

The Making of New Zealand's 1920 Health Act

HEALTH systems the world over were rudely shaken by the 1918 influenza pandemic. Even those in medically advanced industrial societies were made to look hopelessly inadequate by the unprecedented mortality of 'the great 'flu', which may have killed 22 million people worldwide.¹ This greatest of modern natural disasters proved a more effective spur to public health reform than the peacetime pleas of health administrators or the fitful enthusiasms of politicians: 1919 saw the creation of a Ministry of Health in Britain and a federal Department of Health in Canada, and Australia's federal Department of Health followed in 1921.² New Zealand was no exception to this wave of administrative reform following the influenza pandemic, but its response was modified by the fact that it already had a Minister and Department of Health, the second in the British Empire. This had been achieved by a 1900 Health Act which earned the praise of British experts and the envy of its Australian neighbours. Yet the amount of public criticism aimed at New Zealand's health department over its handling of the 1918 pandemic indicated further room for improvement. The result was a new health act in 1920, which radically restructured New Zealand's public health administration. Profiting not only from the sharp lessons of the pandemic and also from nearly two decades' experience under the 1900 Act, the 1920 Health Act remains a major landmark in New Zealand's health history. It was so well-conceived and well-drafted that it survived with only minor amendments until the 1956 Act currently in force, which

1 A.W. Crosby jnr, *Epidemic and Peace, 1918*, Westport, Conn., 1976; R. Collier, *The Plague of the Spanish Lady. The Influenza Pandemic of 1918-1919*, London, 1974, pp.305-6.

2 W.M. Frazer, *A History of English Public Health, 1834-1939*, London, 1950, pp.350-1; C.F. Brockington, *A Short History of Public Health*, London, 1956, pp.60-61; J.H. Harley Williams, *A Century of Public Health in Britain, 1832-1929*, London, 1932, pp.64-65; H.E. Macdermot, *One Hundred Years of Medicine in Canada, 1867-1967*, Toronto and Montreal, 1967, pp.80-81; Janice P. Dicken McGinnis, 'The Impact of Epidemic Influenza: Canada, 1918-1919', in *Medicine in Canadian Society: Historical Perspectives*, ed. S.E.D. Shortt, Montreal, 1981, pp.471-83. A.J. Metcalfe, 'The Growth and Development of Public Health Services in Australia', *Medical Journal of Australia* (January, 1951), pp.45-51; M. Roe, 'The Establishment of the Australian Department of Health; its background and significance', *Historical Studies, Australia and New Zealand*, 17 (1976), pp.176-92.

still follows the general pattern of the 1920 Act.³ Such a notable landmark invites closer examination of its origins.

Fortunately there is ample evidence for the drafting process of the 1920 Health Act, most notably among the papers of the royal commission on the influenza epidemic. One file in particular contains the Health Department's submission to the Epidemic Commission, together with various drafting notes and comments. While the department's official historian credits the proposals for new legislation to the Chief Health Officer, Dr. T. H. A. Valintine, who then became Director-General of Health under the 1920 Act, this seems to be an instance of that familiar pattern in administrative history, where the superior official who carries ultimate responsibility also takes the credit for his subordinates' originality and hard work. The evidence of the drafting process points overwhelmingly towards Valintine's deputy, Dr. R. H. Makgill, as the real author of the 1920 Health Act. The official historian concedes that Makgill drafted the Act, but the file in the Epidemic Commission papers demonstrates that the ideas and detailed proposals also came from Makgill rather than Valintine.⁴

Though the 1920 Act initiated a major restructuring of New Zealand's health system, its debt to the previous health act is also significant, for there are many elements of continuity discernible between them. The parentage of the 1920 Act must therefore in part be attributed to the architect of the 1900 Act, Dr. J. M. Mason, who was Valintine's predecessor as Chief Health Officer. Indeed, if Makgill sought expert advice during his drafting of the 1920 Act, it was far likelier to have come from Mason, who was still in Wellington, than from Valintine, who was overseas; but no direct evidence of Mason's advice has yet been found. Another significant influence on the shaping of the 1920 Act was of course the actual operation of the previous Act. The final shape of the 1920 Act cannot be fully understood without reference to its predecessor or the work of the Health Department in the two decades between the Acts, or the personalities of the three key figures in the department in these years. Together these strands form the web of context in which the 'lessons' of the 1918 influenza epidemic exerted their more direct and urgent influence.

Appropriately for a colony like New Zealand, this is a tale of two Scotsmen and an Englishman, later joined by an Irishman. Such emphasis on individuals may seem inappropriate, but it must be remembered that New Zealand's public health administration was very rudimentary and small-scale in 1900, and in it individuals could exert significant influence.

³ Victoria, Australia, had a Minister and Department of Health from 1889. F.S. Maclean, *Challenge for Health: A History of Public Health in New Zealand*, Wellington, 1964, pp.12-25.

⁴ *Appendices to the Journal of the House of Representatives* (AJHR), H-31 (annual reports); Board of Health: H.6/1 and H.29/2/2 (25240), New Zealand National Archives (NZNA), Wellington; Evidence of Dr R.H. Makgill, 17 March 1919, H.3/1, Epidemic Commission, 1919. pp.733-84.

⁵ *N.Z. Official Yearbook*, 1911, p.55.

The Health Department's head office in Wellington in 1911 numbered only twelve, including clerks and one cadet.⁵

Mason was aged 35 in 1900. He was an outspoken Scot, who had qualified as a lawyer before turning to medicine. He trained at Edinburgh and Glasgow before completing the Cambridge Diploma in Public Health and proceeding to postgraduate work at Brussels and Paris. Mason was a member of the Epidemiological Society, London, and an associate of the Association Générale des Ingénieurs, Architectes et Hygiénistes Municipaux. He came to New Zealand in 1895 and took up general practice at Otaki, but his chief interest was in public health, and he brought to New Zealand first-hand experience of the burgeoning interest in this field which swept France and Germany in the 1890s. Rapid advances in bacteriology seemed to him to hold the key to solving the major health problems of urban society.⁶

Valentine was the same age as Mason, but brought different interests from a different background. He was born in Sussex, educated at Marlborough, and had married the daughter of a county court judge. He trained at St Bartholomew's, London, and served as a surgeon at the West Sussex Hospital before coming to New Zealand in 1891 to take up a 'back-blocks' practice in Inglewood. He was an outstanding horseman, but after losing a leg in a riding accident in 1894 he found general practice too strenuous, and turned to an administrative career in the government health service. His main interest was the fight against tuberculosis which led to a lifelong devotion to hospitals and sanatoria. His colleagues found him charming and kindly, but his energy and determination often made him seem dictatorial.⁷

Makgill was the youngest of this trio, aged 30 in 1900. Like Mason he was a Scot, a nephew of Lord Haldane and Professor John Haldane, and the son of Captain Sir John Makgill, RE. The family emigrated to New Zealand in the 1870s, where Makgill attended Auckland Grammar before returning to Scotland to study medicine. He graduated from Edinburgh with first class honours, and later completed the Cambridge Diploma in Public Health. After postgraduate work in bacteriology he returned to New Zealand in 1894 to become surgeon and pathologist at Auckland Hospital. He went to South Africa in 1900 as surgeon attached to the 2nd Gordon Highlanders, Natal Field Force, but returned in 1901 to become the district health officer at Auckland. Like Mason, he was an enthusiast for public health, and a 'fearless and at times a pungent critic' of anyone indifferent to issues of public sanitation.⁸

These three men were the architects of the health system New Zealand has known for most of the present century. If Valentine was the true

6 *New Zealand Medical Journal* (NZMJ), 23 (1924), pp.265-6; *Who's Who in New Zealand*, ed. G.H. Scholefield, Wellington, 1908, p.105; Maclean, pp.19-20.

7 *Who's Who in New Zealand*, 2nd ed., Masterton, 1925, p.224; NZMJ, 44 (1945), pp.273-4.

8 *ibid.*, p.136; NZMJ, 45 (1946), pp.572-3.

founder of New Zealand's modern hospitals, then Mason and Makgill must be credited with the public health system. All three deserve to be better known, for they represent an heroic era in health reform and yet have been overshadowed by more flamboyant figures such as Truby King.

Before 1900, public health in New Zealand was administered under the Act of 1876, which was closely modelled on the English Health Act of 1875. A central Board of Health chaired by the Colonial Secretary advised the government on matters of quarantine and prevention of disease. But the 1876 Act was permissive rather than mandatory. The central board met infrequently and local authorities found that they could ignore it and the Act with impunity. The board itself did not meet between 1896 and 1900.⁹

In 1900, however, an outbreak of bubonic plague in Australia galvanized doctors and politicians into action. A two-man commission soon found plague-infested rats in Auckland, and advised drastic measures to prevent an outbreak. A short Bubonic Plague Prevention Act was rushed through Parliament in June.¹⁰ Before the end of the session it was replaced by a more comprehensive Public Health Act, drafted largely by Mason. Though obviously still derived from the 1875 English Act, it was a simplified version, omitting many details which had no possible relevance for New Zealand conditions. Part I defined the structure of a new health department under its own minister, and set minimum qualifications for district health officers; Part II dealt with sanitation, covering such matters as infectious diseases, hospitals and mortuaries, drains, privies, refuse disposal, water pollution and nuisances. Part III dealt with quarantine, and Part IV set out elaborate procedures for compulsory smallpox vaccination.¹¹

Mason described the new Act as 'the most complete and drastic Health Act of any English-speaking country', which put New Zealand 'in the van' of public health systems.¹² This is not to be seen as mere self-congratulation since other experts agreed. *The British Medical Journal* (BMJ) of 2 February 1901 described it as 'a well-framed and most enlightened piece of legislation', likely to keep New Zealand in 'the very favourable position in respect of sanitary administration in which it at present stands'. Part III on quarantine was described as 'excellent'; indeed, 'quite a model piece of legislation'.¹³

In his address to the 1908 Intercolonial Medical Congress of Australia (at which he was elected President of the Public Health Division),¹⁴ Mason explained that the 1900 Act was a deliberate attempt to remedy the limita-

9 Maclean, pp.11-13. See also pp.428-9 for a summary of public health law before 1900.

10 *ibid.*, p.14. See also M. Hannah, 'The Plague Scare, 1900', BA(Hons) Research Essay, University of Otago, 1975, pp.45-50.

11 New Zealand Statutes (1900), No.25, pp.103-55; Maclean, pp.428-34, has a useful summary. Hannah, p.81, n.2 suggests some Australian influences.

12 AJHR, 1901, H-31, pp.1-13.

13 *British Medical Journal* (BMJ), 2 February 1901, p.298.

14 J.M. Mason, 'Public Health in New Zealand', *Proceedings of the Inter-colonial Medical Congress of Australasia*, Hobart, 1909, p.1.

tions of the 1875 English legislation. District health officers were now required to be qualified in bacteriology and sanitation, and were not allowed to engage in private practice, but were to devote themselves entirely to public health. This was in sharp contrast to the situation in Britain, where health officers were usually too busy earning a living to spare much time for public health issues. As Maclean remarks, 'this was a very far-sighted provision and, at that period, a unique one'.¹⁵ The BMJ editorial also remarked upon the 'exceptional powers' bestowed upon health officers, who seemed able to do almost anything they judged necessary to prevent the spread of infectious disease, at no personal liability, and to compel local bodies to undertake essential sanitary measures.¹⁶

The other radical departure from the British model was the creation of a separate Department of Public Health. Mason was appointed Chief Health Officer, and quickly gathered around him a small group of exceptionally able district health officers: Makgill in Auckland, Valentine in Wellington, Frengley in Nelson, Finch in Christchurch and Ogston in Dunedin. Under Mason's energetic direction, the fledgling department embarked on an ambitious programme to improve health standards and reduce the death rates from disease. Typhoid, plague, smallpox, TB — these now-forgotten killers — were still the scourge of New Zealand cities in the early 1900s. The health officers' first priority was to persuade borough councils to spend ratepayers' money on such basics as sewerage, clean water and rubbish disposal, but it soon became evident that the 'very extensive powers' conferred by the 1900 Act were more apparent than real.¹⁷

Makgill's 1903 report from Auckland began gloomily: 'The labour has been great, and the outcome microscopic. Indeed, in some directions there is a very distinct retrograde movement.'¹⁸ Valentine's report that year for Wellington included a section entitled 'Anomalies of the Public Health Act', pointing out such absurdities as the fact that although any local body could appoint a sanitary inspector, two adjacent councils could not combine to pay the salary of a better qualified inspector to serve them both. Valentine added: 'It has been noted by more than one competent authority that the New Zealand Health Act of 1900 is one of the most complete acts on the subject in the English language. It certainly strikes the ordinary reader as such, and he would probably consider that it would carry a District Health Officer as far as he could wish to go. But the act is neither so complete nor so far-reaching as it would at first sight appear to be. Sometimes it is actually bewildering.'¹⁹

The key problem was that although the new Act was stronger, the local authorities were often too small and impoverished to implement it. In the

15 Maclean, p.17.

16 BMJ, 2 February 1901, p.298.

17 Maclean, p.16.

18 AJHR, 1903, H-31, Appendix A, p.2.

19 *ibid.*, p.35.

Wellington health district, Valintine had no fewer than 92 to deal with.²⁰ Most of the larger boroughs were aware of their responsibilities, and were willing to spend what they could, especially if the works were visible and vote-catching. But the smaller towns and road boards often deliberately ignored their public health duties, and the health officers found that where cajoling or bullying failed, they were rendered virtually helpless.

Yet progress was made, slowly and fitfully in many places, with striking success in others. Makgill dealt capably with another bubonic plague scare in 1902 and with an outbreak of water-borne typhoid fever in Auckland, making the discovery that a combination of high tides and heavy rainfall regularly flooded lower Queen Street basements with raw sewage. Makgill's reports on such matters attracted praise for their logic and lucidity. The department's precautions proved entirely effective in containing the smallpox outbreaks of 1903 and 1904, and new sanatoria were built as part of the campaign against TB.²¹

While Makgill battled against bad sanitation in Auckland, Valintine devoted considerable energy to sanatoria and the TB problem, developing a deepening interest in hospital administration. He was appointed Inspector-General of Hospitals in 1907 and soon won a reputation for adroit diplomacy with stubborn boards.²² Before this he had become Mason's deputy as Assistant Chief Health Officer in 1902. Mason paid generous tribute to Valintine's 'very valuable work' in this role: 'Much of the smoothness with which the Department has run is due to his tact and knowledge of human nature. He has conducted difficult negotiations with great skill, and has been in the fullest sense of the word my right hand man.'²³

When Makgill became Government Bacteriologist in 1904, Dr J. P. Frengley replaced him as district health officer in Auckland, and kept up not only the pressure for reform but also the detailed style of Makgill's reports, which had set such a high standard for the other health officers. Frengley deserves fuller notice here as one of the outstanding Health Department officers of that generation. He was younger than Makgill, being only 27 when he came to New Zealand in 1901, but he was already impressively qualified. He had trained at the Catholic Medical School, Dublin, and was admitted FRCS in 1899 and FRCPS for both Ireland and England in 1901. He also obtained the Diploma in Public Health and later became a fellow of the Royal Institute of Public Health. Frengley shared the enthusiasm of Mason and Makgill for public health reform, but his own health was never robust, and he carried an exceptional burden during the 1914-18 war, crowned with heroic but exhausting work during the influenza

20 *ibid.*

21 AJHR, 1902, H-31, Appendix, pp.19-23; Appendix B, pp.23-41. Makgill's 1901 report was quoted admiringly in Andrew Balfour and H.H. Scott, *Health Problems of the Empire. The British Empire, A Survey*, V, London, 1924, p.180.

22 NZMJ, 44 (1945), p.274.

23 AJHR, 1902, H-31, p.19.

epidemic. Though he was chosen ahead of Makgill to be Deputy Director-General of Health in 1920, his health broke down in 1924 and he died in 1926.²⁴

The anomalies and minor deficiencies of the 1900 Health Act were partially remedied by amendments in 1901, 1902, 1903, 1904 and 1907, mostly relating to the prevention of infectious diseases. As part of the general consolidation of the New Zealand Statutes, these amendments were incorporated in a consolidated 1908 Public Health Act, which re-enacted the substance of the 1900 Act.²⁵ But the work of the department was considerably enlarged as the result of a major public service restructuring in 1909, which also saw a change of leadership.

Under circumstances which remain obscure, Mason was abruptly pensioned off, with an equivalent salary, to a post in the High Commissioner's office in London, which he resigned in less than a year to return to private practice in Wellington. The posts of Chief Health Officer and Inspector-General of Hospitals were then combined as an economy measure, with Valintine as the new head of department.²⁶ Under Valintine, the emphasis and direction of the Health Department changed significantly. The hospital boards were given responsibility for the prevention of infectious diseases and administration of the regulations covering the sale of food and drugs, which many local bodies had proven themselves incapable of administering. This was hailed at the time as a necessary rationalization, giving the department only 36 boards to deal with instead of 380 local bodies.²⁷ Valintine's interest in the hospitals was now given full rein, and in June 1911 he organized a national conference of hospital boards and commissioned a detailed survey of hospital facilities. The results can be seen in the department's bumper annual report for 1911.²⁸ Valintine's other chief interest was manifested in a 1912 conference on TB, which produced an impressive set of proposed amendments to the health legislation, including compulsory notification and treatment.²⁹

Little came of these proposals, however, because of the outbreak of war in 1914. Anything involving major expenditure was shelved for the duration, except for course hospital building, which had the ready justification of providing for repatriated soldiers. The only other significant exception to the rule of wartime economy was the launching of a departmental journal in 1917.³⁰ First called the *Journal of the Department of Public Health, Hospitals and Charitable Aid* (later shortened to the *New Zealand Journal of Public Health and Hospitals* just before its demise in 1921 in another period of retrenchment), it was originally designed as a monthly bulletin to

24 NZMJ, 25 (1926) p.41; *Who's Who in New Zealand*, 2nd ed., p.80.

25 *New Zealand Official Yearbook*, 1912, p.181.

26 Maclean, p.19.

27 AJHR, 1910, H-31, p.2.

28 AJHR, 1911, H-31, pp.148-261, Conference of Hospital Boards..

29 AJHR, 1913, H-31A, pp.1-25; proposals, pp.7-8.

30 AJHR, 1918, H-31, pp.1-10. (The shortest annual report since 1900.)

keep hospital boards informed of infectious disease notifications. As such it represented a happy combination of public health and hospital concerns. The initiative for its inception, however, appears to have come from the Minister rather than the Chief Health Officer.³¹

The journal was a very remarkable achievement, because the war had rendered the Health Department seriously under-staffed. Makgill had gone to Egypt with the NZEF, and was recalled to New Zealand only on the outbreak of a cerebro-spinal meningitis epidemic at Trentham Camp in 1916 (for which he wrote the report).³² Soon after this both he and Valentine were transferred to the Defence Department, leaving Frengley as acting Chief Head Officer with a depleted staff and a greatly increased burden of work. His assistant, Dr M. H. Watt, had been appointed district health officer at Wellington in 1917, but with so many doctors serving overseas it was extremely difficult to find suitably qualified temporary officers. E. Killick, the department's chief clerk, was promoted to Secretary in 1917 to ease the burden on Frengley.³³

Fortunately, the Minister of Health from 1915, G. W. Russell, took an active and sympathetic interest in the affairs of the department, despite a heavy wartime burden of other portfolios.³⁴ His main concern was Internal Affairs, whose work had expanded fourteen-fold since the start of the war, which meant that less than a quarter of any day could be devoted to health matters. Yet early in 1918 Russell initiated plans for an internal organization which would separate the 'scientific work' connected with hospitals and public health from the routine administration of such controls as the Plumbers' Registration Act.³⁵ He also proposed a large number of districts, with more health officers, once the war was over. In the meantime, there were only four for the whole country.

Such were the reduced circumstances of the Health Department when the 1918 influenza pandemic struck. From the start it was a source of controversy as well as tragedy. The infection was thought at the time to have arrived on the *Niagara* with the Prime Minister and Minister of Finance, who were suspected of 'pulling strings' to avoid quarantine.³⁶ But influenza was not then regarded as a notifiable dangerous disease, and all the doctors involved in the ship's inspection agreed that it was 'ordinary' mild influenza. It is still not clear whether the *Niagara* introduced a deadlier new virus, or whether the existing 'mild' virus transmuted into a killer 'flu, but the results were appalling. In the space of two months, from mid-October

31 The establishment of a New Zealand Board of Examiners for the Royal Sanitary Institute was another sign of increased professionalization; AJHR, 1913, H-31, p.10.

32 AJHR, 1917, H-19J, pp.12-22.

33 AJHR, 1918, H-31, p.7. Watt was the first New Zealand medical graduate to be appointed a district health officer.

34 *Dictionary of New Zealand Biography*, ed. G.H. Scholefield, Wellington, 1940, II, pp.264-5.

35 NZNA, H.3/1, Epidemic Commission, pp.632-5.

36 R.M. Burdon, *The New Dominion*, Wellington, 1965, pp.15-17; Collier, pp.93-97.

to mid-December, at least 49% of the population was stricken with 'flu, in some few places over 80% of households being affected.³⁷ Schools, shops, pubs, theatres and even banks were closed as public life came to a halt. Teams of volunteers set up emergency hospitals in schools and church halls. Doctors and nurses worked themselves to exhaustion. Soup kitchens were set up to feed hundreds of convalescents, with Red Cross and Boy Scout volunteers as couriers of soup and medicines.³⁸

Most people survived, but 6,091 Europeans and at least 2,160 Maoris succumbed to pneumonia or other complications of the 'flu. The overall death rate from a population of 1.15 million was 7.45 per thousand, but the Maori death rate was seven times worse than the European. At the height of the epidemic in Auckland special trains took scores of coffins twice daily for burial at Waikumete Cemetery. Unlike ordinary influenza, which kills the very young and the very old, the 1918 pandemic struck at adults in the prime of life, between 25 and 45 years, depriving thousands of children of a parent.³⁹

This remains New Zealand's worst recorded natural disaster in terms of mortality and the extent of disruption to everyday life. The impact of such widespread mortality at the micro-level of households and families was often traumatic and tragic. Yet at the macro-level of public life and national institutions, the epidemic left remarkably few tangible legacies; things quickly returned to normal and people carried on as if nothing had happened. The epidemic coincided with the end of the First World War — indeed, the crowds celebrating the Armistice early in November did much to spread the infection — and people may have suppressed their painful memories of one alongside the other. Wartime committees enabled New Zealand to cope with the emergency; the war also helped communities to absorb the epidemic losses with equanimity.

The 'lessons' of the epidemic in Auckland have been ably examined elsewhere,⁴⁰ and often speak for the rest of the country. Prominent in the aftermath were strong criticisms of the Minister of Health and his department, for failure to quarantine the *Niagara*, for failure to take adequate precautions against such an epidemic, and for demonstrable failure to prevent mortality. With hindsight it is obvious that the department had no clear warning of what was to come, for in its early stages there was nothing to distinguish the severe wave of the 'flu from the 'mild' strain circulating in

37 AJHR, 1919, H-31, 'Influenza Pandemic: Report on the Epidemic in New Zealand', p.29; *Inglewood Record*, 11 December 1918.

38 M.H. Holcroft, 'The Great Epidemic', *New Zealand's Heritage*, Wellington, 1973, VI, part 76, pp.2133-8; G. W. Rice, 'Christchurch in the 1918 Influenza Epidemic', *New Zealand Journal of History*, 13 (1979), pp.109-37; G.W. Rice, 'Crisis in a country town: the 1918 Influenza Epidemic in Temuka', *Historical News*, 51 (1985), pp.7-13.

39 G.W. Rice, 'Maori Mortality in the 1918 Influenza Epidemic', *New Zealand Population Review*, 9 (1983), pp.44-61. For revision of mortality totals, see my forthcoming book, *Black November* (Allen & Unwin, Wellington).

40 Linda Bryder, 'Lessons of the 1918 Influenza Epidemic in Auckland', *New Zealand Journal of History*, 16 (1982), pp.97-121.

the previous few months. Even in normal times the department simply lacked the staff to deal with a public health emergency on such an unprecedented scale.

Frengley had taken charge in Auckland when the death-toll there began its sharp rise in early November. The newly-appointed district health officer for Auckland, Dr O'Sullivan, died in the epidemic, as did the port health officers at Napier and Wellington. Frengley's deputy in Wellington, Watt, fell ill at this critical time, leaving the Health Department's head office without a qualified medical officer. In the Minister's dramatic recollection, there 'was nobody but Miss Maclean, a cadet officer and myself, with the whole country in flames. . . . From every corner and village came cries for help; people dying, the doctors and nurses down.'⁴¹ Russell took charge himself. Trying to cope with hundreds of urgent telegrams and appeals for scarce or non-existent resources, this was a superhuman task, and he nearly cracked under the strain. His peremptory tone and arbitrary decisions taken in the heat of the moment upset the mayors of many towns, and ended with a complete breakdown of communication with Auckland's mayor. As the epidemic waned, many voices called for an inquiry and reform of the Health Department. Russell welcomed the suggestion of a royal commission, declaring that he had done his best and had nothing to hide.⁴²

In the meantime, however, fears of a recrudescence of the epidemic produced the Public Health Amendment Act, rushed through in December 1918.⁴³ This remedied many of the obvious legislative defects revealed by the epidemic relating to inspection and demolition of insanitary buildings, overcrowding, closure of hotels and theatres, appointment of doctors to areas of special need, the establishment of local sanitation committees, and many miscellaneous details. The loophole word 'may' in the 1900 Act was stiffened by the phrase 'and shall when so required'. But the main innovation of this 1918 amendment was the creation of an advisory Board of Health, chaired by the Minister and including the Chief Health Officer, the President of the New Zealand branch of the British Medical Association, the Dean of the Medical Faculty at Otago University, the officer in charge of local government in the Department of Internal Affairs, and five others. Each health district was to set up an advisory board to feed local information to the central Board of Health, which would advise the minister on national health policy, including medical services, hospitals, the training of doctors and nurses, and the relationship between the Health Department and local authorities. While most of the provisions of the 1918 amendment came into force at once, the Board of Health did not assemble until March 1919, when the royal commission had begun hearing evidence on the epidemic.

Makgill had been recalled from the Defence Department early in

41 NZNA, H.3/1, Epidemic Commission, 1919, p.662.

42 *Christchurch Press*, Christchurch, 5 December 1918, p.7; 9 December 1918, p.8; *The Sun*, Christchurch, 9 December 1918, p.5.

43 New Zealand Statutes (1918), No.22, pp.158-64. See also Maclean, pp.434-6.

November to take over Watt's duties as district health officer in Wellington. When the worst was over he went north to relieve Frengley at Auckland for a short time. He then returned to head office as the department's senior official until Valintine returned from overseas late in December. Valintine's absence and Frengley's exhaustion left Makgill to begin preparing the department's submission to the Epidemic Commission, although Valintine contributed a list of questions to guide the commissioners in their investigation. The department also prepared numerous tables, graphs and summaries not preserved in the commission papers, but which presumably formed the basis of Makgill's masterly departmental report on the epidemic later in 1919. Both the department and its minister understandably felt themselves to be on trial before the Epidemic Commission.⁴⁴

The commissioners were appointed in January 1919, under the chairmanship of a retired Supreme Court Judge, Sir John Denniston. They began hearing evidence at Auckland in February, at Wellington and Christchurch during March, and at Dunedin early in April. Over 120 witnesses were heard, representing a wide range of voluntary groups involved in fighting the epidemic.⁴⁵

Makgill's submission on behalf of the Health Department is in a separate file from the rest of the Wellington evidence, though numbered in sequence with that of other witnesses.⁴⁶ It was originally headed 'Measures necessary for strengthening the administration of public health in New Zealand', but someone subsequently crossed this out and wrote 'The position of the Department in regard to local government'. This paper is written in lively, direct prose, and is less formal than Makgill's departmental reports, often drawing on his own personal experience and enlivened with touches of humour (for example, it likens the pioneer health officer of 1900 to a 'sanitary swashbuckler', bullying local bodies to fulfil their public health duties). After admitting that the department's level of staffing was simply 'not sufficient to cope fully with the epidemic', Makgill examined the powers and functions of the department, and found a 'most unsatisfactory' situation. The 1900 Act gave health officers large responsibilities and apparently full powers, but in reality it had attempted too much. The powers were too sweeping: '[perhaps] possible of administration in Prussia but certainly not in New Zealand.' Nervous legislators in 1900 had attached 'check-strings' to the most important powers, giving final decisions to the Minister. Local bodies found they could appeal to him against a health officer's directives, and exploit ambiguous wording as delaying tactics, or

44 AJHR, 1919, H-31A, p.15.

45 AJHR, 1919, H-31A, Report of the Influenza Epidemic Commission, pp.1-44.

46 Evidence of Dr R. H. Makgill, H.3/1, NZNA, Epidemic Commission, 1919, pp.744-84. Makgill later told the Epidemic Commission: 'putting these contributions [of the district health officers] together I compiled the report. I put it in my own language. But the portion relating to the political aspect and the relationship between the Minister and the Department was wholly my own. I did not obtain that from the officers of the Department at all' (ibid., p.835).

simply refuse to obey. District officers were left helpless, feeling constrained by ministerial control.

Major changes were needed: Makgill argued forcefully that health as a scientific pursuit fundamental to the national welfare was too important to be subject to political control. The Board of Health needed to be made fully independent, with executive powers and a mandate to initiate new policy. As presently constituted, it could only advise the Minister. Makgill was especially scornful of the proposed advisory boards, describing them as no more than a 'variety of sanitary debating club', whose resolutions could be ignored if they ran counter to 'popular prejudice'.

Somebody must have anticipated that these sharp criticisms might cause a stir when made public, for there is a separate slip attached to this page on which Makgill added: 'This is a somewhat delicate matter to deal with, but there is absolutely nothing personal in what I am saying. I go further and say that had we had as much interest taken in the past by Ministers of Public Health as the present Minister has shown, I think we should have been in a better position. I do not want in any way to criticise the present Minister.'

Unfortunately the transcript of this part of Makgill's submission was not available two days later when the Minister appeared before the Commission, understandably incensed by newspaper reports in which a departmental officer appeared to criticize his Minister for political interference. As reported, Makgill's scornful remarks about the district advisory boards seemed also to refer to the new Board of Health, of which the Minister was chairman.

Makgill went on to explain that the department itself needed restructuring. The 1909 amalgamation of Chief Health Officer and Inspector-General of Hospitals had been a mistake. The department's work had outgrown the 1900 structure. The existing health districts were far too large, the health officers were overworked and underpaid, and there were too few of them. Much of their time was wasted in travel, and the only chance they had to keep up with the overseas developments was a glance at the journals while on the train.

Makgill described the existing health legislation as 'somewhat chaotic', and in need of complete redrafting to remove uncertainties and loopholes. When hospital boards were given responsibility for infectious diseases, many clauses had become ambiguous: responsibility was now divided and doubtful. Health officers found they had to resort to 'persuasion and menaces', or even 'Machiavellian intrigues', to persuade local bodies to undertake necessary sanitation works. Well-defined powers and procedures adapted to New Zealand conditions were urgently needed. But Makgill warned against copying overseas legislation, citing detailed examples of unworkable clauses taken from the British Act. Those relating to housing, he declared, had been 'disastrous'. British standards were 'far too niggardly' for a young country like New Zealand, with room to expand. The mandatory powers copied from British legislation for the removal of dilapidated buildings were 'useless' in the New Zealand situation. Makgill distinguished

three types of local authority in New Zealand, and argued that the health legislation had to be adapted to take account of the differences between them: first, the cities and larger regional centres, with their own staff and inspectors; second, the well-intentioned boroughs which only needed guidance and resources; and third, the small towns and rural boards, whose approach to sanitation could only be described as 'primitive'. The latter were declared by Makgill to be 'useless' as sanitary authorities. The Health Department needed powers to undertake necessary works and recover costs from negligent local bodies.

In short, Makgill's submission called for new legislation: an independent Board of Health as a strong controlling body; smaller health districts; more officers and inspectors on better rates of pay; and a major restructuring of the department itself, with clearer definition of powers and functions.

The Epidemic Commission heard Makgill's evidence on 17 March 1919. Next day, the newspapers reported only those passages which referred to 'ministerial control' and the Board of Health.⁴⁷ Russell had given his evidence to the commission on 13 March, but now returned on the 18th to read out a prepared statement in which he 'took the strongest exception to the statements made regarding the Board of Health'. He denied any intention to interfere with the scientific side of the Health Department, and swung the blame back upon the department's own heads, challenging them to produce evidence of any requests for money or recommendations which had been refused by him as Minister for political reasons: 'To sneer at Ministers as politicians and to say that politicians reflect popular wishes rather than scientific needs is a very cheap and easy way for [officials] to escape the responsibility that rests upon them.'⁴⁸

While Russell's sensitivity is understandable, after the extreme and often unfounded public criticism he had suffered during the influenza epidemic, this was an unfortunate rift between department and minister, for as the Minister's evidence on 13 March had shown, there was a large measure of agreement between himself and Makgill on the need for fresh legislation and restructuring within the department. Russell gave much more detail than Makgill to show that the Health Department was chronically understaffed and overburdened with the administration of some very diverse legislation. He flatly declared that the amalgamation of Chief Health Officer and Inspector-General of Hospitals had been 'false economy', which 'should never have been carried out'. Russell added, 'I know, and regret it, that the people of New Zealand are not willing to pay for brains and scientific training.'⁴⁹ Elsewhere he had publicly declared that 'ill-advised retrenchment [had] been followed by neglect and indifference . . . [and] for many years the Health Department [had] been starved and cramped'.⁵⁰ Like Makgill, he proposed new health districts based

47 *Lyttelton Times*, 18 March 1919, p.7.

48 *ibid.*, 19 March 1919, p.7. NZNA, H.3/1, pp.797-808.

49 NZNA, H.3/1, p.634.

50 *New Zealand Parliamentary Debates* (NZPD), 7 December 1918, p.987.

on regional centres, with a corresponding increase in the number of medical officers. He also suggested a new post of Chief Sanitary Inspector in each of the four main centres to relieve the district health officer of mundane inspection work, and periodic overseas leave to enable health officers to keep abreast of the latest advances in public health. The rest of the Minister's lengthy submission was a defence of his actions and decisions during the epidemic, which might be summed up by his belief that 'the best possible was done under the most exceptional circumstances'.⁵¹

It was an ironic coincidence that the Board of Health set up by the 1918 amendment act first met, with Russell as chairman, in Wellington the day after Makgill's submission. Valentine, as Chief Health Officer, expressed regret that the newspapers had distorted the evidence of 'such a loyal, progressive and energetic officer as Dr Makgill'. Russell replied that his Cabinet colleagues had seen no alternative to a statement before the Commission in response to such public criticism, and said he wished he had been able to read Makgill's paper beforehand. But Valentine pointed out that they had been 'a very rushed Department, and had to get a lot of data [ready] for the Commission'. In fact, Makgill, Frengley and Valentine had all agreed that the Minister gave his evidence in 'a most sporting and honourable manner', and Valentine had gone across to tell Russell in person that he had never stood so high in their opinion as he did then.⁵²

Once the ministerial feathers had been smoothed, the Board of Health spent most of this first meeting discussing quarantine regulations and the need to teach home nursing. Consideration of the Health Department's suggested reforms was deferred to its next meeting on 22 May. But by then the Epidemic Commission's report had been published, and health reforms were once more postponed until board members had studied the report in detail. Thus it was not until 8 August 1919 that the Board of Health met to discuss the recommendations of the Commission.⁵³ By this time, Valentine had been granted six months' leave to travel overseas, and Makgill appeared on the board as Acting Chief Health Officer. He was also busy writing the Health Department's official report on the influenza epidemic.

The board went through each of the commission's recommendations and simply referred all matters relating to the remodelling of the health legislation to Makgill and the department. Several other matters were held over until the next meeting, such as the definition of health officers' powers and the proposal for a specialist quarantine officer. The Minister's suggestion of a Chief Sanitary Inspector, though warmly endorsed by Makgill, was not supported: the Board considered such a post more appropriate to the Local Government Board. At the Board's fourth meeting on 18 September, Makgill outlined his proposals for the internal reorganization of the Health Department. These were approved and went forward as the

51 NZNA, H.3/1, p.674.

52 Board of Public Health Minutes, 18-19 March 1919, H.29/2/2 (25420) NZNA, pp.8-9.

53 Board of Public Health Minutes, 8 August 1919, H.29/2/2 (25420), NZNA, pp.2-3.

Board's own recommendation to the Minister.⁵⁴

By now there was a new Minister of Health, Sir Francis Bell. Russell had lost his seat in the 1919 election.⁵⁵ The new Minister, however, sent his apologies to the next two meetings of the Board, and appears to have taken no active part in the drafting process of the new Health Bill. On 11 December 1919 Makgill was able to report that the work of internal reorganization was virtually complete, and ready to operate from the start of 1920. But the new title 'Director-General of Public Health' could not be used until the new Health Bill had become law. Makgill then outlined his proposals for reorganizing the Board of Health in line with the proposed legislation, and these were approved with little comment.⁵⁶

Valentine returned from overseas leave to resume his post as Chief Health Officer in January 1920, but it is evident that the bulk of the legislative redrafting and administrative reorganization had been achieved by Makgill during his absence. Valentine must have made his own comments on the draft legislation early in 1920, but no evidence of them has survived in the archives. Though the department's proposals for the new Health Bill were forwarded to the Minister over Valentine's signature on 17 May 1920, they bear the stamp of Makgill's forceful style. The very first paragraph echoes the language of Makgill's submission to the Epidemic Commission: 'The general purport of the Bill should be to throw on every Local Body strong enough to bear it the whole burden of sanitary administration within their district. Their hands should be strengthened in every way possible, and the position of the Department must be to encourage, guide and if necessary to compel the Local Authority to carry out the Acts dealing with public health measures. There must be no dubiety as to where the responsibility rests. The Hospital Boards must cease to have any functions as sanitary bodies.'⁵⁷

This detailed proposal paper then set out lists of the acts which were to be fully administered by the Health Department, with eleven others which required some measure of direct supervision in conjunction with other government departments. In another departure from overseas precedents, it was noted that the Sale of Food and Drugs Act in Britain was a charge on the local authorities, but that in New Zealand 'this would only result in confusion and expense' so that 'the Act would soon become a dead letter'.⁵⁸ This was one of the nine major acts which obviously had to be administered directly by the Health Department. The three main functions of the department were defined as direct executive duties; supervision of public health

54 Board of Health (manuscript) Minute Book, H.6/1, NZNA, pp.40-46.

55 Apparently for reasons of local politics rather than overt disapproval of his performance as Minister during the epidemic. See W. H. Scotter, *A History of Canterbury*, Christchurch, 1965, III, p.403.

56 Board of Health, Minute Book, H.6/1, NZNA, pp.48-56.

57 Evidence of Dr R.H. Makgill, Epidemic Commission, 1919. Memorandum, Health Bill, 1920, (copy) 17 May 1920, H.3/1, NZNA, pp.1-15.

58 *ibid.*, p.2.

work by other departments or local bodies; and mandatory powers to assume the duties of feeble local bodies or to compel recalcitrant authorities to carry out their public health duties. The continuity between these proposals and Makgill's submission is clear.

Much detail was devoted to the constitution and functions of the new Board of Health. This was to have executive powers in all matters relating to health administration and local government. A membership of twelve was proposed, including medical experts, doctors, representatives of local bodies, and an expert on town planning. The most striking feature of this section was the exclusion of the Minister of Health from membership of the board, on the grounds that his residual powers and financial control made his formal membership unnecessary. He was entitled to attend meetings as an observer, and in some cases to convene a special meeting. This exclusion was justified on the grounds that such central boards in other countries did not include the minister.⁵⁹ Here was a clear instance of Makgill's determination to eliminate 'ministerial control'.

The outstanding feature of the proposals was a new administrative structure for the Health Department. New Zealand had possessed a School Medical Service since 1912 and a School Dental Service since 1919; these were to be transferred to the department as separate Divisions of School Hygiene and Dental Hygiene. The other five Divisions comprised Public Hygiene, Hospitals, Nursing, Child Welfare, and Maori Welfare. Each division was to have its own Director, under the overall supervision of a Director-General of Health and a Deputy Director-General. The number of health districts was to be increased to eight, and the staff of district health officers increased to twelve, with two at each of the main centres. The sanitary inspectors employed by hospital boards were to become departmental officers, as the department assumed full responsibility for infectious diseases. The rest of the proposal paper dealt in considerable detail with the duties of local authorities and such topics as model by-laws, insanitary buildings and loans for necessary sanitary works. The paper concluded with the confident prediction that the new act should be shorter than the existing one, 'from which much useless lumber can be expurged [sic]'.⁶⁰

A few days later, on 22 May, a short memorandum summarizing the main features of the proposal was sent to the new Minister of Health, C. J. Parr, inviting his comments.⁶¹ Parr was a former mayor of Auckland, who had actively collaborated with Makgill and Frengley to improve the city's sanitation in the early 1900s. Parr's comments, dated 7 June, were terse and pointed. After expressing general approval of the proposed bill's scope, Parr declared the Board of Health too unwieldy, and instructed the department to amend the draft bill to reduce it to seven or eight members. Makgill

⁵⁹ *ibid.*, p.5.

⁶⁰ *ibid.*, p.14.

⁶¹ NZNA, H.3/1; Epidemic Commission, 1919, Evidence of Dr R.H. Makgill. Memorandum for Minister of Public Health, (copy) 22 March 1920. The copy in National Archives has Makgill's marginal comments.

noted in a marginal comment that this was being done, but with the proviso that further members could be added later if necessary, on the model of the Board of Trade. Parr flatly rejected the proposal that the Health Department take over full responsibility for hospital administration: 'Please therefore eliminate this aspect.' Nor was the Government willing to give the department control of all medical and nursing services in hospitals, because of the enormity of the financial implications of such a move 'in the present critical time of public finance'. We may suspect that Valentine had intervened to protect the independence of his favoured domain, the hospital system, but Parr added, 'otherwise, in my judgment, the proposal has much to recommend it.'⁶²

The Minister then asked if it was necessary to have some sort of modified state medical service for back-blocks districts, and Makgill replied that the department currently had no power to appoint a doctor to a back district, but that he would include such a provision in the bill. The only other substantive query concerned the medical inspection of schools: the Minister anticipated some opposition in Parliament, which 'will require to be handled carefully'. But in the meantime it would do no harm to draft the clauses in anticipation; Makgill replied that he had already done so, and provided for a Division of School Hygiene. The Minister urged that drafting proceed as swiftly as possible, to which Makgill answered: 'The Crown Law draftsman is now working at it on my rough draft.'⁶³

The Board of Health, which had last met in December 1919, gathered on 18 June only to hear that the drafting of the new Health Bill was delayed by pressure of work in the Crown Law Office.⁶⁴ Copies of the Bill were finally circulated late in July, and the Board reassembled on 26 August to examine the draft clause by clause. Of the 23 amendments proposed at this meeting (by Messrs Barr, Elliott and Ferguson), most were very minor additions and alterations (for example to add locomotives as sources of smoke nuisance). The only substantive proposals related to the Board of Health, which was to be enlarged yet again with the addition of two doctors nominated by the New Zealand branch of the BMA, a civil engineer and two lay persons.⁶⁵ In the final version of the 1920 Health Act, the Board got its civil engineer but only one doctor; of the two lay persons, one was 'a woman deemed to be representative of the interests of women and children' — a proposal which did not emanate from the Board.⁶⁶

How important was the role of the Board of Health in shaping the 1920 Health Act? On the evidence of the handwritten Minute Book, the answer must be: not very. The meeting of 26 August concluded with reference to 'the excellent work and high ability shown by Dr Makgill in connection with

62 *ibid.*, Minister of Public Health to Chief Health officer, (copy), 7 June 1920, pp.1-2.

63 *ibid.*, p.2.

64 Board of Health, Minute Book, H.6/1, NZNA, pp.70-71.

65 *ibid.*, 26 August 1920, pp.86-96.

66 New Zealand Statutes (1920), No.451. 'Health', p.177.

the drafting of the Bill'.⁶⁷ How much he relied on expert advice from within the department is impossible to judge from the surviving evidence, but it is beyond question that Makgill was the department's leading expert on public health, in contrast to Valintine's preoccupation with hospitals. We have already noticed several instances from his submission to the Epidemic Commission where Makgill warned against uncritical copying of overseas models. Yet it must also be acknowledged that he was revising legislation derived from the English Health Act of 1875, and that most of his ideas had a British origin. In one of his later appearances before the Commission, Makgill said that he had for many years held the idea that a body like the English Local Government Board should act as a strong central authority to control the activities of the Health Department in New Zealand. Here, it would seem, is the origin of Makgill's insistence on the independence of the new Board of Health.⁶⁸

It is surely more than a passing coincidence that the earliest proposals for a new Ministry of Health in Britain were circulating in 1918, and that its 'Consultative Committees' closely resemble the district advisory boards of the New Zealand Board of Health set up by the 1918 health amendment. Even more convincing is the administrative structure adopted in 1919 for the new Ministry of Health in Britain, which took over the functions of the old Local Government Board: medical services were organized under ten sections or divisions, including general health and epidemiology, maternity and child welfare and school medical services.⁶⁹ This seems very likely to have been the model for New Zealand's 1920 Health Department, with the important difference that Makgill's proposals kept a key role for an independent Board of Health. The only direct evidence of an Australian influence comes from a report of 9 June 1920 on the Health Department's responses to the recommendations of the Epidemic Commission, where it is stated that the wording of a clause relating to the inspection of insanitary buildings was copied from new legislation in Victoria. Elsewhere Makgill admitted that he had found the Victorian legislation helpful.⁷⁰

The committee report on the Health Bill was tabled on 23 September, with only two proposed amendments. One was apparently minor: to alter 'occupier' to 'owner of premises' in respect of a condemned house. The other was more significant: to make the Minister of Health chairman of the new Board of Health. These amendments were agreed and the Bill soon passed through the Legislative Council, with only two minor amendments relating to water supplies and medical inspection of schools. The new Health Act became law on 5 November 1920. There had been remarkably little debate or discussion as it went through the legislative process (in con-

⁶⁷ Board of Health, Minute Book, H.6/1, NZNA, pp.95-96.

⁶⁸ Epidemic Commission, 1919, H.3/1, NZNA, pp.744, 835; *Lyttelton Times*, 20 March 1919, p.6.

⁶⁹ Brockington, pp.459-62.

⁷⁰ Epidemic Commission, 1919, evidence of Dr R.H. Makgill; Memorandum for Minister of Public Health (copy), 9 June 1920; NZNA, H.3/1, memo 26 August 1920, H.1/181/1.

trast to heated exchanges over the Masseurs' Registration Bill). Makgill's bid for independence from 'ministerial control' was defeated by the legislators, but in all other substantive respects the 1920 Health Act stood as he had proposed it.

Valentine retired in 1930, after a stormy decade of debates over maternal mortality in which the department and the doctors were often at loggerheads. Makgill also retired in 1930. He had remained at head office, latterly in a consultative role, writing reports and exercising his considerable drafting talents again on the Nurses' and Midwives' Registration Act of 1926. As Watt, now the new Director-General, observed on the occasion of Makgill's retirement, he had occupied at one time or another all the senior positions in the department, and his knowledge of its work was 'unequaled'.⁷⁵ Though offered the post of Medical Secretary in 1909, Makgill had chosen to continue with his scientific work as Government Bacteriologist. As the department's official historian commented: 'All he did was marked by a high degree of technical knowledge, a mastery of detail, and outstanding administrative ability.'⁷⁶ Like Valentine, he was awarded the CBE for his services to public health.

Makgill emerges as an unsung hero of New Zealand's public health history, maintaining the drive for reform begun by Mason in 1900. Thanks to the 1918 epidemic, Makgill seized the opportunity to put in place a legislative landmark which kept New Zealand's health system among the best in the world for the next 30 years. Apart from Valentine's contribution to the hospital service, Makgill's role in New Zealand's public health history has no near rival. Across the Tasman, J. H. L. Cumpston provides comparison as the outstanding figure in Australia's Quarantine Service and the first Director-General of the Commonwealth Department of Health. Makgill obviously shared Cumpston's Fabian-Progressive delight in facts and statistics, but a better Australian counterpart might be J. S. C. Elkington, whose early career was similarly spent as a field officer pioneering sanitary reform and disease prevention. He too was an exceptionally able administrator, and a writer of reports which have been described as 'masterpieces of administrative literature'.⁷⁷ The same might be said of

71 NZPD, 1920, vol.188, p.122; Maclean, pp.436-42; See also Balfour and Scott, pp.182-3.

72 *Documents on Health and Social Service, 1834 to the present day*, ed. B. Watkin, London, 1975, pp.49-52.

73 Commonwealth of Australia, Official Yearbook, No.4 (1911), pp.1113-15; No.14 (1921), pp.968-71; R. Mendelsohn, *The Condition of the People; Social Welfare in Australia, 1900-1975*, Sydney, 1979, pp.238-40; D. Gordon, *Health, Sickness and Society*, St. Lucia, Queensland, 1976, pp.484-5, 798; J.H.L. Cumpston, 'Public Health in Australia, Part III: Developments after 1850', *Medical Journal of Australia*, 6 June 1931, pp.679-85.

74 AJHR, 1921-22, H-31, p.2.

75 AJHR, 1932-33, H-31.

76 Maclean, pp.29-30.

77 Michael Roe, 'The Establishment of the Australian Department of Health: Its Background and Significance', *Historical Studies, Australia and New Zealand*, 17 (1976), pp.176-92.

Makgill's many official reports, which set high standards for their field in New Zealand's administrative literature. New Zealand was fortunate to have an individual of such exceptional ability to draft its 1920 Health Act.

GEOFFREY W. RICE

University of Canterbury

LANDFALL

Since 1947 the best in New Zealand writing has appeared in *Landfall*

POEMS STORIES
INTERVIEWS ARTICLES
BOOK REVIEWS ART

Landfall is published quarterly — March, June, September & December.

Forward subscription:
\$33 + G.S.T. N.Z.,
\$39 Overseas to:

The Caxton Press, P.O. Box 25-088
Christchurch, New Zealand.

