "nuisance," by which overcrowding of dwelling-houses, factories, and workshops was dealt with. This was a year of great cholera prevalence.

In 1868 a new vaccination law was passed, which was tested by the storm of smallpox which swept over London in 1871. The Medical Department of the Council was strengthened in 1869, and £2,000 was granted as an annual subsidy to scientific investigations in 1870. In 1871 a Secretary for Public Health was appointed, and the Royal Sanitary Commission met and made important recommendations as to consolidation

of central responsibilities and as to local medical officers. I am proud to say that it was a joint committee of the British Medical Association and the Social Science Association which memorialised the Government in May, 1868, for a Royal Commission. The recommendations of the Commission were, in brief, that administration concerning the public health and the relief of the poor should be in separate departments. It was thought that the motive power, as well as the sanctioning of sanitary progress, should lie with the Board. It was to have a legislative side to amend and promote law, and an administrative side to organise an efficient system of supervision. It was to be helpful, admonitory, and stimulant; compulsory, if needs be. As we know, this scheme was not adopted, but administration was centred in the hands of a *single secretariate.*

The new office started virtually as a continuance of the old Poor Law Office, and it was as if the old Poor Law Board, subject only to such conditions of consultation and reference as it might impose on itself, was constituted Central Sanitary Authority. To this we may ascribe the unsatisfactory areas in which many local medical officers serve, the moderate amount of central inspection existing over local sanitary districts, and the chaotic state of our organisation in general. A forward policy of legisation was not adopted, but sanitary administration relied, and still relies, for motive power practically on the educational influence of inspection and advice. Had the hint of the Sanitary Commission been followed the Secretary and Engineer Inspectors, who worked the Local Government Act of 1858 under the Secretary of State, and the Medical Department, which had worked the Public Health Act of 1858 under the Privy Council, would have formed the Health Division of the new office as formerly under the General Board of Health. The Act which constituted the Local Government Board was passed in 1871, and the staff of the Poor Law Board General Office, Local Government Act Office, and partly of the Medical Department of the Privy Council, were made part of one Board.

In 1872 the Act was passed which amended the constitution and powers of local authorities and further concentrated central responsibilities, and this Act together with an Act of 1874 introduced various minor amendments of law. At last, in 1875, was passed the great consolidating Public Health Act which it had been the object of the Commission to secure. In 1875 was passed the Sale of Food and Drugs Act; in 1876, the Pollution of Rivers Act; in 1878 the consolidating Factory and Workshops Act and the Contagious Diseases (Animals) Act; in 1879 the Public Health (Interment) Act; in 1881 the Alkali, etc., Works Regulation Act; the Dairies, Cowsheds and Milkshops Order in 1885;

statutes which, with the Artizans' Dwellings Improvements Acts, 1875–1882, and the Housing of the Working Classes Act, 1885, and with the principal Act of 1875 constitute our national sanitary code of laws.

The Medical Act of 1886, though amending that of 1858, did not institute a one-portal system of entry into our profession, but the inspection of examinations by the Medical Council under the Privy Council.

Under the scare of Cholera, 1884, a survey was appointed with four inspectors added.

The Local Government legislation of 1888, 1889 dealt with county medical officers' reports, etc., and of district officers, but decentralisation of power to county councils was the essential feature.

In 1889 the Infectious Diseases Notification Act was passed.

From 1890 onwards public opinion and legislation have progressed more or less slowly, but I do not propose in this address to detail their evolution. Suffice it to say that voluntary movements supported by the State have been initiated against the spread of tuberculosis, into the origin of cancer, into the qualifications of midwives, the medical inspection of scholars, the maintenance of hospitals and their freedom from abuse. The Factory and Workshop Act, 1901, imposed the duty of notification of certain diseases upon the medical attendant, certifying surgeons, or poor-law officers. The Midwives Act of 1902 and Births Notification Act of this year imposed duties (in the latter case obligatory and without payment) upon the medical practitioner, and non-compliance renders him liable to be summoned and fined 20s. But I do not claim to do more than present here the outlines and trend of sanitary history during the past decade or so, interesting as it is, and I pass on to my next subject.

The second portion of my theme is the constitution and rôle of the proposed Health Ministry and the co-ordination of our public medical services.

The basis of any national scheme of health organisation is to my mind a Minister who, with his department and service, would be closely associated on the one side with the medical profession and on the other with the public. I would add that an expert Minister, of Cabinet rank, would be the ideal person if such a leader could be found. In other words, his special powers and influence should be as full as possible. I attach great importance to the individual as leader. Do we not see from the Messiah and Mahomet to Lord Lister, General Booth, and Mr. J. Chamberlain the proof of what I say? What improvement in national health, happiness, and prosperity would have resulted with great leaders of health.

Then the Minister would be immensely strengthened by close associa-

Advisory Council.

tion with an *Advisory Council*, representing largely the medical profession of the Empire. Such a Council would collate, record, and advise the Minister on all, *especially legislative*, matters relating to public health in the Empire.

On such a Council, in addition to the representatives of the medical profession at home and the Colonies, would be found those of all the great Departments of State, including the public health services (Civil, Naval, and Military, the last two being, of course, independent administratively), the Education Department and medical education, the Home, Colonial, and Foreign Offices, Veterinary Medicine, and the Board of Agriculture, India and the Colonies.

Administrative Committee.

The Minister would also preside over a Public Health *Committee*, which would be a department to administer the Public Medical (civil) Services. It would be based upon the Local Government Board and General Register Office, and consist of representatives of Public Health, Pathology, the General Register Office, engineering, law, poor law, finance, with perhaps a Parliamentary secretary. The extremely valuable scientific work which has emanated from the Local Government Board in the past is a good augury of what its laboratory investigations of preventive medicine problems might develop into.

The object of the Ministry would be to see that preventable disease is prevented by the application of scientific knowledge, and of its Administrative Committee to see that there was a national system of health officerships, so that local authorities should have at their service an officer of special qualifications bound to observe, inquire, and advise impartially in all matters concerning the health of his district. We know that this is not yet attained, and that faulty local sanitary arrangements are identified with too powerful private interests.

Above all, the tenure of office of the health officer must be improved, as the Society of Medical Officers of Health has affirmed.

In order to carry out the prevention of disease, adequate numbers of medical inspectors are required, who would visit systematically places where local excesses of disease exist, in order to confer with authorities and officers on their origin. Equally, also, the medical responsibility of the Poor Law, of Public Vaccination, and of Local Sanitary Officers should rest with them. Such systematic and methodical territorial inspection is known not to exist, and it would entail considerable enlargement of the staff to watch the excesses of preventable diseases presented in the local annual reports. Such an inspection department would be the eyes and ears of the Administration and responsible to the Minister, and would afford him information by actual *inquiry* of the conditions locally,

and of the endeavours being made or necessary to supervise, check and watch filth, industrial and contagious diseases, and infant mortality.

Essentially the system would be one of *visitation and not of correspondence.*

Another division of the sanitary defence force would consist of the *public medical services*, viz., civil medical officers of sanitation, schools, factories, poor law and pathology, bacteriology and quarantine, responsible to central as well as local authorities, adequately organised and with such security of tenure of office as to defend them against *unjust and undue interference in the proper and conscientious performance of their duties.*

A word may be said in conclusion as to the rôle of the Minister and the problems confronting him. He would be free from the incubus of the control of the machinery and finance of municipal and rural services apart from health law. At the same time he would be in close relationship with the Local Government and Education Departments; he would have the advantage of a medical training, and would be the mouthpiece of the medical profession of the Empire on the conditions and requirements of the national health.

As Dr. R. Rainy, M.P., recently said at a meeting discussing the need for a Minister of Health, the Minister would take charge of the air and would see that our air was supplied properly, also the light; and that the conditions under which food is bought and sold, and the source of supply, were satisfactory.

The medical condition of children educated by the State would be observed by him and regulated; and water supplies, drainage, and sanitary works, together with the conditions and hours of labour, would be duly supervised by him. He would educate people in what produced health and ill health. The question of vaccination and the specific treatment of disease, as well as the conduct of research, would be his.

Above all he would use his influence and machinery to prevent deaths and disability from preventable diseases, as presented by the casualty lists of the Registrar-General and of local authorities.

In the light of New Zealand's happy experience in their first Public Health Minister, Sir Joseph Ward, we may now say that it is only a question of money that weighs against an improved standard of national health and a higher level of happiness and prosperity.

Public opinion is as ripe in this country as it is in Canada, New Zealand, the United States, or the Continent for this appointment; and we should see to it, by urging the appointment of some Commission, that this living question may not be allowed to drop out of the range of practical politics.