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‘A Nation’s Health is a Nation’s Wealth’:
Perceptions of ‘Health’, 1890-1914

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Abstract

This thesis is an examination of the way health issues were perceived in New Zealand from 1890 to 1914. It investigates how these views changed and the manner in which they were reflected in health policies and programmes. Perceptions of health are examined within their social, political and cultural context. It is argued that in the period from 1890 to 1914 health issues were increasingly prominent on the public agenda. The nineteenth century was characterised by a distinct lack of interest in health, primarily because New Zealand was believed to be an inherently healthy country. From the late nineteenth and early twentieth centuries this view was challenged by the growing importance of medical science, the increasing influence of the medical profession and a number of public health scares. With the biomedical revolution of the 1880s there was more scope for human intervention in health matters and a different understanding of health. More frequent debates about health increasingly characterised the health status of the population as a national asset. New Zealand's strength as a nation was thought to be connected with its health. This shift in perceptions was related to increasing government intervention to control and protect its population's health. The Liberal Government responded to this need by incorporating health into their programme of government intervention through a centralised bureaucracy. By looking at a number of health policies in their socio-political context this thesis provides a holistic view of the history of health in New Zealand. From this framework of analysis a number of broader themes are discussed: the changing role of medicine, the role of the government in providing for health, New Zealand's relationship with Britain, and the construction of a national identity.

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Abbreviations

<i>AJHR</i>	Appendices to the Journals of the House of Representatives
<i>BMA</i>	British Medical Association
<i>NZG</i>	New Zealand Gazette
<i>NZJH</i>	New Zealand Journal of History
<i>NZMA</i>	New Zealand Medical Association
<i>NZMJ</i>	New Zealand Medical Journal
<i>NZPD</i>	New Zealand Parliamentary Debates
<i>NZS</i>	New Zealand Statutes
<i>WTU</i>	Alexander Turnbull Library

Preface

This thesis examines issues relating to health in New Zealand in the period from 1890 to 1914. In particular it investigates changing perceptions of health and locates these in wider socio-political concerns and anxieties. It is a study of ideas. It is not possible to discuss every perception of health held in this period; rather this thesis examines ideas which were prominent on the public agenda. This ideas-based study brings together a number of different perspectives to provide a multi-layered examination of health. That is, it displays how health issues were important not only for their health-related significance but also because they often reflected broader social and political concerns and trends.

This study of perceptions of health has been arranged chronologically and by broad themes. Chapter One discusses the approaches other historians have made towards the area of health and places the arguments proposed in this thesis within that context.

Chapter Two provides a discussion of pre-1900 health issues and argues that in the nineteenth century health concerns were not so prominent; New Zealand, in both popular and medical frameworks, was commonly believed to be a healthy country. It is argued that health was viewed in environmental terms. Maori, at the time of contact, were believed to be a strong, healthy race because of New Zealand's

climatic advantages. In turn, it was thought that the Pakeha settlers would be able to benefit from this advantageous climate. By the close of the nineteenth century, however, these views were beginning to be challenged, particularly by the medical profession.

Chapter Three looks at these challenges and suggests that 1900 was a turning point in ideas about health with the first questioning of the state of health in New Zealand prompted by the bubonic plague scare. It is suggested that the external threat of the plague highlighted concerns about New Zealand's sanitary state: the first occasion that health issues were perceived as a threat to the entire nation. The emphasis on sanitation is likely to have been influenced by the growing knowledge about the bio-medical developments of the late nineteenth century.

Questions about New Zealand's healthy state led to the establishment of the Department of Public Health. The creation of the Department, along with a survey of its early work, is incorporated in Chapter Four. It is argued that this was the first major recognition of health as a national asset and highlights the growing significance of health issues. Maori health work is discussed and parallels are drawn with broader health policy. The chapter also stresses the importance of the Liberal Party in the direction of and emphasis placed on health policies.

Chapter Five is based around the theme of degeneration and it is argued that concerns about degeneration and the related anxiety about the low birth-rate had a profound impact on perceptions of health. Concerns in New Zealand were stimulated by similar anxieties in other parts of the British Empire. New Zealand's health was seen as a facet of the strength of the British Empire. It is argued that much of the response to these anxieties was directed at infant and child health: the 'future' of the nation.

The response to growing anxieties about health in the early twentieth century was embodied in the implementation of a number of policies which increasingly restricted and controlled society in general and the practice of medicine in particular. This is the focus of Chapter Six. It discusses a number of pieces of legislation which have otherwise been viewed in isolation and argues that these policies were a result of

increasing concerns about New Zealand's health and part of the desire to create a 'healthy society'.

A number of different primary sources have been used in this thesis to assess changes in perceptions of health, particularly public opinion and government attitudes about health. It has not been possible to carry out extensive primary research into every event and policy covered in this thesis, but a number of sources have been chosen which gauge the opinion of different sectors of society. One of the most useful sources has been a number of contemporary pamphlets, particularly those held at the Alexander Turnbull Library and the Auckland Institute and Museum Library. These include Plunket Society pamphlets, speeches and articles written by doctors and health officials, government department publications and other pressure group material and propaganda. These have been particularly useful because they often display strongly held opinions about the state of New Zealand's health and other health related matters. Much of this material was circulated throughout most levels of society and was often targeted at a different audience than say, for example, government department reports.

Newspapers were another effective gauge of wider public opinion of the time. A selection of newspapers has been chosen: two of these, the *Press* and the *New Zealand Mail*, because of their extensive indexes, which are held at the National Library. The indexes made the newspaper research, which can otherwise be rather overwhelming, much easier and more complete. Other newspapers which have been looked at are the *New Zealand Herald* and the *Auckland Weekly News*. The *Press* and the *New Zealand Herald* were daily papers which were primarily news focused and the other two papers had more feature articles and non-news related material. Advertisements in newspapers were also a useful gauge of the prevalence of non-standard medical treatments which played an important part in health debates. Numerous articles in the *New Zealand Medical Journal (NZMJ)* gave the medical context of health issues and thus provided an important source.

The most useful official publication was the Department of Public Health's Annual Reports in the *Appendices to the Journals of the House of Representatives (AJHR)*. These reports included a wealth of material and the opinions of key health

officials came through very strongly. Other reports of Native Medical Officers and the Education Department were also of use. The *Parliamentary Debates* also provided an excellent portrayal of the government's intentions, contentious issues and a variety of opinions on every issue. Specific reports in the *British Parliamentary Papers* and Australian Royal Commissions were also valuable official sources and highlighted debates in other parts of the British Empire.

Unfortunately there was only a limited amount of relevant primary material at Archives New Zealand. There were few Department of Public Health archives before 1920 and they primarily consisted of material such as local boards of health reports, which detailed numbers of infectious diseases. There was a small body of material in the Internal Affairs Department and the Maori Affairs Department. The archival material was generally lacking material on public health issues and debates, the primary concern of this thesis. Much has been written by historians in the area of health and debates which are relevant to this thesis are considered in Chapter One.

1 Approaches to the Topic

In a thesis which focuses on the perception of health, it is necessary to discuss issues related to its meaning. In this case health is most appropriately described as public health, if the term is used in its broadest sense; that is, the general health and well-being of a community. In different medical, social and historical contexts health and well-being may be defined in different ways. In some, well-being may not be an appropriate term at all. The focus here, however, is on perceptions of health: how health was viewed by different sectors of the community. Health is a generic term: it may be used in a variety of different situations to mean different things. Although the term health is primarily used to describe the health of the general public, it has also been used in specific situations to illustrate health on an individual level.

Health tends to be viewed in negative terms by illness or disease. It is viewed as a deviation from the normal expectations of a particular society. If a society lacks illness or disease it is described as healthy. In contrast, if sickness is present, above a certain level, the society is viewed as unhealthy. Health policies tend to focus on the removal of ill health rather than actions to facilitate the establishment of good health.

Western healthcare ideologies see illness in terms of its biomedical treatment. Conversely, non-western cultures have often emphasised other aspects, including the spiritual, with a more holistic view of health. Spiritual transgressions have been seen as explanations for illness and disease; this is particularly relevant to the traditional

Maori view of health and illness.¹ The supernatural was at the heart of pre-European Maori perspectives: illness often resulting from an offence, a hara, against the supernatural domain.²

In the last thirty to forty years, social scientists have emphasised the significance of the social, cultural and political context of health and have suggested that health is culturally constructed. One of the most prominent exponents of this interpretation, Michel Foucault, has studied the development of the 'clinic',³ the origins of western medicine and the importance of power and knowledge in the determination of health and illness. Foucault emphasised the significance of the medical gaze or medical perception; that is, the way the body, and in turn health and illness, were viewed in different ways in different periods. He suggested that there was no one medical truth, rather that it had changed over time.⁴ Foucault's work is particularly relevant because he looked at the way language and ideas used by doctors created society's knowledge about health and illness. He also discussed the way that these perceptions of health have emerged and changed over time and the way they have been constructed to permit some groups to exert power over others. Foucault's book was about control, about the subjugation of one group by another.

The medicalisation thesis, developed during the 1970s by social scientists, emphasised the use of medical knowledge as a form of social control.⁵ Medicine was seen to construct and redefine aspects of normal life as medical problems.⁶ Michael Belgrave, in a discussion of the treatment of medicine by historians has argued that:

In shifting the emphasis of study away from the doctor and towards the patient, many researchers looked more closely at the way medical treatment was an exercise of power....the scientific rationality of medical technology has come under attack as medical knowledge and the process of clinical innovation are placed in a wider

¹ For an extensive overview of Maori health systems from a contemporary perspective see: Mason Durie, *Whaiora, Maori Health Development*, 2nd ed., Auckland: Oxford University Press, 1998, Chapter Two. For a historical perspective which focuses on Maori health and medicine see: W.H. Goldie, *Maori Medical Lore*, Read before the Auckland Institute, 7th December 1903, Christchurch: Kiwi Publishers, 1999.

² Raeburn Lange, *May the People Live, A History of Maori Health Development 1900-1920*, Auckland: Auckland University Press, 1999, p.8.

³ This is an English translation of Foucault's 'la clinique', which referred to both clinical medicine and the teaching hospital.

⁴ Michel Foucault, *The Birth of the Clinic, An Archaeology of Medical Perception*, New York: Vintage Press, 1975.

⁵ Clive Seale, 'Medicalisation and Surveillance', in *Medical Knowledge: Doubt and Certainty*, Clive Seale and Stephen Pattison (eds.), Buckingham: Open University Press, 1994, p.112.

⁶ Sarah Nettleton, *The Sociology of Health and Illness*, Cambridge: Polity Press, p.27.

intellectual and cultural context. The result has been an uneasy and often tense dialogue between the physician-historians and their social science critics; the former fearing that medical history has been high-jacked by a hostile and radical [clique] ignorant of the clinical aspects of disease; the latter suspecting that traditionalist medical history serves professional monopoly rather than academic enquiry.⁷

Historians of medicine have often taken an approach which advocates the primacy of medical developments at the expense of a discussion of broader social and cultural issues. F.S. Maclean's *Challenge For Health*, traced the history of public health in New Zealand but did not come to any conclusion about underlying forces which may have been driving health policy, other than a recognition of the role that infectious diseases played. Indeed, Maclean divided his history thematically into infectious diseases and wrote a chapter on each. There were also chapters on infant welfare and Maori welfare: a suggestion, perhaps, that these two spheres of health were nothing more than another 'epidemic'.⁸ A more recent example of a health history which emphasised medical developments was Derek Dow's *Safeguarding the Public Health*. It was an extensive history of the Department of Public Health. What it lacked was a discussion of broader social and political forces shaping society. This would help to explain why particular policies and programmes were initiated. For example, Dow discussed the growing importance of child health in the early twentieth century but did not explain why this occurred.⁹ A discussion of health issues requires recognition of the important role medical developments have played, but should be set alongside a discussion of the social and cultural context in which they existed.

Thomas McKeown has disputed the impact of medical developments in *The Role of Medicine, Dream, Mirage, or Nemesis?*¹⁰ McKeown argued that facts such as diet and environment had a more significant effect on populations than medical developments. This thesis does not seek to provide statistical and medical analyses for the beneficial, or otherwise, effect of the policies mentioned. But McKeown's argument must be taken into consideration when the effect of any health initiative is discussed. Like McKeown, F.B. Smith, discussed the impact of medical

⁷ Michael Belgrave, "'Medical Men' and 'Lady Doctors', the Making of a New Zealand Profession', PhD Thesis, Victoria University, 1985, pp.8-9.

⁸ F.S. Maclean, *Challenge For Health, A History of Public Health in New Zealand*, R.E. Owen: Wellington, 1964.

⁹ Derek A. Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Public Health*, Wellington: Victoria University Press, pp.12, 79.

¹⁰ Thomas McKeown, *The Role of Medicine, Dream, Mirage, or Nemesis*, New Jersey: Princeton University Press, 1979.

developments in the nineteenth century in Britain and has concluded that medicine did not play a decisive role in any lowering of the death rate in the nineteenth century. Smith argued rather that nutrition, housing and working conditions, had a more significant impact on people's health.¹¹ Environmental factors were certainly thought to be an important facet of health in the nineteenth century, and Smith argued that the turning point in the impact of medical developments was 1906, when the infant mortality rate began falling decisively.¹²

At the other end of the spectrum some social historians have seen health as important only in that it provides a site for other social issues. A prime example of this approach was Erik Olssen's 'Truby King and the Plunket Society, An Analysis of a Prescriptive Ideology'.¹³ Olssen focused primarily on the ideology of regulation and control established by the Plunket Society.

A holistic approach, one which considers the importance of medical, social and political issues, might provide a more balanced interpretation of events, and recognition of the complex nature of health issues.

The emphasis of social and medical historians has meant that the important influence of centralisation and growing state involvement in society in this period has not always been given significant weighting.¹⁴ This context is important when discussing the numerous policies and programmes which were developed and implemented by the Liberal Government. Growing state intervention was entirely consistent with Liberal philosophy and therefore should be part of a discussion of the implementation of new health policies. The level of state intervention also showed their recognition of the growing importance of good health to a nation's development. There are varying viewpoints among historians on the motivations behind the Liberals' policy: this divergence of opinion will be discussed in Chapters Two and Four. W.H. Oliver argued that the Liberals' state socialism was 'strongly disciplinary and paternalist' and disputed explanations which insisted their primary goals were

¹¹ F.B. Smith, *The People's Health, 1830-1910*, Canberra: Australian National University Press, 1979, p.415.

¹² *ibid.*, p.11.

¹³ Erik Olssen, 'Truby King and the Plunket Society, An Analysis of a Prescriptive Ideology', *New Zealand Journal of History (NZJH)*, 15:1 (1981), pp.3-23.

¹⁴ See for example: Dow, *Safeguarding the Public Health*.

‘justice, compassion, humanism, and of popular demand’.¹⁵ Oliver’s suggestion that the Liberals’ motives cannot entirely be explained in terms of utopian idealism may have overstated the negative aspects of paternalism.¹⁶ Although the Liberals’ health policies may seem paternalistic and controlling, their motivation was to protect society. A paternalistic approach does assume that the Liberals believed they had the best interests of the public in mind.

Not all historians of health neglect the political dimension of the construction of health or healthcare provision. Though the system of charitable aid was not a particular focus of this thesis, Margaret Tennant’s *Paupers and Providers* has provided a thorough analysis of both the central and local politics behind the charitable aid system. Tennant discussed the relationship between the public health system and charitable aid, arguing that the amalgamation of health and hospitals in 1909 meant that ‘charitable aid fell even further down the list of priorities’.¹⁷ Alongside the political analysis, Tennant provided a social analysis of the charitable aid system. This socio-political examination of charitable aid is the approach which is to some extent followed in this thesis. Patricia Sargison’s history of nursing also included political dimensions. It discussed the registration of nurses in the context of the Liberal Party’s ideologies and principles. Sargison argued ‘Measures which catered for the interests of particular sections of the community were acceptable if they promoted self-reliance as well as the interests of the community as a whole, and particularly if they were perceived to protect the colony from “Old World evils”’.¹⁸ Historians of hospitals have been more likely to deal with the impact of political frameworks on the operation of hospitals because they have a formalised structure which lends itself to such an analysis.¹⁹

It is argued in this thesis that events and issues in Britain stimulated concerns about health in New Zealand. Current health history has generally accepted the

¹⁵ W.H. Oliver, ‘Social Policy in the Liberal Period’, *NZJH*, 13:1 (1979), p.29.

¹⁶ Oliver’s emphasis of the negative aspects of the ‘paternalism’ of the Liberals may have been influenced by the time he was writing: 1979, at the height of Muldoon’s paternalism.

¹⁷ Margaret Tennant, *Paupers and Providers, Charitable Aid in New Zealand*, Wellington: Allen and Unwin, 1989, p.41.

¹⁸ Patricia Ann Sargison, “‘Essentially a Woman’s Work’: A History of General Nursing in New Zealand 1830-1930”, PhD Thesis, University of Otago, 2001, p.109.

¹⁹ See for example: John Angus, *A History of the Otago Hospital Board and its Predecessors*, Dunedin: Otago Hospital Board, 1984.

influence of Britain, usually displaying how various policies were modelled on similar British ones.²⁰ What is not always discussed, however, is the influence of British concerns on debates in New Zealand and the way that these anxieties became New Zealand's anxieties. If New Zealand had an unhealthy and weak population then the British Empire was weakened, so the claim went.

Maori and Pakeha health issues have tended to be viewed in isolation, historians separating the two. In Maclean's *Challenge for Health*, it was a separate chapter. Other historians have written entire books on Maori health.²¹ There has not yet been a substantial discussion of the inter-relationship between Maori and Pakeha health. This thesis cannot fill the gap entirely. It does, however, propose a number of correlations in the relationship between Maori and Pakeha health which could provide the basis for further research. Ideas about Maori health often influenced and stimulated the direction of broader New Zealand health debates. The idea that Maori were originally a particularly healthy and strong race because of New Zealand's climate helped to entrench the notion of New Zealand as a healthy country. Late nineteenth century concerns about sanitation in Maori communities and an overall decay and decline of Maori pre-empted many concerns in the early twentieth century about Pakeha health. As a consequence of this relationship between Maori and Pakeha health it did not seem appropriate to have a separate chapter on Maori health issues. Rather Maori health has been integrated throughout to further demonstrate this connection.

There is a tendency in much health and medical history to use what might be termed a 'Whig interpretation' of historical issues. Thus, a medical development which has had a profound impact since its discovery is focused on even though at the time of its introduction it may not have been particularly prominent. This argument has been developed by Davey and Seale: 'A history of medical knowledge focuses on the thoughts and actions of a relatively restricted section of society, whose 'high profile' in the twentieth century may deceive us into imagining that important medical

²⁰ See for example Cooper's discussion of the influence on the British Midwives Act on a similar act in New Zealand, Marion A. Cooper, 'Towards the Professionalisation of New Zealand Midwifery', 1840-1940', M(Phil) Thesis in Midwifery, Massey University, 1998, p.35.

²¹ See for example Lange's, *May the People Live*, Derek A. Dow, *Maori Health and Government Policy, 1840-1940*, Wellington: Victoria University Press, 1999.

discoveries in the past had an immediate impact on society as a whole'.²² Historians have sometimes viewed health policies out of their social and political context. This is particularly noticeable in the discussion of policies which have had a negative effect on groups of people or have been seen to unfairly restrict or control sectors of society. Although the negative impact of such policies should not be excused, an historical interpretation must highlight the broader social, cultural and political context in which they occurred. A prime example of this in the New Zealand context was the recent portrayal of the Tohunga Suppression Act.²³ In recent public debates the Act has often been described as a piece of cultural suppression but, as will be argued in Chapter Six, it was passed at a time when a number of policies were established to control the practice of medicine.

The primary contribution of this thesis is the creation of a health history which brings together a number of health ideas, issues, events, policies and legislation which collectively display shifting themes and broader trends in society. The use of health as a 'lens' with which to examine the past provides a perspective on the nature of society. Perceptions of health, reactions to health events, the role of health and health policy in society, all changed between 1890 and 1914. This examination of health uses themes as a basis, rather than policies or events, and creates a more holistic view of health. These issues cannot be seen in isolation from other contemporary trends and broader concerns in society. There has been extensive research into health history but it has been almost entirely on a policy by policy, or event by event basis. There are histories of Plunket, doctors, School Medical Service, establishment of the Department of Public Health, smallpox, and tuberculosis, to name a few. In isolation, however, the study of these issues has not always highlighted more general trends which were at work in society. When a number of health related issues are examined, other trends and concerns may be more obvious. These include the breakdown of and reaction to the healthy country 'mythology', the progression from a view that health was primarily environmentally determined to one that was largely medically determined, the movement of health from a private to a public concern, and the need to control in order to protect the health of society.

²² Basiro Davey and Clive Seale, 'An Historical Approach to Medical Knowledge', in Seale and Pattison, p.30.

²³ David Williams, 'Matauranga Maori and Taonga', Wai 262, Waitangi Tribunal, p.124.

2 New Zealand, A Healthy Country?

Environmental factors were viewed as the key determinants of health in the second half of the nineteenth century and New Zealand was viewed as an inherently healthy country. New Zealand's climatic and other environmental advantages, such as wide-open spaces and fresh air were considered to be the cause of this healthy state. New Zealand was even promoted in Britain as a health resort and an ideal place for invalids and sickly people. This healthy country mythology contributed to a lack of concern and public debate about health issues. Public health policy in the 1890s continued essentially unchanged, along the lines of the system which had already been in place for 14 years. What makes this continuity more remarkable was the extensive medical developments which occurred in the late nineteenth century and the possibilities these held for public health. The limited public health work which was undertaken was directed at sanitation, quarantine and vaccination. Although there were calls for improvements in sanitary conditions, poor sanitation basically went unchecked in this period. Requests for intervention to stem the 'decline of the Maori' also went unheeded. As well as the influence of environmental ideologies, the political motivations of the Liberal Party were also a restricting factor in the initiation of new policy. All these issues are considered collectively in this chapter to demonstrate that health policy in the late nineteenth century was influenced by a number of complex and interconnected social, political, cultural and medical ideologies.

The public health system at the turn of the century operated on the basis of legislation enacted in 1876. The fact that this legislation existed without major change for nearly fifteen years shows that the lack of health policy was not a new characteristic, rather it was a theme which characterised New Zealand's early colonial history. The Public Health Act 1876 was enacted to deal with problems which arose under the 1872 Act as well as the abolition of provincial government in 1876. One of the fundamental changes in this new Act was the appointment of a Central Board of Health, presided over by the Colonial Secretary, which would have between four and seven members appointed by the Governor. The Board was to oversee the work of local boards of health, who were to submit reports to it on the sanitary conditions of their district. The local boards of health also had the power to appoint officers to carry out their sanitary duties in the district.¹ Like much of New Zealand's legislation, the 1876 Act was based on a British act which had been passed a year earlier. There was little debate in either the House of Representatives or the Legislative Council, although brief concerns were raised by one member about the lack of power available to compel local authorities to undertake their public health duties, and another was concerned about the centralising nature of the Bill.²

It has generally been agreed that the Central Board of Health was a completely ineffective body, from the time of its institution until its disestablishment in 1900; it met only sporadically and generally in times of potential crisis.³ An article in the *Press* termed it a 'man-of-war without guns'.⁴ One of the central tenets of public health in the period prior to 1900 was a reliance on local authorities for the implementation of policy. The Central Board of Health failed to compel local boards of health to undertake their sanitary responsibilities and in consequence very little work was undertaken in the 24 years of its existence.⁵ This failure may be blamed, to

¹ Public Health Act 1876, *New Zealand Statutes (NZS)*, 1876, pp.380-382.

² *New Zealand Parliamentary Debates (NZPD)*, 21(1876), p.499 (G.M. Waterhouse), p.501 (J.A.R. Menzies).

³ The Central Board of Health's ineffectiveness has been highlighted by both Derek A. Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Public Health*, Wellington: Victoria University Press, p.34, and F.S. Maclean, *Challenge for Health, A History of Public Health in New Zealand*, Wellington: R.E. Owen, p.119.

⁴ 'Proposed Public Health Department', *Press*, 5 July 1900, p.4.

⁵ Attempts to locate the Central Board of Health minute book failed, despite considerable assistance from archivists at National Archives where it is supposedly held. The last known reference to the minute book was in Michael Hannah, 'The Plague Scare, 1900. Factors relating to the establishment of the Department of Public Health', BA(Hons) Essay, University of Otago, 1975.

a certain extent, on the nature of the Public Health Act 1876.⁶ The Act was permissive in nature, although the Central Board of Health and local boards of health were not short of powers, there was no compulsion to exercise these powers. For example, the provisions of the Act were qualified with 'may, if it thinks fit', 'may, from time to time'.⁷ In the debates over the Public Health Act 1900, Joseph Ward, the first Minister of Health, argued that 'in any reform of the health laws of the country, it ought to be one of the first essentials that it should remove from the local public bodies the duty now devolving upon them, which is never, or hardly ever, carried out'.⁸ Some local boards of health met sporadically throughout the 1880s and others through the 1890s but there was no continuous program of health policy or sanitary reform. The Auckland Local Board of Health's minute book showed a number of brief meetings were held throughout the 1880s but from 1888 to March 1900 the Board failed to record any minutes of meetings held, suggesting a total disinterest in public health.⁹

There has not been, as yet, a comprehensive and adequate answer to this question: why was there such a complete disinterest in matters relating to public health? F.S. Maclean has argued that 'Some of the blame for this deplorable inactivity must rest with the successive governments of that period'. However, we are not provided with any further analysis.¹⁰ Derek A. Dow, in *Safeguarding the Public Health*, has suggested that attempts to prevent infectious disease foundered on the belief that 'New Zealand was a peculiarly healthy country'.¹¹ Dow provided a few early examples of this belief from the 1860s but did not discuss further the reasons why this belief was held or the long-term effects it might have had on policy.

The inaction over public health is particularly interesting in the context of the extensive and far reaching scientific discoveries in the latter part of the nineteenth century. The discovery of the 'germ theory' of disease fundamentally changed public health. Through the work of Louis Pasteur and Robert Koch in the late 1870s and

⁶ The *New Zealand Medical Journal (NZMJ)* published an article on the failure of the Public Health Act 1876: Dr. Ogston, 'Sanitary Affairs in New Zealand', *NZMJ*, Series 1, 3 (1890), pp.238-244.

⁷ Public Health Act 1876, *NZS*, 1876, pp.377-417.

⁸ *NZPD*, 113 (1900), p.191.

⁹ YBAD 4483 1a Local Board of Health Minute Book, Archives New Zealand, Auckland.

¹⁰ Maclean, p.120.

¹¹ Dow, *Safeguarding the Public Health*, p.15.

1880s, it was shown that a number of infectious diseases were caused by the presence of a particular bacillus.¹² This was a significant shift from previous theories based around the idea of 'miasma': that is, the transmission of diseases through bad smells. The debate on the Public Health Bill in 1876 displayed the prevalence of miasmatic views of disease: George Lumsden raised concerns about 'the filthy drains that were running under people's noses'.¹³ However, numerous articles in the *NZMJ* from the late 1880s showed that New Zealand doctors were aware of the new medical developments and many supported them. Other doctors were more sceptical. The editor of the *NZMJ*, in a discussion of the germ theory of influenza, argued that:

It does not follow in the matter of the bacillus theory the new generation is right and the old generation wrong. It takes but a few years' experience of medicine to realise the fact that an attitude of good, honest doubt is the safest to assume with regard to alleged new discoveries as to the origin and cure of disease; that when a theory looks most perfect we should then be most specially on our guard against fallacies.¹⁴

The editor went on to give the example of the discovery of the plasmodium malariae, which upset the bacillus theory of malaria. The significance of contemporary medical discoveries was not always recognised because there was not yet understanding of their wide-reaching and long-term effects. Even if the germ theory of infection was accepted and sometimes promoted by medical practitioners, for changes to eventuate in public health, both the public and the government needed to be in touch with these developments. Despite comments in a *Press* editorial of 1891 that, 'It is one of the most hopeful signs of the times to observe the growing importance that is being paid to medical and sanitary science. Without attention to these important subjects civilisation itself would prove a huge blunder...',¹⁵ there seemed to be little public debate in the newspapers and in the House of Representatives on issues of public health. By the late 1890s, however, the government did establish a bacteriological laboratory which suggested recognition of the importance of such methods. It was likely that the disinterest shown by local and central authorities in matters of public health meant that new developments in medical science were given little regard.

Public health work which was undertaken was directed around quarantine, sanitation and vaccination. The bacteriological revolution did not change the

¹² Roy Porter, 'Medical Science', in *The Cambridge Illustrated History of Medicine*, Roy Porter (ed.), Cambridge: Cambridge University Press, 1996, pp.184-185.

¹³ *NZPD*, 23 (1876), p.23.

¹⁴ L.E. Barnett, 'The Asclepiad and the Germ Theory of Influenza', *NZMJ*, Series 1, 9 (1896), p.27.

¹⁵ 'Editorial', *Press*, 21 January 1891, p.4.

direction of these policies. Quarantine was used as the first line of defence against infection and the provisions of the Public Health Act 1876 provided for quarantine stations at major ports and allowed the quarantine of vessels and persons from infected ports.¹⁶ Maclean commented that the period 1876-1900 was 'a relatively quiet one, so far as quarantine was concerned'.¹⁷ From 1890 to 1900 there were no serious infectious disease threats from abroad and it is likely that this added to the apathy of both central and local government in the area of public health.

Even before the microbiology revolution of the 1880s, sanitation was seen as a key determinant in the spread of infectious disease. Theories of miasma insisted disease spread from rubbish and dirt while bacteriology held that disease was spread by bacteria which thrived in unclean environments.¹⁸ Various drainage schemes and attempts to clean up cities did occur in the years prior to 1900. In 1891, the *Times* reported that in the previous year Christchurch 'was the healthiest of the four largest towns in New Zealand, and we doubt if there is another town of the same size in the whole world which can show such a light bill of mortality. Probably no more striking proof of the value of a good drainage system could be adduced'.¹⁹ Certainly there was an appreciation of the advantages of better sanitary conditions but, in general, little work was done to facilitate their improvement. Accepted understandings about the relationship between sanitation and infectious diseases were not, even by the late nineteenth century, entirely consistent with medical perspectives. This was reflected in debates in the Legislative Council where G. Jones argued that:

The principal reason why we have not small-pox nowadays as we used to have it in olden times, before the days of Jenner, is that we are more cleanly in our habits, that our sanitary arrangements are more perfect, and that we are more careful how we live. That is the reason. It is well known that small-pox, like many other zymotic diseases, is the product of filth.²⁰

¹⁶ For a discussion of nineteenth century quarantine measures in New Zealand see H.D. Morrison, 'The Keeper of Paradise: Quarantine as a Measure of Communicable Disease Control in Late Nineteenth Century New Zealand', BA(Hons) Essay, University of Otago, 1981.

¹⁷ Maclean, p.50.

¹⁸ Pamela Wood's PhD thesis discussed the significance of 'dirt' in nineteenth century Dunedin. Wood argues that dirt was viewed as representative of a settlement's progress. Pamela J. Wood, 'Constructing Colonial Dirt: A Cultural History of Dirt in the Nineteenth Century Colonial Settlement of Dunedin, New Zealand', PhD Thesis, University Of Otago, 1997.

¹⁹ 'Topics of the Day', *Press*, 2 March 1891, p.4.

²⁰ *NZPD*, 102 (1898), p.57.

Vaccination was the area in which there were the most concerted public debates and in which there was more intervention by the medical profession. A Vaccination Act was passed in 1863 establishing compulsory vaccination and although in 1871 the compulsion to vaccinate infants was lifted, it was re-established in 1872 and remained in place until 1920. Vaccination was given importance because of the fear of smallpox. Alison S. Day, in her thesis on the 1913 smallpox epidemic, argued that the fear of smallpox 'shaped government public health policy of the nineteenth century by placing emphasis on quarantine, isolation and compulsory vaccination'.²¹ Despite this, there were often vocal opponents to vaccination, particularly when compulsory. Many of these opponents were concerned with the arm-to-arm method of vaccination which involved the removing of lymph from a recently vaccinated patient. It was suggested that this method actually spread infectious diseases and even caused diseases such as leprosy, syphilis and cancer.²² The *Parliamentary Debates* of the 1880s and 1890s were scattered with speeches about vaccination. It was consistently an issue where there was no consensus of opinion. Statistics were often provided by the pro-vaccinationists to show that 'the evidence proved that vaccination had been a good preventive against small-pox...the benefit of vaccination far exceeded the risk of injury'.²³ However, others argued that statistics from London showed that as vaccination increased so did the deaths from smallpox.²⁴ The anti-vaccination campaigns of the nineteenth century differed somewhat from those of the twentieth century, the main opposition being to the dangers of vaccination. The twentieth century campaigns, while stressing the dangers, also opposed compulsory vaccination on the grounds of individual freedom.

Despite considerable opposition in the House of Representatives, returns from the 1890s show a relatively high level of child vaccination, particularly when compared with later years. In the years 1890-1894 the average proportion of vaccinations of children under 14 years of age was 49.60 per 100.²⁵ According to Maclean, vaccination reached as many as two thirds of registered births in 1896-

²¹ Alison S. Day, 'The Maori Malady: the 1913 Smallpox Epidemic and its 19th Century Background', MA Thesis in History, University of Auckland, 1998, p.3.

²² *NZPD*, 43 (1882), p.596 (T. Fraser), *NZPD*, 44 (1883), pp.666-668 (H. Dodson).

²³ *NZPD*, 43 (1882), p.341 (T. Dick).

²⁴ *NZPD*, 44 (1883), pp.665-666 (Dodson).

²⁵ *NZPD*, 95 (1896), p.486 (F.R. Flatman).

1898.²⁶ There has been no obvious explanation for such high figures, whereas other peaks in vaccination can be tied to smallpox scares. It does suggest that there was some change in policy. Perhaps the Registrar of Births began carrying out his obligations under the Public Health Act, which required a notice of vaccination to be sent to every registered birth.

Vaccination was also promoted among Maori, particularly from the 1880s. It was thought that if there were ever an outbreak of smallpox this would have a devastating impact on Maori communities. Mr H.K. Taiaroa, MP for Southern Maori, said that 'If small-pox should come to New Zealand, the Natives, on account of being ignorant of the disease, would not take proper precautions, and a great number of them would die in consequence, particularly as so few of them have been vaccinated'.²⁷ When Richard Seddon, Prime Minister, was questioned on the subject of Maori vaccination he maintained that 'the Government was most desirous of extending to the Maori race the privileges given to Europeans'.²⁸ Debates about vaccination in Maori communities in the early twentieth century show that in general most Maori were eager to be vaccinated and it is likely that this was also the case in the late nineteenth century.

The prevalence of the idea that New Zealand was a healthy country becomes obvious rather quickly in any concerted study of primary sources relating to health from the nineteenth and early twentieth centuries. Despite this body of evidence the healthy country mythology has received little attention in work on the history of health in New Zealand. Dow has drawn attention to this claim with reference to a booklet published by the Department of Health: *New Zealand – A Healthy Country: Striking Facts and Records: Survey of Activities of the Department of Health*. New Zealand's healthy state was attributed to the work of the Department.²⁹ Dow also provided a small number of examples of this notion from the 1860s but does not dwell on either the reasons for this idea or the possible effects it may have had.³⁰ The title of a volume of essays edited by Linda Bryder is *A Healthy Country, Essays on the*

²⁶ Maclean, p.244.

²⁷ NZPD, 48 (1884), p.229.

²⁸ NZPD, 83 (1894), p.585.

²⁹ Dow, *Safeguarding the Public Health*, p.9.

³⁰ Dow, *Safeguarding the Public Health*, p.18.

Social History of Medicine in New Zealand, and she raises it as a common theme among some of the papers.³¹ W.H. Oliver, in an article on social policy in the Liberal period, maintained that, compared with Britain, there has been little concern for public health and a possible reason for this was the belief in the advantages of New Zealand's colonial conditions.³² Although the 'healthy country' myth is raised from time to time, there is scope for a more thorough description, analysis and consideration of the effect this idea had on different governments and their policies.

In the nineteenth century at least, New Zealand's healthy state was attributed not to any intervention of state agencies, but to a number of climatic and demographic factors. The idea that New Zealand was inherently healthy probably derived from the first impressions of Maori which were recorded by European explorers. Raeburn Lange's first chapter of *May the People Live*, 'Strong made healthy looking people', provides a characteristic example of such impressions.³³ Although some of this 'healthy nature' was attributed to inherent qualities of Maori, it is likely that observers looked for other possible factors which could 'breed' such a fit healthy race. New Zealand's climatic conditions were one of the most obvious. How else could an 'uncivilised' race have such desirable physical characteristics? This view characterised impressions of Maori and was still firmly entrenched in the early twentieth century when the President of the New Zealand Branch of the *British Medical Association (BMA)* argued: 'As in native races Maoriland evolved the highest type of savage, so enthusiasts hope that it will develop the highest type of the Anglo-Saxon variety'.³⁴

The first impressions of Maori by early settlers emphasised the 'savage', 'war-like' aspects of Maori culture. Images of Maori often focused on Maori as warriors.³⁵ It is, therefore, easy to see how these images also assumed Maori were a strong,

³¹ Linda Bryder (ed.), *A Healthy Country, Essays on the Social History of Medicine in New Zealand*, Wellington: Bridget Williams Books, 1991, p.4.

³² W.H. Oliver, 'Social Policy in the Liberal Period', *NZJH*, 13:1 (1979), p.32.

³³ According to Lange the chapter title is a phrase from the journal of William Bayly, astronomer on the *Adventure* during Cook's second visit to New Zealand (entry for 12 April 1773): Robert W. McNab (ed), *Historical Records of New Zealand*, vol 2, Wellington 1914, 204, in Lange, *May the People Live, A History of Maori Health Development 1900-1920*, Auckland: Auckland University Press, pp.1, 285.

³⁴ 'President's Address', *NZMJ*, Series 2, 8:33 (1910), p.2.

³⁵ For a comprehensive discussion of Maori in European art see: Leonard Bell, *Colonial Constructs, European Images of Maori 1840-1914*, Auckland: Auckland University Press, 1992.

healthy people. Even in the 1950s, the standard text on New Zealand public health presented such a view. Maclean wrote 'The Maori population before the arrival of Europeans is estimated to have been 250,000, and they were a warlike, vigorous, and healthy race'.³⁶ An article in the *NZMJ* in 1890, described Maori men as 'tall, upright, well developed' and referred to Abel Tasman's comments that Maori were of 'gigantic stature'.³⁷ Constant inter-tribal warfare was thought to have kept Maori at the peak of physical fitness. This was aided by New Zealand's climate, which was thought to produce good health. Late nineteenth century views of Maori health stressed natural or environmental factors: good Maori health was through no major effort of their own. Nature was the determinant of their good health; Maori were viewed as responding to the environment like passive subjects.

The advantageous nature of New Zealand's climate was promoted as a 'popular' idea as well as by the medical profession and politicians. The climate was believed to promote good health; there were high sunshine hours, a moderate rainfall and plenty of fresh air. A Department of Tourist and Health Resorts pamphlet said that the advantageous characteristics of New Zealand's climate were breeziness and sunshine, and described New Zealand as having 'an air which exhilarates, sharpens the appetite and the zest for living'.³⁸ In a debate on the Public Health Bill, F. Lawry said that New Zealand had 'the purest and most healthy population in the world, and we have that in spite of legislation....We have in this country every natural condition to bring about good health and longevity'.³⁹ Not only was New Zealand promoted as a healthy country, it was regularly promoted as the healthiest country. Dr. W.E. Collins, president of the New Zealand Branch of the *BMA* maintained that 'We have the good fortune to live in a country the physical condition and climate of which conduces to the maintenance of a high standard of health and strength'.⁴⁰ The lack of overcrowding and wide-open spaces were seen as further factors to New Zealand's advantage. Collins argued, in a paper given in London, that for a phthisical patient 'in an overcrowded country he is much more likely to take in by the lungs or by the

³⁶ Maclean, p.189.

³⁷ Thos W. Bell, 'Medical Notes on New Zealand', *NZMJ*, Series 1, 3 (1890), p.76.

³⁸ A.S. Wohlmann, *The Mineral Waters and Health Resorts of New Zealand*, Wellington: Department of Tourism and Health Resorts, 1904-1905, p.2.

³⁹ *NZPD*, 113 (1900), p.221.

⁴⁰ 'Presidential Address by Dr. W.E. Collins at Annual Meeting of NZ Branch of BMA', *NZMJ*, Series 2, 3:11 (1904), p.222.

intestinal canal, fresh quantities of poison, than he would in a country where there is a small population and plenty of fresh air'.⁴¹

It was often stressed that New Zealand's healthy state lay entirely with the climate and bore no relationship to government initiatives. This is shown in the arguments of W.W. Collins, a Member of Parliament. He told the House,

I think I might truthfully say that this colony is probably one of the healthiest spots under the sun; but that fact is not due to any wisdom exercised in the past by the Government of the colony. The health which we enjoy, and which we have enjoyed for so many years, is rather due to the fact of the natural advantages we enjoy than to anything which the legislature has done.⁴²

A key theme of nineteenth century perspectives of health was the emphasis on environmental causes for both good health and illness. In comparison to the twentieth century, there were fewer possibilities for public or state involvement in improving health standards. The prevailing view was that environment was the fundamental causal factor.

Statements about the healthy state of New Zealand were not entirely fictional; statistical evidence was regularly used for verification. At a meeting of the Hunterian Society in London, a paper was read about New Zealand, which argued that the death-rate was 10.23 for every 1,000 people, which compared very favourably with England's rate of 19.00 per 1,000.⁴³ One speaker told those present that 'the Colony is a decidedly healthy place to settle in; and I submit that, indirectly, the death-rate might be brought down lower still if the New Zealand Government, which is always alive to the interests of the masses, were to introduce certain new ideas'.⁴⁴ This was an ongoing theme in comments about New Zealand as a healthy nation. The country's health was accepted but it was often remarked that there was still room for improvement. In a debate in the House of Representatives, C.H. Mills commented that 'as we have grown up in a very genial climate we have become somewhat careless in sanitary matters'.⁴⁵ Perhaps this room for improvement was tied in with

⁴¹ William E. Collins, 'A Paper on New Zealand read before the Hunterian Society of St. George's Hospital, November 7th 1895, London, p.10.

⁴² *NZPD*, 113 (1900), p.205.

⁴³ The Hunterian Society was established in London in 1819 and still exists today. Its motto is 'for the cultivation and promotion of the science and practice of medicine.

⁴⁴ Collins, 'A Paper on New Zealand' p.2.

⁴⁵ *NZPD*, 113 (1900), p.204.

the growing concerns about degeneration raised in the twentieth century, which will be discussed in Chapter Five.

Entrenched views about New Zealand's healthy status were tied in with New Zealand's relationship with Britain. New Zealand was seen as a place where emigrants could come to escape the evils of the old world, such as high rates of disease and death. As Miles Fairburn has argued, New Zealand was portrayed in British literature as an 'ideal society'.⁴⁶ It is interesting to trace the development of the healthy country myth from the initial impressions about Maori health and the apparent climatic advantages of New Zealand to the use of both these views as a marketing tool to prospective emigrants.

The natural advantages of New Zealand led to its promotion as a health resort for those suffering from frequent illnesses. Thos W. Bell, in an extract from his Masters thesis published in the *NZMJ*, argued that 'besides a fine climate, New Zealand possesses other advantages, entitling it to rank as one of the most important health resorts in the world'. Thermal springs were thought to be advantageous to those suffering from a wide range of diseases because the 'hot and cold mineral springs, (are) exceedingly valuable in the treatment of disease'.⁴⁷ Thermal springs, as well as having a tourist function, were promoted in many pamphlets as having medicinal benefits to those with specific ailments, such as skin diseases, as well as for 'invalids' and 'convalescents'.⁴⁸ The Department of Tourist and Health Resorts said that 'in the great majority of our recognised health resorts mineral-water treatment is looked upon as the chief curative agent'.⁴⁹ Both bathing in the mineral water and drinking it were thought to be beneficial.

Medical professionals often suggested that certain categories of people were most likely to benefit from New Zealand's climate; William E. Collins' paper to the Hunterian Society provided a list of the types of people likely to be advantaged. This list included those who were 'delicate', made a slow recovery from disease,

⁴⁶ Miles Fairburn, *The Ideal Society and its Enemies, the Foundations of Modern New Zealand Society, 1850-1900*, Auckland: Auckland University Press, 1989, p.20

⁴⁷ T.W. Bell, 'Medical Notes on New Zealand, *NZMJ*, Series 1, 3 (1890), p.71.

⁴⁸ *The Health and Pleasure Resorts of New Zealand*, n.d. p.17, 20, Wohlmann, p.1

⁴⁹ Wohlmann, p.4.

consumptives and those with bronchial diseases.⁵⁰ Not surprisingly, concerns were raised over the number of sick people coming to New Zealand. In a debate over the Hospitals and Charitable Institutions Bill in 1885, Dr. A.K. Newman argued that 'one of the drawbacks which the colony will always suffer under will be its reputation for having a good climate....The consequence of that is, large numbers of people come out here by direct steamers and otherwise in shoals, and many of them will be burdens on the colony'.⁵¹ Such people were also undesirable in a new colony establishing itself as a 'healthy society' without the ills of the 'old world'. Concerns over the number of sick immigrants easily led to concerns about degeneration within the population. Despite concerns about the cost of sick emigrants and the effect on the health of the nation the Chief Health Officer argued that: 'Viewed from the point of international equity, it seems to me it would be as unfair as it would be unchristian to deny any fellow-creatures the privilege of sharing the beneficent effect of our climate'.⁵²

It is difficult to measure the extent to which ideas about the healthy state of New Zealand can be connected with the disinterest in public health matters in the period 1890-1900. Politicians readily accepted that New Zealand was an inherently healthy country because of its climate and this is likely to have undermined any arguments that there needed to be more government intervention in public health matters. Although politicians may have used the advantages of New Zealand's climate as justification for a hands-off stance, the medical profession did not see it this way. Throughout the late nineteenth century there were increasing calls from both the medical profession and the public, especially in newspapers, for changes to the health system.⁵³

In contrast to the healthy country philosophy that circulated regarding Pakeha health in New Zealand, Maori health was increasingly questioned. Throughout the nineteenth and into the early twentieth centuries concerns were raised about the future

⁵⁰ Collins, pp.11-13.

⁵¹ *NZPD*, 51 (1885), p.606.

⁵² Report of the Department of Public Health, *AJHR*, 1901, H-31, p.13.

⁵³ See for example: Dr. Ogston, 'Sanitary Affairs in New Zealand', *NZMJ*, Series 1, 3 (1890), pp.238-242, 'Canterbury Branch, New Zealand Medical Association, President's Retiring Address,' *NZMJ*, Series 1, 4 (1890), p.52, W.E. Hacon, 'The Sanitary Defence of New Zealand' *NZMJ*, Series 1, 5 (1892), pp.153-156, 'The Plague', *Press*, 30 December 1899, p.7.

of Maori both numerically and culturally. Some in the medical profession argued that any numerical decrease in Maori 'was in existence before Europeans settled in New Zealand'.⁵⁴ However, the more prevalent view was that Maori were declining, in one way or another, because of European settlement. This view was not unique to New Zealand. Throughout the Pacific Islands many explorers, missionaries and early visitors subscribed to a 'fatal impact' theory where the noble savage and their environment were seen to be irrevocably changed through contact with Europeans. As well as the effects of disease and war, the 'native' populations were unable to compete with the new, more advanced civilisations.⁵⁵

The size of the Maori population at the time of first contact has been debated in recent years and this thesis does not attempt to come to a conclusion about the size of Maori population at contact or the exact rate of decline.⁵⁶ What is critical, however, is that Maori were viewed by a significant portion of the settler population as a race in decline and many believed that Maori would die out altogether. Official census results showed that Maori population reached its lowest point in 1896, with a total of 39,805.⁵⁷ Even before this time, however, concerns were raised about the decrease in the Maori population. Thomas Lambert, the Native Medical Dispenser in Wairoa, reported in 1885 that 'careful observation of the Natives during the last nine years leads me to conclude that the mortality rate is much higher than has ever been suspected, and it is rapidly increasing'.⁵⁸ Similar comments were made in Parliament. For example, in a debate on the need for medical assistance to various Maori communities, Newman said 'the Maoris in that district were dying out in a shockingly-rapid manner'.⁵⁹ The notion of Maori dying out was not just limited to numerical extinction. It was also argued that Maori would be culturally absorbed by a more civilised and powerful race, Europeans. Maui Pomare argued in a Department

⁵⁴ Thos W. Bell, 'Medical Notes on New Zealand', *NZMJ*, Series 1, 3 (1890), p.145.

⁵⁵ For a discussion of these ideas in terms of Pacific historiography see: K.R. Howe, 'The Fate of the 'Savage' in Pacific Historiography', *NZJH*, 11:2 (1977), pp.137-154.

⁵⁶ The most extensive analysis of Maori population figures has been given by Ian Pool, *Te Iwi Maori, A New Zealand Population, Past, Present and Projected*, Auckland: Auckland University Press, 1992.

⁵⁷ Census of the Maori Population, *AJHR*, 1896, H.31B. The census which were taken were far from accurate, this has been discussed in Pool, *Te Iwi Maori*, pp.65-66.

⁵⁸ Reports From Native Medical Officers, *AJHR*, 1885, G.2A, p.8.

⁵⁹ *NZPD*, 56 (1886), p.105.

of Public Health report that 'there is no hope for the Maori but in ultimate absorption by the Pakeha'.⁶⁰

There are numerous debates about Maori decline which emphasise the impact that destructive European habits had on Maori. Bell, in the *NZMJ* commented that 'European customs and diseases, are also, without doubt, killing many. Excess alcohol and tobacco shorten their lives considerably'.⁶¹ Maori were thought to be in a 'transitional phase', in which they lived a life consisting of both negative Maori and Pakeha customs.⁶² A census enumerator wrote that: 'I feel that as a people they can have no hope of permanency unless, having cast aside their old habits and modes of life, they adopt those of their European neighbours in their entirety, as at present, mixed up with the new habits and ideas which they have acquired from us, they still retain some of the very worst of their own old customs'.⁶³ Some commentators even went as far as saying: 'The physical condition of those Natives who adhere to their old mode of living is, if not generally very good, much better than amongst the Natives who live near white settlements. The latter fall into the vices of the Europeans, but neglect to imitate them in taking means to preserve their health'.⁶⁴ Maori were thought by some to be better suited to traditional Maori modes of living. That is, when they were on elevated pa sites with good drainage and fresh air: 'The Maori of the present day does not possess the vigorous constitution of his ancestors. In former times they lived on the tops of the hills and the high ground, were clad with mats that protected them from the weather; whereas now they live...in low lying places, often damp and wet, and...the natural result is fever and pulmonary complaints'.⁶⁵

Arguments over Maori degeneration as a race also came through in the debates about Maori survival. Degeneration or decay may be seen, in this context, in isolation from concerns which were raised about European degeneration in the twentieth century and will be discussed in Chapter Five. Concerns about Maori degeneration were not stimulated by British concerns; rather they were a part of the growing

⁶⁰ Report of the Department of Public Health, *AJHR*, 1906, H.31, p.67.

⁶¹ Thos W. Bell, 'Medical Notes on New Zealand', *NZMJ*, Series 1, 3 (1890), p.145.

⁶² Report of the Department of Public Health, *AJHR*, 1906, H.31, p.74.

⁶³ Census of the Maori Population, *AJHR*, 1886, G.12, p.3.

⁶⁴ Reports of Officers in Native District, *AJHR*, 1885, G.2, p.8.

⁶⁵ Census of the Maori Population, *AJHR*, 1891, G.2, p.5.

anxiety about the survival of the Maori race. Various reasons were given for the supposed degeneration of Maori. Often this was put down to laziness. Maori were not always in paid work and this together with communal living was thought to have had a detrimental effect: 'The communism of to-day means indolence, sloth, decay of racial vigour, the crushing of individual effort, and spreading of introduced infectious diseases, and the many evils that are petrifying the Maori and preventing his advance'.⁶⁶ Government officials thought that Maori did not have to work as hard as previously, and the image of Maori as a decaying warrior was common. The Resident Magistrate in Hokianga commented that 'The present generation does not appear to be nearly so healthy or robust as that which is passing away. This may, I am inclined to think, be owing to the fact that the Natives of to-day are not as provident or industrious as those of former times'.⁶⁷ A similar remark was made by the Medical Dispenser in Wairoa: 'In fact the majority of the younger Natives...have quite lost the grand physique of the old men and women who may still be met with, full of vigour, and disease-resisting capabilities'.⁶⁸

Although the view of Maori as a declining or dying race was present in the words of government officials and politicians, the extent of this view in wider Pakeha society was unclear. Certainly it would have filtered through and been known throughout the wider society, but there is little evidence of public debate in newspapers, one of the best sources for contemporary views. Maori health was not a topic which seemed to register particularly high on the Pakeha agenda, but perhaps this was because of the isolation of many Maori communities from the growing towns and cities in the late nineteenth century. There is some indication that Maori were themselves concerned. The Resident Magistrate in Mangonui reported in 1885 that some viewed themselves as a dying race:

They have been much disposed in the past to regard the great mortality from fever which has occurred, in a superstitious manner, and to conclude that they were a doomed people. I have endeavoured earnestly, upon all possible occasions, to point out to them the utter foolishness and recklessness of such reasoning, and have urged that in physique and general healthiness, they are highly favoured.⁶⁹

⁶⁶ Report of the Department of Public Health, *AJHR*, 1906, H.31, p.74.

⁶⁷ Reports of Officers in Native Districts, *AJHR*, 1885, G.2, p.1.

⁶⁸ Reports from Native Medical Officers, *AJHR*, 1885, G.2A, p.8.

⁶⁹ Reports of Officers in Native Districts, *AJHR*, 1885, G.2, pp.2-3.

Some commentators did attempt to challenge the prevailing view of Maori as a dying race; John Ballance commented in Parliament that the 1886 census showed that ‘the decline in the number of the Native race was not nearly so rapid as had been generally anticipated’.⁷⁰ The previous year a Native Medical Officer had written:

comparing the rate of mortality with that of previous years, I consider it less; probably, through the care and attention of those gentlemen who have been kindly supplied by the Government with drugs for the use of the Natives. On the whole, however, with the exception of typhoid fever, there is less disease amongst them than formerly; and this I attribute to their more sober habits and general prosperity.⁷¹

It was commonly believed that Maori were not able to pull themselves from the threat of extinction: the assistance of European medical treatment was essential. Maori health was also viewed in moral terms: sobriety was recognised as a facet of good health. It was interesting that during a time of national depression, this official suggested Maori were seen as in a place of ‘general prosperity’. At the other end of the spectrum some commentators, when faced with statistics which provided evidence for Maori population increase, failed to believe them: ‘The births reported have been slightly in excess of the deaths, but, notwithstanding this, I am inclined to believe that the Native population is slowly, but steadily, on the decrease. Deaths of both adults and infants take place on the gum fields and elsewhere of which no report is made’.⁷² The sub-enumerator in South Wairarapa came to a similar conclusion: ‘The births seem to balance the deaths, but I think it must be admitted that they are steadily decreasing’.⁷³

Education in Pakeha ways of health, along with the assistance of Pakeha medicine, was seen as the only way to counter Maori decline. Newman, in a debate on the necessity of vaccination for Maori, argued that ‘I believe it is inevitable that it [Maori] will disappear; it is questionable whether the Government can prevent this: but they can – and it is our duty as an educated people to see that it is done – delay the process of extinction for a considerable number of years’.⁷⁴ Education was stressed as imperative in countering Maori decline: ‘it is to education chiefly that we must turn as a means for raising the people generally. I do not hold with those who think that, of

⁷⁰ *NZPD*, 54 (1886), p.157.

⁷¹ Reports from Native Medical Officer, *AJHR*, 1885, G.2A, p.1

⁷² Reports of Officers in Native Districts, *AJHR*, 1885, G.2, p.1.

⁷³ Census of the Maori Population, *AJHR*, 1896, H.13B, p.8.

⁷⁴ *NZPD*, 48 (1884), pp.231-232.

necessity, the Maori race is doomed to extinction. I believe that education – physical, mental, and sanitary – rightly applied, will work its salvation’.⁷⁵

Despite the view of Maori as a dying race, there was little government action in the nineteenth century to address Maori ill health. Dow has argued the importance of the government funded Native Medical Officers and disputes comments by Apirana Ngata that prior to 1900 there was no government recognition of the importance of Maori health.⁷⁶ In comparison with the Maori health reforms which occurred in the twentieth century, there was only a limited involvement in Maori health. Ngata probably understated this involvement to the same extent that Dow has overstated it. Although Dow provided statistical analyses to show the doctor to Maori ratio was relatively high, it must be remembered that these were Pakeha doctors dealing with Maori patients. There were immense cultural and communication barriers and the effectiveness and rate of usage of the doctors would have varied depending on both the doctor’s ability and the community’s acceptance. Lange argued that the system was poorly funded and the numbers of doctors fluctuated: ‘Very little money was provided for the subsidies, and so they were thinly spread over the country. Some districts with few Maori had a subsidised doctor, while heavily populated areas did not’.⁷⁷

In the nineteenth century, health work in Maori communities was also carried out through the Native School system. Lange has argued that ‘the most comprehensive Maori health work before 1900 was done by the staff of the Native schools’.⁷⁸ Health education was a key part of the Native School’s curriculum. Inspector-General James Pope saw the education of Maori and the health of Maori going hand in hand. Teachers were expected to distribute medicines and assist with nursing in times of epidemics. Health was promoted in an educational context through the Native school’s system. This focus seems to have been largely influenced

⁷⁵ J. Thompson (Headmaster of Te Aute College), ‘A Present-Day View of the Maori Race’, *Church Missionary Intelligencer*, London, March 1892, in Report of Native Schools, *AJHR*, 1892, E.2, p.4.

⁷⁶ Derek Dow, ‘“Specially Suitable Men?”’, *Subsidized Medical Services for Maori 1840-1940*, *NZJH*, 32:2 (1998), p.164-166.

⁷⁷ Lange, *May the People Live*, p.73.

⁷⁸ *ibid.* p.75.

by Pope, in his role as superintendent. Pope's influence, as a civil servant, on the policy of the Department was a common theme of the Liberal era.⁷⁹

Pope produced a booklet for use in Native Schools which encapsulates a number of prominent views about the state of Maori and possible ways to reverse the perceived decline.⁸⁰ The book, *Health for the Maori: A Manual for Use in Native Schools*, was promoted as a way to counter Maori decline through health education.⁸¹ The object of the book was stated: 'to impress upon the minds of the rising generation of Maoris truths that are of the highest importance to their race, and which they must learn to respect if they are to escape extermination'.⁸² The book was essentially an education manual to share Pakeha knowledge with their less fortunate Maori neighbours. It was divided into two parts, the 'disease' and the 'remedy'. Pakeha knowledge had helped them conquer the disease but Maori were still in the 'pre-conquest' phase. Pope wrote of the importance of pure air, clean water, healthy food, proper clothing, regular work, European modes of medical treatment, and education. Fresh air, 'is one of the very best things for preserving health...fresh air very often destroys or removes things that cause bad smells and that hurt the health'.⁸³ Miasmatic theories of disease were still the norm in the 1880s; more recent medical developments had yet to filter through to those outside the medical profession. European medical practices were promoted over traditional Maori *tohunga* who, it was thought, could do a great deal of harm. The importance of work, a common theme in articles designed to promote the 'reform' of Maori, and the good health which would result were also significant. The main characteristic of the Maori health policies in the late nineteenth century is that these were Pakeha responses, operating through Pakeha frameworks and although neither widespread nor very well funded, they were no worse (and probably in some cases somewhat better) than the treatments afforded to Pakeha settlers.

⁷⁹ For further discussion of the relationship between civil servants and politicians see chapter three.

⁸⁰ For a discussion of health in the Native Schools see: Katharine Sophia Goodfellow, 'Health for the Maori? Health and the Maori Village School, 1890-1940', Research Essay, University of Auckland, 1991.

⁸¹ James H. Pope, *Health for the Maori: A Manual for Use in Native Schools*, Wellington: Government Printer, 1884.

⁸² *ibid.*, (Preface).

⁸³ *ibid.*, p.44.

Although Pakeha and Maori health may be viewed in comparative isolation, they both raise a number of common themes. Environmental influences on health were a recurrent theme: health being determined, to an extent, by environmental factors such as climate. In an article which stressed New Zealand's environmental advantages Bell argued: 'Taking, then, New Zealand as a whole, considering its advantages, it is the healthiest country in the world'.⁸⁴ Humans were viewed as relatively passive subjects, health policies able to do little to assist those with bad health. There was also, in the nineteenth century, a distinct lack of health policy for both Maori and Pakeha. This was particularly significant in the case of Maori health which was increasingly in doubt as the population declined. It is possible, though there is no evidence, that the increasing concern with Pakeha health in the early stages of the twentieth century was stimulated, to an extent, by the concerns raised about Maori health in the nineteenth century. Maori health did help to bring health issues onto the public agenda and although little was done at the time, Maori health issues were increasingly publicised.

Along with the role that medical issues and debates played in determining health policy, the political motivations of the government were also a significant factor. The Liberal Party has generally been seen as a political movement for reform, particularly in their first decade in government. In the context of public health, in this decade, there is simply insufficient evidence to support this assertion. In the 1890s the Liberals neither introduced nor passed any significant legislation relating to public health. It was likely that the 'healthy country' myth played a role, but it is also useful to consider Liberal politics in the broader policy-making context.

It must be noted first that there was some limited concern about sanitation, quarantine and vaccination. Much of this was related to the growing population in urban areas. Concerns were raised about the insanitary state of some urban centres and the importance of quarantine as a means to keep some infectious diseases from entering New Zealand. The urban population in New Zealand grew rapidly in the second half of the nineteenth and twentieth centuries. Auckland City and suburbs

⁸⁴ Thos W. Bell, 'Medical Notes on New Zealand', *NZMJ*, Series 1, 3 (1890), p.75. For other examples of New Zealand's favourable environment see: *NZPD*, 51 (1885), p.606 (Newman), *NZPD*, 113 (1900), p.221 (Lawry).

grew from a population of 10,206 in 1861 to 57,616 in 1896.⁸⁵ Throughout New Zealand urban populations doubled between 1891 and 1921.⁸⁶ The Liberal Party received relatively high support in the towns and cities and as David Hamer has noted 'The more urban a community was, the most likely it was to vote Liberal [sic]'.⁸⁷ In consequence, it would seem likely that concerns about sanitation and quarantine in the centres would have had an influence on the Liberals' policy. However, the Liberal Party also gained increasing support in the country and it is unlikely that their rural constituents would support public health measures which only benefited those in urban areas. This may have been one of the many factors which influenced the Liberals' apathy regarding public health in this period. Despite any possible electoral pressure, health issues basically went unnoticed in the first decade of the Liberal reign. The status quo was maintained, because the Public Health Act 1876, which had been in place for 14 years, was left virtually unchanged in the Liberal Government's first decade in power. In this period the Liberals certainly did not live up to their reforming reputation regarding public health.

Historians have debated in some detail what drove the Liberals. Some have argued that they were driven by ideology and others have suggested the ad hoc nature of their policy was essentially in response to particular events. Sinclair emphasised the ideological attempts in the Liberals' policy, writing 'their legislative acts were conscious attempts to apply, as far as they thought possible or desirable, certain political theories'.⁸⁸ In contrast, Oliver has called Liberal reform, 'intelligent improvisation to meet the demands of the moment'.⁸⁹ It might be argued that the establishment of the Department of Public Health in 1900 was such an example and this suggestion will be developed further in Chapter Four. Oliver's suggestion that the Liberals' policy was made in response to events is also valid in the period from 1890 to 1900, as there were no significant public health demands. Although there

⁸⁵ 'Colonial Auckland, Boom and Bust, 1850s to 1890s', *New Zealand Historical Atlas*, Malcolm McKinnon (ed.), Bateman: Auckland, 1997, plate 57.

⁸⁶ 'The Urban System, Cities, Towns and the Links Between Them, 1891-1961', *New Zealand Historical Atlas*, plate 65.

⁸⁷ David Hamer, *The New Zealand Liberals, the Years of Power, 1891-1912*, Auckland: Auckland University Press, 1988, p.150.

⁸⁸ Keith Sinclair, 'The Liberal Party's Legislation, 1891-1898', *Ends and Means in New Zealand Politics*, Robert Chapman (ed.), Auckland: Auckland University Press, 1961, p.11.

⁸⁹ W.H Oliver, *The Story of New Zealand*, London: Faber and Faber, 1960, p.147.

were sporadic outbreaks of infectious disease, there was no major international epidemic which threatened the health and security of New Zealand.

Regardless of the influence of ideology, the Liberals saw themselves as a party of the people putting public opinion into practice. They prided themselves in not moving before the public called for it. It could be argued that health policy in the period 1890 to 1900 reflects this. Although there were growing calls for reform by the medical profession and the from time to time an editorial and article in the newspapers, essentially there was no concerted public debate on the issue of public health.

Another factor which precluded a shift in policy by the Liberals was the financial burden of any comprehensive system of public health. Such a system would involve an increase in rates or taxes, and many individuals and local boards were not willing to spend more money. The President of the Canterbury Branch of the *NZMA* compared New Zealand with Britain in terms of sanitation expenditure and concluded 'England has spent £27,000,000 on the improvement of local sanitation. Here in New Zealand we trust to quarantine, and spend nothing on local sanitation'.⁹⁰ Funding for public health was always a limiting factor. Although the advantages of a comprehensive system were widely accepted there was often reluctance among communities to pay for it and a corresponding desire to cut costs where possible. For example, in a debate on Hospitals and Charitable Institutions, F. Sutton argued that 'he had always held that hospitals and charitable institutions should be first charges upon local funds. He felt sure that these institutions would be far better and more cheaply managed if they were managed by the residents of the districts in which they were situated than if managed by the General Government'.⁹¹ Such sentiments were, however, seldom supported with money.

As has been argued above, during the 1890s there were a number of calls for the reform of the public health system.⁹² The most consistent calls came from the

⁹⁰ 'Canterbury Branch of the New Zealand Medical Association, President's Retiring Address', *NZMJ*, Series 1, 5 (1890), p.52.

⁹¹ *NZPD*, 44 (1883), p.642.

⁹² In Wellington in this period a Sanitary Reform Association was in existence, however the work of the Association is unknown. The only evidence of the existence of a Sanitary Reform Association is

NZMA. In 1890 the 'permissive' nature of New Zealand's public health laws was criticised.⁹³ There were also a number of requests for a Department of Public Health and a Minister of Public Health. At the annual meeting of the *NZMA* it was asserted, 'That a Department of Public Health – with duly qualified officers – is necessary for the general wellbeing, is undeniable; but we must be prepared to wait for it, and urge its establishment over and over again'.⁹⁴ A small number of articles in newspapers urged reform. The *Press* complained of the ineffectiveness of the Central Board of Health and also suggested the establishment of a Department of Public Health.⁹⁵

It has been difficult to gauge the impact such calls for reform had on the Liberal Government. Dow has argued that the *NZMA* played a leading role in the government's reform of the public health system in 1900 after years of agitation for change. He maintained that 'It is simply not true to claim, as did F.S. Maclean, that the 1900 Public Health Act was inspired by the threat of plague'.⁹⁶ The inspiration, Dow argued, came from the Medical Association. Two points should be made in light of Dow's argument. The first is that although the Medical Association did have a relatively consistent campaign for reform, the Liberal Government did not heed their suggestions over a period of at least a decade and not until the threat of the bubonic plague was near New Zealand. The second point is that there was no concerted public debate on the issue of public health reform, and it is likely that much of the Medical Association's case fell on deaf ears. Doctors had been campaigning for reform of registration for a considerable period of time before it was granted in 1914. These circumstances suggest that prior to 1900, the concerns of the medical profession may not have been placed high on the agenda by the Liberals. The Liberal Party were unlikely to introduce or pass legislation in public health when it was not the subject of public debate, because the Liberals were driven by public opinion. Hamer endorses this view and argues that 'The limits of reform in the Liberal era were defined as the

from a paper: Dr. Albert Martin, 'Causation of Specific Diseases', A Paper read before the Wellington Sanitary Reform Association, c.1890.

⁹³ Dr. Ogston, 'Sanitary Affairs in New Zealand', *NZMJ*, Series 1, 3 (1890), p.238.

⁹⁴ 'Sixth Annual Meeting of the New Zealand Medical Association, *NZMJ*, Series 1, 4 (1891), p.284.

⁹⁵ 'The Plague', *Press*, 30 December 1899, p.7, 'The Plague, Experience of a Christchurch Doctor, His Opinions', *Press*, 28 February 1900, p.5.

⁹⁶ Derek A. Dow, 'Seddonic Plague', in Linda Bryder and Derek A. Dow (eds.), *New Countries and Old Medicine, Proceedings of an International Conference on the History of Medicine and Health*, Auckland: Pyramid Press, 1995, pp.44-45.

limits which the people themselves wished to impose....In their use of the power of the state, the Liberals established a tradition of pragmatic interventionism'.⁹⁷

Nineteenth century New Zealand health history was characterised by the distinct lack of concern shown by both the public and the government. Most believed that New Zealand was an inherently healthy country, sufficiently protected against the threat of infectious disease. Environmental factors, primarily climate, were thought to have created in New Zealand a 'healthy society'. The image of Maori before western contact as the 'noble savage' was used to support the healthy country mythology. Maori health, however, had deteriorated. They were no longer perceived as warriors on hill-tops, who, having adopted a number of destructive European habits, could not compete with the more advanced, British civilisation. Maori health was not the only anxiety to be raised in this early period. There were also concerns raised that a disproportionate number of unhealthy immigrants were entering New Zealand's shores to take advantage of the healthy climate. The healthy country myth seems to have also influenced the actions of the Liberal Party, which showed little interest in matters of public health in the 1890s. The only concerted calls for reform in this period came from members of the Maori community and the *NZMA*. These concerns were left unheeded until 1900 when New Zealand was faced with a potential crisis.

⁹⁷ David Hamer, 'Centralisation and Nationalism, 1891-1912', in *The Oxford Illustrated History of New Zealand*, Keith Sinclair (ed.), Auckland: Auckland University Press, 1990, p.126.

3 External Threat and Internal Weakness

In matters of public health, 1900 can be seen as a turning point. The bubonic plague scare caused New Zealand's healthy state to be questioned for the first time. This questioning took the form of a public frenzy, not based on medical knowledge, but on public perceptions about the serious consequences of an outbreak of the disease. The external threat of the plague sparked questions about the sanitary state of New Zealand. Urban areas in the late nineteenth century were growing rapidly, exacerbating insanitary conditions. Concern was also raised over the possible impact of the plague on Maori, who were already suffering from a number of other imported diseases. The impact of the plague scare highlights increasing public concern about health issues. The bubonic plague scare in New Zealand has been written about by a number of historians.¹ The plague scare has usually been viewed in the context of the establishment of the Department of Public Health. This chapter looks at the perception of the bubonic plague in New Zealand, the way in which it sparked questions about sanitary standards and the shift in popular opinion about who was responsible.

¹ Derek A. Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Health*, Wellington: Victoria University Press, 1995, pp.42-48, Michael Hannah, 'The Plague Scare, 1900. Factors Relating to the Establishment of the Department of Public Health', BA (Hons) Essay, University of Otago, 1975.

The late nineteenth century seemed to be almost free, in New Zealand's case at least, from the threat of a major international epidemic. A cholera epidemic in 1892 and 1893 in Europe caused a small number of meetings by the Central Board of Health concerning quarantine, but this was minor when compared with the mass hysteria and public outcry which arose over the possibility of a bubonic plague outbreak.² New Zealand, Australia and the United States of America, because of their distinct geographical locations, were relatively isolated from the epidemics of Europe. The growth of a major steamship network from the 1870s meant the speed at which infectious disease was spread was only limited by the speed of the steamships.³ Ports around New Zealand became the potential entry points for disease.

New Zealand's reaction to the threat of the bubonic plague may be seen in the context of the international experience of the plague and the similar reactions which occurred throughout the world. The outbreak of the plague which threatened New Zealand's shores originated in the Chinese province of Yunnan in 1871. It spread to Canton and Hong Kong in 1894, Bombay in 1896, Calcutta in 1898, Formosa, Japan and Honolulu in 1899, Manila, Adelaide, Sydney and San Francisco in 1900.⁴ As with other outbreaks of the plague, this epidemic provoked mass hysteria and fear. As Rajnarayan Chandavarkar argued, 'no other epidemic evoked the fear and panic generated by the plague'.⁵ Much of the fear of the plague was unfounded and based on images of the Black Death of the fourteenth century which wiped out a quarter of Europe's population. In general, the public knew little about the epidemiology or spread of the disease and medical understandings were highly contested. It was likely that this contributed to the fear in communities. In 1898 it was discovered that the plague was spread by rats and it was thought that this may have been through the fleas hosted by the rat.⁶ As P.H. Curson has shown, there was debate amongst the medical profession over the causes of the plague. Some accepted the theory of the flea but

² F.S. Maclean, *Challenge for Health, A History of Public Health in New Zealand*, Wellington: R.E. Owen, 1964, p.115.

³ William H. McNeill, *Plagues and Peoples*, London: Penguin, 1976, p.147.

⁴ Günter B. Risse, 'The Politics of Fear: Bubonic Plague in San Francisco, California, 1900', in *New Countries and Old Medicines, Proceedings of an International Conference on the History of Medicine and Health*, Linda Bryder and Derek A. Dow (eds.), Auckland: Pyramid Press, 1995, p.3, Hannah, p.iv.

⁵ Rajnarayan Chandavarkar, 'Plague Panic and Epidemic Politics in India, 1896-1914', in *Epidemics and Ideas, Essays on the Historical Perception of Pestilence*, Terence Ranger and Paul Slack (eds.), Cambridge: Cambridge University Press, 1992, p.204.

⁶ Chandavarkar, pp.215-216.

others still believed that the disease arose from filth and insanitary surroundings.⁷ An Australian pamphlet on the disease tied the plague directly to sanitary conditions: 'Once introduced to a community, the poison will spread, or not spread according to the sanitation of the district. In a clean community, living under healthy conditions, it has no chance, but under the opposite circumstances of filth and overcrowding it spreads like wildfire'.⁸

The general reaction of governments and local authorities to this outbreak was to increase state intervention and to institute programmes of sanitary reform. The ignorance about the etiology and spread of the plague meant that these programmes of reform were based primarily around improving sanitary conditions, as such conditions were thought to spread what was seen as a highly infectious disease. In fact the bubonic plague was not a highly infectious disease and was only spread through the presence of rats carrying fleas with the disease. It was rare for it to be spread from one individual directly to the next. In the case of India, where the plague killed six million in one decade, the state enacted a number of stringent and far-reaching restrictions and controls which Chandavarkar argued 'proved at best oppressive and at worst fatal'.⁹ In Sydney, the local authorities carried out a campaign of quarantine, isolation, fumigation, cleansing and rat extermination.¹⁰ It was based on the premise that rats spread the disease, which suggested contemporary medical opinions were known and acted on. Campaigns such as these were, however, preventative in nature, for once the disease had taken hold there was nothing public health officials could do to cure or even efficiently treat the disease.

Although the New Zealand experience of the bubonic plague was limited to one confirmed case and death in 1900 and only a small number of cases in the next decade, there was an immense public debate over the possible effects of the plague in New Zealand. The strength of this outcry was influenced by concerns about the plague as an 'international epidemic', for it had already shown that national boundaries did not limit its spread. As in other parts of the world, the fear of the

⁷ P.H. Curson, *Times of Crisis, Epidemics in Sydney 1788-1900*, Sydney: Sydney University Press, 1985, p.139.

⁸ Alfred Neale, *Plague and Security*, Sydney: Turner and Henderson, 1900, pp.11-12.

⁹ Chandavarkar, p.217.

¹⁰ J. Ashburton Thomson, 'An Account of the Epidemic of Plague at Sydney', *Public Health: The Journal of the Incorporated Society of Medical Officers of Health*, 18:1, (October 1900), pp.17-18.

effects of the plague in New Zealand was influenced by images of the Black Death in Europe. New Zealanders saw how the plague took hold in Sydney, a city to which they could relate. Newspapers were filled with images of the plague's effect overseas. The numbers of cases and deaths in cities such as Sydney were reported daily.¹¹ The speed at which this information was able to travel heightened fears about the plague. New Zealand and Sydney communicated by telegraph, which allowed the instantaneous transmission of information about the progress of the disease. This, together with the spread of the disease by the new and fast steamships meant that New Zealand did not have the same degree of isolation and protection which it had previously felt. The use of the telegraph for international plague 'updates' meant that the plague could be traced towards New Zealand as it moved down through Asia and Australia. Notices describing the previous day's effects of the plague overseas were likely to have had a much stronger impact than those providing information about last week's cases.

One of the effects of the plague's being an 'international epidemic' was that its possible entry threatened New Zealand as a nation. Although all but one of the twenty-one cases of the plague occurred in Auckland, ports around the country were threatened by the possibility of the plague's introduction.¹² This was demonstrated in the case of Bluff Port where the insanitary conditions were pointed out by the local health officer. He reported that the 'sanitary condition of this port [is] far from satisfactory' with much refuse which would be 'food for rats'.¹³ Politicians thought that an outbreak of the plague would have disastrous economic effects on the entire nation. These concerns led the government to introduce the Bubonic Plague Prevention Bill specifically to deal with the immediate threat of the plague until permanent measures could be enacted for dealing more adequately with public health. During a debate on the Bill, Joseph Ward told the House 'that the Government regard this not as a provincial matter, but as a colonial matter.'¹⁴ This demonstrates the significant shift in the government's view of its role in dealing with health and epidemics. What was once a matter for the local authorities to deal with was now an

¹¹ See for example: *New Zealand Herald*, 16 April 1900, p.5.

¹² Maclean, p.288.

¹³ Report on the Sanitary Conditions of the Bluff Port, 27.4.1900, IA 1 1900/1548, Archives New Zealand, Wellington.

¹⁴ *NZPD*, 111 (1900), p.95.

issue of such significance that the Government thought it necessary to enact legislation which covered the entire country.

The popular perception of the plague saw it first and foremost as a threat from abroad. Quarantine was one of the first measures carried out as a precaution against the plague. The standard practice was for a city, colony or country where the plague was present, to be declared 'infected'. All ships arriving from this destination would be quarantined for a predetermined length of time. In some cases the passengers would be kept isolated but often were allowed to disembark after submitting to a medical examination. Even though the plague was seen as an external threat the efficacy of quarantine as a preventer of disease was questioned. It was argued in the *NZMJ* that 'It is now recognised by all authorities that a quarantine period of longer duration than is necessary to assure the medical inspector that no case of plague exists on the vessel is not only costly, but is useless as a means of defence'.¹⁵ As this quotation shows, the arguments against the use of quarantine also highlighted costs associated with it. Concerns were raised over the possible economic effects that quarantine would have on New Zealand should it be declared infected. As Ward argued in the House when faced with a case of the plague, 'the Government are anxious to prevent the dislocation of trade in Auckland'.¹⁶ Since much of New Zealand's revenue was in trade, the closure of international ports to New Zealand ships would have had a substantial effect on New Zealand's economy. In contrast, J.M. Mason, the Chief Health Officer, argued that quarantine was more for the benefit of the health of passengers, than in the general public's interests. In his Annual Report in 1901, he wrote that 'The separation and observation of those persons who have been in attendance or in contact with a victim of this fell disease is as much, nay, far more in the interests of such people themselves as in that of the rest of the community'.¹⁷

Quarantine was also compared with sanitation as a means of protection against the plague. Officials frequently asserted that sanitation was a superior means of defence and debates about the bubonic plague in New Zealand quickly turned into

¹⁵ 'Epidemics and Sanitation', *NZMJ*, Series 2, 1:1 (1900), p.33.

¹⁶ *NZPD*, 111 (1900), p.95.

¹⁷ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.3.

debates about sanitation. Dr James, Health Officer for the Port of Wellington, for example, was critical of quarantine but cautioned against its removal in New Zealand:

it is considered an antiquated method in England, where it has been abolished; but what persons who advocate the abolition of quarantine seem to forget is that they didn't abolish it in England until the local government authorities got their sanitation machinery into perfect working order....But what would it be here?....There is merely a pretence at efficient sanitation so far as enforcing the laws, and, more particularly, so far as taking any steps which would justify the Government in abolishing quarantine are concerned.¹⁸

The debate over quarantine and sanitation demonstrated the internal weakness and external threat parallel. The initial emphasis on quarantine was soon overshadowed by a concern about New Zealand's sanitary state. Internal deficiencies became the real danger, while the external threat of the plague raised doubts about the sanitary state of New Zealand, which had until this time escaped major examination. Thus, Mason advised that 'while we guard against the enemy from without, let us not forget that our main danger lies within our walls. Plague, like typhus and some other infectious diseases, while it cannot be produced by filthy habits and insanitary surroundings *per se*, still finds in these that *optimum habitat*, that best of all conditions, wherein it may flourish and thrive'.¹⁹ As well as illustrating the growing concerns about the state of New Zealand and its standard of health, Mason's view showed that not all doctors believed the plague was solely a product of insanitary conditions.

Sanitation was, however, emphasised as the primary means of prevention against the plague. Some doctors, such as J.F. Molyneux, who worked during the plague in Hong Kong, maintained that the greatest precaution against the plague was the maintenance of high standards of sanitation.²⁰ The official government response also seemed to reflect this emphasis on sanitation. The government appointed Mason and J.A. Gilruth as sanitary commissioners, and in a telegram from Ward, Mason was instructed that 'Your special duty will be to examine the various cities and ports in the colony with a view to the prevention of disease of any kind being disseminated through imperfect sanitation or other unhealthy conditions such as the accumulation of rubbish and filth'.²¹ Part of the sanitation campaign was a crusade against rats.

¹⁸ 'The Bubonic Plague', *New Zealand Mail*, 22 March 1900, p.50

¹⁹ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.4.

²⁰ 'The Plague', *Press*, 27 February 1900, p.5.

²¹ *New Zealand Gazette (NZG) Supplement*, 1 (1900), p.775. Ward to J.M. Mason, 14 April 1900, General File (appointments), IA 1 1900/3224, Archives New Zealand, Wellington.

Rats were associated with dirt and disease and although it seemed common knowledge that rats played a role in the spread of the plague there is little discussion of the exact nature of this role. Popular opinion in New Zealand over the impact of rats seemed to be similar to that in Sydney. An article in the *Press* stressed that rats were 'active agents' in the spread of the plague, commenting that, 'the connection between rats and the plague has often been referred to of late'.²² This does suggest that there was, to a certain extent, public knowledge of recent international medical developments. As will be argued later in this chapter, it is likely that medical developments played a key role in the emphasis placed on sanitary conditions. An inventive campaign against rats was initiated in the main cities around New Zealand where people were paid for each rat they brought in. At a conference in Wellington on the subject of the plague, it was decided that local bodies should be encouraged to offer a price per head.²³ A similar system was very successful in Sydney.²⁴

The growth of cities and towns in the late nineteenth century meant that concerns about overcrowding and insanitary conditions became commonplace. This is likely to have been one of the reasons why there was such a strong emphasis on sanitation. The bubonic plague scare provoked many towns and cities to examine their own position regarding sewerage, drainage and water supplies. C.H. Mills argued in Parliament that 'as the smaller cities grow into larger ones we begin to find out that the time has arrived when sanitary precautions, which have not been attended to in former years, have now to be treated with a somewhat drastic power'.²⁵ The Auckland Local Board of Health, after lapsing in its meetings since 1888, held a number of meetings in 1900 to discuss the health of the city and the possible measures which could be implemented to prevent the plague.²⁶ The scare provoked a high level of public debate about the sanitary condition of cities. This was illustrated in the *New Zealand Herald*, where an examination of letters to the editor in just one issue showed numerous letters regarding concerns about rubbish, drainage in the central city and Ponsonby, and the removal of nightsoil.²⁷ Unhygienic conditions did exist prior to 1900, but the plague scare provided an ideal forum for those with concerns to air them

²² 'Rats and the Plague', *Press*, 19 August 1900, p.4.

²³ 'Sanitary Conference', *New Zealand Times*, 4 May 1900, p.3.

²⁴ Curson, p.156.

²⁵ *NZPD*, 113 (1900), p.204 (Mills).

²⁶ Local Board of Health Minute Book 1a, YBAD 4483, Archives New Zealand, Auckland.

²⁷ 'Correspondence', *New Zealand Herald*, 10 April 1900, p.3.

to a receptive public who were already deeply concerned and provoked self-examination at a level that had previously not occurred.

Despite growing concerns about New Zealand's cleanliness and susceptibility to disease, a certain portion of the population still held fast to the 'healthy country' mythology. An article in the *Press* maintained that it was unlikely that the plague would gain a foothold in New Zealand because of locality and sanitary arrangements in the cities.²⁸ Debate about the possibility of an outbreak of the plague in New Zealand tended to relate its likelihood to climatic factors. An article in the *New Zealand Mail* argued that in Australia's case 'the danger of any widespread outbreak of the dreaded disease in Australia will diminish as the cooler months approach'.²⁹ The idea of a relationship between warm climates and the plague probably arose from the belief that the plague originated and took hold in countries which had a warmer climate, such as China and India. Miasmatic theories of disease connected warm weather with the bad smells and odours which were associated with disease. Warm weather probably meant that the sewers and drains did have a stronger smell and it is likely that this also influenced the ideas about a climate-plague relationship. At a Christchurch City Council meeting it was argued that Auckland's warmer and wetter climate left it more vulnerable to the plague: 'There was considerable danger at Auckland that the disease might come in there owing to the climatic conditions'.³⁰

Another entrenched belief about the plague was that certain cultures were more susceptible to infection. In a letter published in the *New Zealand Herald*, the correspondent disputed the fear and concern portrayed by the paper and argued that the plague was not likely to affect the white population much.³¹ Although this seemed to be a common view, it was doubted by some in the medical profession. A Christchurch doctor maintained that 'when I was in Hongkong we thought the danger to Europeans comparatively slight, because they were cleanly and lived in different sanitary conditions to the Chinese, but recent results in Europe where even doctors

²⁸ 'The Plague', *Press*, 27 February 1900, p.5.

²⁹ 'Echoes of the Week: The Plague', *New Zealand Mail*, 1 March 1900, p.18.

³⁰ 'The Plague, Meeting of Local Bodies, Recommendations to the Government', *Press*, 8 March 1900, p.3.

³¹ 'The Plague Scare, What Reasons are there for it?', *New Zealand Herald*, 4 May 1900, p.6.

have died of the disease, show that our original suppositions were quite erroneous'.³² Although it seems the view that Europeans were relatively safe from the plague was questioned, the belief that those of Asian descent were susceptible remained. In the *New Zealand Mail* it was argued that the plague more readily attacked those on a low diet and from the East.³³

Within New Zealand there was concern that an outbreak of the plague would have devastating results in Maori communities. Ward, in the House of Representatives, said that 'if it got amongst the Natives, according to information the Government has in its possession, the results would be simply appalling'.³⁴ Comments like Ward's were typical of attitudes to Maori health at this time. The impact of European diseases on Maori was increasingly evident. It was becoming clear that Maori were more vulnerable to many infectious diseases than Europeans, and both sanitation and genetics were blamed for this. It is also possible that the association of the plague with Asia and the significant effect the disease had there, meant that there was, to a certain extent, a stigmatising of 'the other'. That is, those who were non-Europeans were thought to be of inferior genetic makeup and therefore would be more seriously affected by this disease. In the New Zealand context, Maori fell into 'the other' category. The plague scare provoked questions about the overall state of European health, but in the case of Maori, the scare was part of a more serious questioning of the appalling state of Maori health. Reactions such as Ward's, referred to above, were characteristic of the contemporary concerns about Maori as a dying race.

By the early twentieth century the medical developments of the 1880s, primarily regarding 'germ theory', were beginning to be more commonly known and it is likely that this knowledge was one of the reasons for the emphasis on maintaining high sanitary standards. Through the discovery of bacteria, it was established that infectious diseases were caused by the presence of microscopic organisms. Scientists found that bacteria could not spread in a vacuum, rather they were transferred through means such as water vapour. At the turn of the century there was no way to kill

³² 'The Plague, Experiences of a Christchurch Dr, His Opinions,' *Press*, 28 February 1900, p.5.

³³ 'Climate and the Plague', *New Zealand Mail*, 1 March 1900, p.18.

³⁴ *NZPD*, 111 (1900), p.96.

bacteria or treat disease once people were infected and public health work was targeted, therefore, at preventing the spread of infectious disease by maintaining sanitary standards. The medical profession and the Department of Public Health placed a great deal of emphasis on clean water supplies and effective waste disposal and this focus indicates the influence of contemporary medical knowledge about germs and the way they were spread. Gilruth, the Government Bacteriologist and Veterinarian, in an article published in the *Press*, outlined the benefits of 'Bacteriology' and argued that the spread of disease was largely due to poor sanitation. He said that the discoveries in this field meant that a sanitary science could be established and laws of public health formulated. On the plague specifically, Gilruth maintained that 'strict attention to sanitation, combined with a crusade against rodents, is the most important element in the work of combating the bubonic plague'.³⁵ The growing acceptance of the medical discoveries of the 1880s played a role in the increasing concerns about the possible sanitary weaknesses which were highlighted by the bubonic plague scare.

Environmental explanations for the state of health were increasingly challenged in the early twentieth century. Armed with knowledge about the spread of disease, there were growing opportunities for the state to intervene to protect a community's health. The shift away from Social Darwinian and naturalist explanations for the state of health saw an emphasis placed on nurture and culture. The prominence of nurture had particular relevance for health policy and helped entrench the significant role of the medical profession. There was greater faith that health could be improved by human intervention, and the increasing emphasis placed on medical knowledge and involvement suggested a greater role for human agency.

Despite the growing influence of mainstream medical beliefs about the spread and prevention of infectious disease, some retailers still exploited public anxiety and insecurities by advertising tonics to prevent and cure the plague. Compound Syrup of Hypophosphites was promoted by one chemist as a tonic to strengthen and tone the systems of those who lead sedentary lives and were therefore more susceptible to disease.³⁶ One retailer was game enough to state that he was so positive 'that

³⁵ J.A. Gilruth, 'Bacteriology and its Benefits', *Press*, 9 July 1900, p.3.

³⁶ *Press*, 21 April 1900, p.6.

Vitadatio will prevent and cure the plague, that I will give £10 to the first person who takes the plague whilst taking Vitadatio'.³⁷

The turn of the century brought about a change in the perception of New Zealand's health. For the first time the bubonic plague scare raised major questions about sanitary standards, a matter thought to be intimately connected to the nation's health. Health became a national rather than a provincial matter, but it took an external threat to provoke this transformation. The medical developments of the late nineteenth century helped to focus the emphasis on sanitation and the importance of scientific determinants for health. Human intervention was thought to be paramount in the prevention of the plague. Although medical knowledge at the time of the plague was highly contested, recent developments saw sanitation as the primary means of defence over the nineteenth century focus on quarantine. New Zealand's response to the plague mirrored those overseas, where programmes of sanitary reform were instituted; although there was only one confirmed case in New Zealand the frenzied public reaction far outweighed the actual threat. The primary result of the plague scare was that it brought health issues into the public spotlight, where they have stayed to the present day. The national threat provoked the government to make a response at the national level.

³⁷ *New Zealand Herald*, 28 June 1900, p.7.

4 Preservation of Health

The Department of Public Health was established at a time when both political and medical conditions were favourable. The plague raised sufficient doubts about the state of New Zealand's health and the Liberal Party was in the midst of implementing a far reaching programme of state centralisation and control. The establishment of the Department was the first major recognition of health as a national asset, a theme which was later to characterise a number of health policies. It also reflected an appreciation of the importance of public health work, particularly that involving sanitation, to the health of the country. The work of the Department of Public Health meant that health became an issue on the public agenda and created popular interest in health matters. A number of Maori health initiatives were also implemented in the early years of the Department's existence, which can be viewed in the context of increasing state involvement in the health of the population. These initiatives were directed at Maori and were the product of the work of several young active Maori political leaders. Their broader acceptance and promotion by politicians and health professionals indicates the importance of health issues in the early twentieth century.

There has been some debate over the reasons why the Liberal Party established the Department of Public Health in 1900. F.S. Maclean, in *Challenge for Health*, argued that the bubonic plague played the defining role in the creation of the Department: 'Plague has a particular public health interest for this country as it was

the threat of an invasion of plague which brought about the establishment of a Department of Public Health'.¹ Maclean's book took an epidemiological approach and linked public health policy, both in New Zealand and Britain, to infectious disease outbreaks. This view was modified by Michael Hannah in his thesis, 'The Plague Scare 1900. Factors Relating to the Establishment of the Department of Public Health'. Hannah maintained that the plague scare provided the stimulus needed for government intervention in public health. He argued that by 1900 there was pressure from the medical profession for reform, but the plague scare provided the necessary stimuli.² This is a view further supported by Raeburn Lange in his history of Maori health. He acknowledged the medical profession's advocacy in the 1890s but argued that 'it took the dramatic threat of plague in 1900, however, to create a new public awareness of how community health could be endangered by unsatisfactory sanitation'.³ Lange's view of the role of the plague in creating an awareness of the threat of insanitary conditions is convincing.

An alternative perspective developed by Derek A. Dow, in an article on the role of the plague and in his history of the Department of Public Health, emphasised the role of the Medical Association in the creation of the Department.⁴ Dow stressed the role of the medical profession and downplayed the threat of plague, arguing that there was 'a consistent and widespread concern on the part of a wide cross-section of the public, including newspaper proprietors, journalists, doctors and politicians. All it required by 1900 was the spark to light a fuse under the government'.⁵ It could be disputed that journalists, doctors and politicians do not constitute a 'wide cross-section of the public', but that is not really the key issue. There is little evidence to locate the Medical Association as a central agent in the creation of the Department; it was more likely that individual doctors such as J.M. Mason, who was a Sanitary Commissioner and became the first Chief Health Officer, played a role as medical

¹ F.S. Maclean, *Challenge for Health, A History of Public Health in New Zealand*, Wellington: R.E. Owen, 1964, p.282.

² Michael Hannah, 'The Plague Scare 1900. Factors Relating to the Establishment of the Department of Public Health', BA(Hons) Essay, University of Otago, p.79.

³ Raeburn Lange, *May the People Live, A History of Maori Health Development 1900-1920*, Auckland: Auckland University Press, 1999, p.137.

⁴ Dow, 'Seddonic Plague', *New Countries and Old Medicines, Proceedings of an International Conference on the History of Medicine and Health*, Linda Bryder and Derek A. Dow (eds.), Auckland: Pyramid Press, 1995, pp.39-45. Derek A. Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Public Health*, Wellington: Victoria University Press, 1995, pp.42-48.

⁵ Dow, *Safeguarding the Public Health*, p.41.

experts. An editorial in the *NZMJ*, of which Mason was the editor, considered the role of the Medical Association in the lobbying for the Public Health Act 1900. The impression this editorial creates is that the Association's influence was limited to calls for reform in the years before the Act was passed. Indeed, the writer noted that 'Valuable suggestions might have been obtained had the draft Bill been submitted to the profession beforehand, but the exigencies of the hour precluded any such delay'.⁶ Whatever the exact role of the medical profession, there is a strong case for the argument that the Public Health Act 1900 would not have been passed at that time without the threat of the bubonic plague.

What is missing from the debates among historians about the creation of the Department of Public Health is a discussion of the role of the Liberal Party. This Department was established at a time when the government was establishing administrative structures which intervened more extensively in the lives of its citizens. In government, the Liberals created a centralised bureaucracy, which operated through twelve new departments; the two most significant were Agriculture and Labour. At one level the creation of the Department of Public Health was a part of the Liberals' extension of bureaucracy. The threat of the bubonic plague and the concerns about the sanitary standards of New Zealand required a political response. The Liberals' mode of response to threats and anxieties such as these was by extending its bureaucratic arm. In Parliament, J.E. Jenkinson called for a Department of Health and Minister of Health because

We have a Department of Agriculture, a Department of Labour, and a Department of Trade and Commerce, and everything almost except health; and I think the Bill⁷ which it is proposed to bring down would certainly make some provision for such a department, and also for a Minister of Health, which I am sure is more wanted than a great many of the departments which now exist.⁸

As well as demonstrating an understanding of the Liberal Party political modus operandi this statement was significant because it showed the extent to which health had become an important political issue. The Liberal Party's centralisation programme was certainly a factor in the creation of a Department of Public Health, but this does not change the role of the bubonic plague or concerns about sanitation.

⁶ 'The Public Health Act 1900', *NZMJ*, Series 2, 1:2 (1900), pp.93-94.

⁷ The Bubonic Plague Prevention Bill 1900, *NZS*, 1900, pp.3-5.

⁸ *NZPD*, 111 (1900), p.122.

The creation of a Department was a response to these threats and a way to deal with public anxieties about health.

The period of the Liberals was also characterised by the close relationship some public servants had with politicians. These relationships gave the public servants additional power and influence. Edward Tregear, Secretary of Labour has been seen as a prime example of this. K.R. Howe has stressed his close relationship with both John Ballance (Prime Minister) and William Pember Reeves (Minister of Labour) and later with Richard Seddon (Prime Minister). He argued that 'Tregear's success in influencing Liberal labour legislation and developing such a powerful bureaucracy to implement it is in part explicable by the support he received or cajoled from Seddon. It was also facilitated by a socio-political climate in New Zealand in the 1890s that...was more receptive to paternal, bureaucratic control and centralisation'.⁹ In health, as Chief Health Officer, Mason played a key role in the direction taken by the Department of Public Health, particularly in its crusade against tuberculosis. Dow has even suggested Mason's 'training in both public health and law had been of great service in drafting the Public Health Act', though he provides no evidence to substantiate this claim.¹⁰

Calls for the establishment of a Department of Public Health reflected a shift in political opinion to a point where government intervention in health was acceptable. In a debate on the Public Health Bill Joseph Ward, the first Minister of Public Health, argued that 'as cleanliness is next to godliness, the health of the people of this colony should be above party – should be beyond every other consideration than doing that which we believe to be in the interests of the people, and essentially for the preservation of the health of the people of this colony'.¹¹ The relationship between an individual's health and the health of the colony was a growing concern to the government and was later demonstrated in anxieties about degeneration and the declining birth-rate. W.W. Collins, a Christchurch Member, stated in justification for the Department of Public Health that 'without health it appears to me all other things

⁹ K.R. Howe, *Singer in a Songless Land, A Life of Edward Tregear, 1846-1931*, Auckland: Auckland University Press, 1991, p.117.

¹⁰ Dow, *Safeguarding the Public Health*, p.48.

¹¹ *NZPD*, 113 (1900), p.198.

are less than worthless'.¹² The threat of the bubonic plague and the internal concerns about sanitation sparked a re-evaluation of the importance of health to national development, where it had previously been taken for granted. A.W. Hogg, in the same debate on the Public Health Bill said that 'the object of this Bill is to protect not merely the health, but the lives, of the inhabitants of our colony'.¹³ These statements together show a fundamental shift in the significance of health issues. In the nineteenth century there was limited concern about the health of New Zealand's population and certainly there were no concerted public demands for government involvement. The reaction provoked by the bubonic plague and the subsequent self-examination of sanitary conditions in New Zealand gave politicians and public health officials the key role in the protection of the health of individuals as a means for the protection of the nation. Anxieties about health stimulated a real need for intervention by a government body.

The Department of Public Health was established under the Public Health Act 1900.¹⁴ This centralised system removed responsibility for public health from the local boards, who had proved themselves incapable of effectively dealing with public health issues in the nineteenth century. The Department came under the control of the newly appointed Minister of Public Health. The Act provided for the appointment of a Chief Health Officer and six District Health Officers who were to have 'special knowledge of sanitary and bacteriological science'.¹⁵ The role of the District Health Officer included inspecting the district, carrying out bacteriological work, advising local bodies of necessary public health work, and taking appropriate measures in cases of infectious disease.¹⁶ Local authorities maintained their public health duties, but the District Health Officer could now define and instruct on those duties.¹⁷ The Act also made a number of changes to quarantine regulations. Much of the responsibility was held by the District Health Officer who could order ships or people quarantined at his own discretion and was given the powers of the port health officer.¹⁸ The Act retained the compulsory vaccination provisions already in place but

¹² *NZPD*, 113 (1900), p.205.

¹³ *ibid.*, p.202.

¹⁴ 'The Public Health Act 1900', *NZS*, 1900, pp.103-158.

¹⁵ *ibid.*, p.108.

¹⁶ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.2.

¹⁷ Maclean, p.431.

¹⁸ *ibid.*, p.51.

created a system for conscientious objectors. A parent with objections could apply to a magistrate for a certificate of exemption.¹⁹

The creation of the Department of Public Health was met with almost universal praise. New Zealand was now advantageously placed internationally in terms of public health law and structures. Mason, in his first report as Chief Health Officer, wrote that the Act 'puts the colony in the van as regards the conservation of the public health'.²⁰ The 'social laboratory' once included areas such as labour and old age pensions but was now extended to include public health. Mason went on to report that 'For the first time in the history of Great Britain and her colonies has the physical welfare of the people been elevated to a first place in the consideration of the Government'.²¹ The *NZMJ* also found in favour of the new legislation and it was said that 'The old cumbersome machinery which had to be set in motion before a menace to the public health could be removed has given way to a quicker and more modern weapon....this new Act will be, we feel sure, one of the most powerful levers for sanitary reform that this or any other country has ever had placed in its hands'.²² The Act was more powerful, particularly in relation to the role of District Health Officers, but like the Public Health Act 1876, it was limited by its implementation.

Despite the strong praise from various parts of the community, a number of concerns were raised over the centralisation and the individual powers provided for in the Public Health Act. An editorial in the *New Zealand Herald* criticised the Act for the 'despotic power' given to the Premier and maintained that local bodies were the right apparatus for dealing with sanitary matters. The editor argued that 'we have no doubt that these bodies, under the stimulus of public opinion, would have done their duty, and that there are grave evils attachable to ousting them even for a time'.²³ Politicians made similar remarks in debates on the Bill in the House. W.J. Napier, for example, thought that 'the principle of Liberal legislation should be to trust the people; to accustom them to exercise local self-governing powers, and not to

¹⁹ 'Public Health Act 1900', *NZS*, 1900, pp.147-155.

²⁰ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.1.

²¹ *ibid*, p.1.

²² 'The Public Health Act 1900', *NZMJ*, Series 2, 1:2 (1900), p.94.

²³ Editorial, *New Zealand Herald*, 29 June 1900, p.4.

centralise everything in Wellington'.²⁴ This is a curious remark, for it sees centralisation as a step away from Liberal ideology, but when it is considered that the Liberals established twelve new departments, this move would seem entirely consistent with the philosophy of the Liberal Party. The key point is probably that the Liberals were viewed as a party of the people, and the Public Health Act, to an extent, took power from the public's hands. However, in his first report on the Act, Mason advised that it was not entirely free of fault because, in some cases, officials needed more powers. The case of a passenger refusing to submit to examination by port officials was cited as an example.²⁵

Despite the extensive powers contained in the Public Health Act, the early work of the Department of Public Health was relatively limited. It was primarily undertaken by the District Health Officers and involved sanitation, quarantine and vaccination. During the early twentieth century outbreaks of infectious disease were still a primary concern of the Department. It took several years before all the District Health Officers were appointed and very early concerns were raised over the limited work of the Department. An article in the *Press*, for example, questioned the work of the Department of Public Health: 'The Public Health Act having been passed, there can be no excuse on the ground of lack of power. Ample provision is made in that Act for compelling cleanliness and proper sanitary conditions. Since the first burst of energy, however, very little seems to have been done to enforce the power given'.²⁶ It could not be expected that the handful of officers appointed could have a profound effect on the public health of a nation, and even with a Department of Public Health there was still a level of anxiety about health standards.

To some extent the existence of a Department of Public Health meant health issues gained a more prominent position in public opinion. In individual communities the presence of a District Health Officer raised the level of awareness about public health issues and comments in the Department's Annual Reports attribute improved sanitary standards in some communities to the work of the officers. In 1902 it was reported that 'the groundwork of many sound sanitary reforms has been

²⁴ *NZPD*, 113 (1900), p.226.

²⁵ Report of the Department of Public Health, *AJHR*, 1901, H.31, pp.1-2.

²⁶ 'The Plague', *Press*, 5 March 1901, p.4.

laid....Several of the larger cities have actually embarked upon schemes of drainage and water-supply in consequence of the reiteration by the Department of their necessity'.²⁷ By 1905 it was thought that 'the statistics of this period show a remarkable diminution in the incidence of infectious diseases....Auckland and suburbs are "cleaner" now than at the time surveyed in the first annual report'.²⁸ However, as mentioned above, it was unlikely that a handful of District Health Officers could profoundly improve an entire nation's health. The key role of an officer was to educate about appropriate sanitation and highlight areas in which it was lacking. In publicising public health issues, District Health Officers brought public health issues into the public sphere. Although it is difficult to determine the extent of this increased anxiety about health, the attention drawn to issues associated with health is likely to have increased public consciousness and provided the basis for a more serious review of health in the next decade.

Despite the concerns about Maori health that had been raised during the nineteenth century, it was not a specific target of the Public Health Act. The early twentieth century did see, however, a number of Maori health initiatives based around the prevention of sickness through improved sanitary standards, large-scale programmes of vaccination and increased health promotion work. Health for Maori was essentially treated in the same way as Pakeha health; most of the new initiatives were based around sanitation. The impetus for health reform for Maori in the late nineteenth and early twentieth century came primarily from the leaders of the Young Maori Party, who vigorously agitated for intervention in Maori health. The next section of this chapter will survey ideas about Maori health and its improvement and how these shaped programmes of health reform. There is no attempt to provide a complete narrative of the work of health reformers in this period. Such a description and analysis can be found in Lange's *May the People Live, A History of Maori Health Development 1900-1920*.

The Young Maori Party grew up from a number of young well-educated Maori old-boys from Te Aute College in Hawke's Bay. The more prominent of its members, Apirana Ngata, Maui Pomare and Peter Buck, hold special significance for

²⁷ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.1.

²⁸ Report of the Department of Public Health, *AJHR*, 1905, H.31, p.1.

Maori health reform in the early twentieth century. These young men advocated social and economic reforms which would allow Maori to participate in Pakeha society while still retaining much of their cultural identity. It was argued that Maori needed to adapt if they were to survive in the society which had evolved out of the period of colonisation. Ngata, in particular, promoted the worth of Maori culture in a modern context.²⁹ The Young Maori Party emphasised the need for health reform in Maori society. Improvement in Maori health was necessary if Maori were to fully participate in a Pakeha world. The Young Maori Party were successful in gaining the support of Maori and many Pakeha, particularly politicians, for their cause. This support demonstrates the general acceptance of the importance of health issues. Through their work in both the Maori and Pakeha worlds, they were respected throughout society. John A. Williams argued: 'this group was more successful in gaining their specific goals than the older leaders of the protest movements. They were more fully at home in European society, and they had a better understanding of what goals were within their reach in European politics'.³⁰ The men themselves, particularly Pomare and Buck had both Maori and Pakeha ancestry and this probably helped to broaden the degree to which their exhortations were accepted.

In 1901, shortly after the establishment of the Department of Public Health, Pomare was appointed Native Health Officer, the first Maori doctor in the Department. Pomare's work was described by Mason, the Chief Health Officer, as 'physical salvation amongst the Natives', his duties being 'to go amongst the Natives, visit their various paha, inquire into their general health, condition of the water-supply, and the diverse ingenious, if not scientific, methods employed in the disposal of nightsoil'.³¹ Pomare's articulate and skilled descriptions of his work reflect a number of policies prominent in the Young Maori Party:

I launched forth in my new duties full of hope, fear and trembling. Fear and trembling did I say? Yea! For I knew the deeply rooted superstition of ages, the strongholds of Tohungaism, the binding laws of Tapu, the habits and practices of centuries, the mistrust of the Pakeha, for these were the Goliaths in the way of sanitary progress amongst my people. For what did sanitary reform mean? It meant the dissolution of time-honoured customs, the tearing down of ancestral habits and teachings, the alteration of Maori thought and idea of living; in fact a complete

²⁹ G.V. Butterworth, 'A Rural Maori Renaissance? Maori Society and Politics, 1920-1951', *Journal of the Polynesian Society*, 81:2 (1972), p.163.

³⁰ John A. Williams, *Politics of the New Zealand Maori: Protest and Cooperation, 1891-1909*, Oxford: Oxford University Press, 1969, p.151.

³¹ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.14.

revolution in their socialistic, communistic and private life. It meant more - it meant the gentle persuasion, the authority not of force but of clear convictions of the evils of the present system of half European and half Maori ways of living and the benefits of a better, more sanitary and higher and nobler way of life.³²

Pomare's colourful reports to the Chief Health Officer provide a wonderful insight into the beliefs and aspirations of his role as Native Health Officer and the possibilities for improvement in Maori health. He was subsequently joined by Buck in 1905, and the two men travelled throughout New Zealand preaching 'the gospel of sanitation'.³³ Pomare's remark reflected the policies of the Young Maori Party: the importance of suppressing dangerous Maori customs and the adoption of beneficial Pakeha modes of health which were promoted by the Native Health Officers. Assimilation was viewed as the key to good health. The men spoke on sanitation and hygiene, on the importance of work and the individualisation of land.³⁴ Education was central to this activity. For example, in a report to the Chief Health Officer, Pomare wrote that 'Education has been and must be a great factor in the advancement of the Maori's social condition. I believe in education; in fact, our work is one of educating the people to see more clearly the advantages of attending to Hygeia's laws. The education of the Maori is of great importance in the regeneration of the race'.³⁵ He went on to promote work as 'the present gospel for the Maoris. Work, constant and systematic, is the only avenue by which the Maori can obtain his salvation'.³⁶ A particular target of the officers was the construction of new houses and Pomare wrote in 1908 that 'within the last three years we have destroyed 1,057 houses, 1,883 new houses have been built and 839 closets erected'.³⁷

Another key part of their work was vaccination and Pomare and Buck vaccinated large numbers of Maori. There were strong calls for vaccinators to be sent to Maori communities in the early twentieth century, partly the result of a pamphlet, *Etahi Mate Rere* written by Pomare and distributed amongst Maori. The pamphlet highlighted the symptoms and treatment of infectious diseases, particularly

³² Sir Maui William Piti Naera Pomare, 'The Maori', 1908, MS-Papers-0901, Alexander Turnbull Library.

³³ This comment was made by Mason in the Report of the Department of Public Health, *AJHR*, 1903, H.31, p.v.

³⁴ Sir Maui William Piti Naera Pomare, 'The Maori', 1908, MS-Papers-0901, Alexander Turnbull Library.

³⁵ Report of the Department of Public Health, *AJHR*, 1904, p.58.

³⁶ *ibid.*, p.59.

³⁷ Sir Maui William Piti Naera Pomare, 'The Maori', 1908, MS-Papers-0901, Alexander Turnbull Library.

advocating vaccination for smallpox.³⁸ According to Pomare, 'the pamphlet was circulated throughout the colony, and as a result a deep desire to be vaccinated was created'.³⁹ He published a number of other pamphlets in Maori including *Taipō Piwa: Nga Take i Toro ai me Etahi Raweke e Kore ai te Toro* (Typhoid Fever: Causes of Outbreaks and Ways to Prevent Outbreaks) and *Ko Nga Tamariki Me Nga Kai Ma Ratou* (Infants and their Foods) in 1916.⁴⁰ The distribution of these pamphlets was a key part of the preventative health promotion work undertaken by the Native Health Officers and, if the reaction to *Etahi Mate Rere* is anything to go by, it was highly successful.

The work of the Native Health Officers was not the only policy initiative. At the same time there was a flurry of activity among the newly established Maori councils and the Native Health Officers. The Maori councils were established under the 1900 Maori Councils Act.⁴¹ The Act, strongly promoted by the leaders of the Young Maori Party, created a system of local government which Williams has said met the 'demands of the Maoris for local autonomy, combined with the young Maori reformers' goals of social reform'.⁴² The Act made specific provision for Maori health. One of the duties of the councils was 'the promotion of the health and welfare and moral well-being of the Maori inhabitants of the district'. The councils could also make by-laws regarding health and sanitation.⁴³ The report of the Maori Council's General Conference in 1903 praised the work of the Councils: 'great good has already resulted from the establishment of the Councils. Some of the Native villages are now models of cleanliness and neatness'.⁴⁴ More recently there has been debate among historians about the success of the Maori Councils. Maclean called the work of the councils a 'dismal failure', but Lange has disputed this, and has argued 'a closer investigation reveals ample evidence that the councils produced a marked improvement in the sanitary condition of countless kainga'.⁴⁵ The appointment of

³⁸ Maui Pomare, 'Etahi Mate Rere', Department of Public Health, 1902, 10,000 copies produced.

³⁹ Annual Report, Department of Public Health, *AJHR*, 1903, H.31, p.72.

⁴⁰ Lange, *May the People Live*, p.155. Lange suggests that this pamphlet was published in 1905 or earlier. Maui Pomare, *Ko Nga Tamariki Me Nga Kai Ma Ratou / Infants and their Foods*, Wellington: Department of Public Health, 1916.

⁴¹ Maori Councils Act 1900, *NZS*, 1900, pp.252-260.

⁴² Williams, *The Politics of the New Zealand Maori*, p.109.

⁴³ Maori Councils Act 1900, *NZS*, 1900, p.256.

⁴⁴ General Conference of the Maori Councils, *AJHR*, 1903, G.1, p.1.

⁴⁵ Maclean, p.198. Lange, *May the People Live*, p.225.

Native Sanitary Inspectors from about 1903, together with an effective Maori council, was likely to have increased a community's ability to fight health problems and improve sanitation. By 1908, 12 inspectors, funded by the government, had been appointed.⁴⁶ Despite the support the councils were given by Pomare, Buck and the Native Sanitary Inspectors, from about 1905 it seems that the Maori councils were in financial difficulty and many had given up work such as the registration of births and deaths.⁴⁷ Buck referred to the problems the councils faced in a report to the Chief Health Officer in 1907: 'The raising of the standard of sanitation amongst the Maoris is slow, owing to the Maori Councils, which act as local governing bodies, resembling their European contemporaries in being slow to appreciate the immediate importance of public-health laws, and therefore somewhat tardy in carrying them into effect'.⁴⁸

Another policy initiative was a system to train Maori girls as nurses. The Young Maori Party had been calling for this as early as 1897. This 'action from within' would send Maori girls, trained as nurses, back into communities 'to be efficient preachers of the gospel of health'.⁴⁹ It was thought that Maori nurses would have more influence over Maori because cultural and language barriers would not be a problem. By the following year two girls had received Education Department scholarships and begun training. The scheme, however, was given little government and hospital support and it was not until 1908 that the first fully qualified graduates emerged from the scheme, Akenehi Hei and Heni Whangapirita. When Maori health was transferred back to the Department of Public Health in 1911 a new system was established, led by Amelia Bagley, where primarily Pakeha nurses were sent out into Maori communities.⁵⁰

⁴⁶ *ibid.*, pp.206-208.

⁴⁷ Williams, *The Politics of the New Zealand Maori*, p.116.

⁴⁸ Report of the Department of Public Health, *AJHR*, 1907, H.31, p.60.

⁴⁹ Report of the Native Schools, *AJHR*, 1898, E.2, p.12.

⁵⁰ There has been a significant amount of material written on both the original Maori scheme and the later Native Health Nursing Scheme. See for example: Anna Deason, 'The Native Health Nursing Scheme, 1911-1930', Research Exercise, Massey University, 2002, Alexandra McKegg, "'Ministering Angels", the Government Backblock Nursing Service and the Maori Health Nurses, 1909-1939', MA Thesis in History, University of Auckland, 1992, Alexandra McKegg, 'The Maori Health Nursing Scheme, An Experiment in Autonomous Health Care', *NZJH*, 26:2 (1992), pp.145-160, Ann McKillop, 'Native Health Nursing in New Zealand 1911-1930: "A New Work and a New Profession for Women"', MA Thesis in Nursing, Massey University, 1998.

A fundamental aspect of these health initiatives was that they were essentially Maori stimulated projects. The policies of the Young Maori Party promoted, to a certain extent, autonomous healthcare provision for Maori along the lines of western, scientific forms of treatment and the prevention of illness. As well as being Maori initiatives, these programmes were generally run by Maori, a definite advantage when it came to communication and acceptance in communities. These programmes were the Maori response to the threat of decline and what the Young Maori Party saw as the need for assimilation. The improvement of health standards was just one of the ways that Maori could be assimilated into Pakeha society.

These policies and programmes emerged at the same time as state involvement in Pakeha health increased. Although the initiatives were unique in terms of the philosophy of the Young Maori Party there were also a number of common themes. Their work was a response to growing anxieties about Maori health, and although these anxieties had been expressed over a longer period than concerns about Pakeha health, both were acted on in the beginning of the twentieth century. Health for Maori and for Pakeha became national issues which required government and public intervention. This was a distinct shift from the environmental view of health where human intervention was not deemed necessary. Connected with this theme was the growing medicalisation of society and the idea that medical treatments could have wide-reaching and favourable effects on communities. The causes of ill health were becoming known and more could be done to prevent them. Medical knowledge, however, was strictly controlled and based around 'modern, scientific' notions of health and illness. The government reaction and support of these schemes (though varying) was also a part of the growing state intervention in health matters and broader social issues. Governments began to recognise the benefits of a healthy society. This is an issue which is discussed further in Chapter Five. Captain G.B. Morris said, as early as 1884, that 'the House sees the importance to the colony of retaining the Natives in a healthy condition, for I say that there is a time not far distant when they will be found to be as good colonists as any other persons in the land'.⁵¹

⁵¹ *NZPD*, 48 (1884), p.230.

However, many Pakeha health professionals and the public saw infectious diseases present in Maori settlements as a threat to their own health. The government support of these schemes may also be seen in this context. The Assistant Inspector of Hospitals, Hester Maclean, effectively summed up this view: 'the insanitary conditions under which the Natives live in close proximity, and their frequent epidemics, are likely to be a serious menace to the growing European population, unless something really practical is done to remedy the state of affairs'.⁵² The Chief Health Officer also stressed Maori health as a Pakeha public health concern in a letter to the Minister of Public Health:

the absolute disregard of the Natives to the essentials of sanitation is a constant danger to the health of the European population, and it is high time that the former should be brought to a sense of their responsibilities...it is quite right that the idiosyncrasies of the Maori should be borne in mind, but sentimentality should not be allowed to hinder action that may be necessary in the interests of the health of the community, and especially the European section thereof.⁵³

At the same time as Maori health was subject to increasing intervention, the Department of Public Health launched a campaign against tuberculosis and provoked major debate about standards of health. The policy and reaction provide prime examples of the relationship between the work of the Department and increasing concerns about health in New Zealand. The first report of the Department of Public Health demonstrates that tuberculosis was a key target of the Department's work. Mason wrote that 'I decided the Department would steadily strive to reduce the incidence and mortality from this disease'.⁵⁴ The Department's focus on tuberculosis was politically driven and was something of a personal crusade of Mason.⁵⁵ Before 1900 there was no evidence of any significant attention or work directed at tuberculosis even though, according to Linda Bryder, tuberculosis was the main cause of settler deaths.⁵⁶ There was, however, evidence that from about 1900, there was

⁵² Report of the Department of Public Health, *AJHR*, 1913, H.31, p.13.

⁵³ Letter from Valintine (Chief Health Officer) to Minister for Public Health, 1 March 1910, Sewerage and Drainage Rotorua 1908-1933, H 1 32/8 (8786), Archives New Zealand, Wellington.

⁵⁴ J. Malcolm Mason, 'The Attitude of New Zealand Towards Consumption', Reprint No.2, From the *British Journal of Tuberculosis*, London, 1907, p.2.

⁵⁵ Mason's private papers show a keen interest in Tuberculosis. 77-075-2, Dr James Malcolm Mason, 1864-1924, Private Papers, Alexander Turnbull Library. See also for example Mason, 'The Attitude of New Zealand Towards Consumption'.

⁵⁶ Linda Bryder, 'If preventable, why not prevented?: The New Zealand Response to Tuberculosis, 1901-1940', in *A Healthy Country, Essays on the Social History of Medicine in New Zealand*, Linda Bryder (ed.), Wellington: Bridget Williams Books, 1991, p.109.

concern about the level of tuberculosis in New Zealand. The 1904 Annual Report advised that:

The prevalence of consumption in the colony requires serious consideration. It is true that the disease is not so prevalent in New Zealand as in other countries, nor is there any reason to believe that it is on the increase; but when our natural advantages as regards climate, soil, and social conditions are taken into consideration, it must be admitted that the mortality returns are larger than might otherwise have been expected.⁵⁷

This statement is typical of the health concerns raised at the beginning of the twentieth century. Anxiety about a particular disease was significant despite the healthy country myth. Entrenched opinions about New Zealand's inherently healthy population were used in the nineteenth century to justify the limited interest in health, but in the twentieth century these same statements were used to show that the population's health was not as good as it was traditionally believed. Tuberculosis rates were thought to be much higher in Maori communities although the Department of Public Health's campaign against tuberculosis was not directed at Maori at all. This point was raised in Parliament, by H.G. Ell who insisted the 'Government had not done something to endeavour to stem the ravages of this disease amongst the native-born population'.⁵⁸

Public concern about tuberculosis was also met by a private campaign by Nurse Maude in the early years of the twentieth century. Sybilla Maude, who is better known for her district nursing work, campaigned against tuberculosis, promoting 'the gospel of fresh air'. She established a camp for tuberculosis sufferers in New Brighton, and a second camp was opened nearby soon after.⁵⁹

Early concerns about the prevalence of tuberculosis were often associated with concerns about national efficiency and possible racial degeneration. For example, Mason wrote, when discussing the need for the prevention of tuberculosis, that 'a nation's health is a nation's wealth'.⁶⁰ Bad health was detrimental to the nation, not just the individual, and was a significant financial burden on the country.⁶¹ Because

⁵⁷ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.20.

⁵⁸ *NZPD*, 120 (1902), pp.82-83.

⁵⁹ Vivienne Allan, *Nurse Maude, The First 100 Years*, Christchurch: Nurse Maude Foundation, 1996, pp.24-27. E. M. Somers Cocks, *A Friend In Need, Nurse Maude: Her Life and Work*, Christchurch: Nurse Maude District Nursing Association, 1950, pp.65-85.

⁶⁰ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.14.

⁶¹ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.ix.

tuberculosis was thought to infect those with a weak disposition more easily, a high level of tuberculosis was associated with signs of racial decay. These ideas of degeneracy and national efficiency will be discussed in more detail in Chapter Five.

The early work of the Department of Public Health consisted of preventative work through the dissemination of information, and the erection of sanatoria for the treatment of patients. This work was influenced by the medical developments regarding tuberculosis in the late nineteenth century. Robert Koch isolated the tubercle bacillus in 1882 and it was established that tuberculosis was an infectious disease. In 1901 tuberculosis was placed on the list of compulsorily notifiable infectious diseases and this showed the influence of medical knowledge about its spread.⁶² The Department's pamphlet and poster campaign also reflected the influence of new medical developments by stressing the infective nature of tuberculosis. One advised that, 'it causes much sickness and many deaths in New Zealand, despite the excellence of our climate, chiefly through ignorance of its infectivity and carelessness on the part of the sufferer and others'.⁶³ To some extent this was a 'scare campaign' which stressed the danger of a disease which had, prior to the turn of the century, received little public attention. The effect of this campaign was to increase public anxiety about tuberculosis and its transmission. According to Bryder, sufferers were stigmatised in consequence and this led to 'popular hysteria' in the early twentieth century.⁶⁴ This provides the best example of the work of the Department of Public Health creating anxiety about health issues.

The other facet of the Department's campaign against tuberculosis involved the institutional treatment of tuberculosis in sanatoria. New Zealand's first sanatorium was opened in Cambridge in 1903, and others were opened in Otaki in 1906, North Canterbury in 1909 and Pleasant Valley in 1910.⁶⁵ These sanatoria were organised according to new medical principles which emphasised 'the great value of fresh air, sunlight, and judicious feeding'.⁶⁶ Although this kind of treatment was seen to follow new 'scientific' principles, as is clear from this quote, climate was once

⁶² *NZG*, 1901, Vol. 1, p.896.

⁶³ Mason, 'The Attitude of New Zealand Towards Consumption', p.2. This contains the text of a notice on consumption which was distributed in places such as railway stations.

⁶⁴ Bryder, 'If preventable, why not prevented?' p.111.

⁶⁵ Report of the Department of Public Health, *AJHR*, 1910, H.31, p.3

⁶⁶ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.13.

again emphasised as a determinant of health and even a feature of healthcare. Sanatoria were a way of removing the danger of infectious disease from a community.⁶⁷ However it does seem that some communities were reluctant to have a sanatorium in their area. Ward, Minister of Public Health, advised against the erection of a sanatorium in Canterbury, because 'The concentration of consumptives in any one town would prejudicially affect that town's prosperity'.⁶⁸ This was yet another example of the Department's work stimulating anxiety, although it was concern about economic effects rather than health issues.

Linda Bryder has argued that the early emphasis of the Department 'was on the institutional treatment of tuberculosis rather than on prevention'.⁶⁹ However, Mason wrote 'That prevention is better than cure is a true, if a trite saying, and it is in this direction, as well as the others, that our efforts as a department of State ought to be directed'.⁷⁰ He certainly does not give the impression that treatment was emphasised over prevention. It may be, however, that for historians there is more evidence of institutional treatment than of pamphlets and posters.⁷¹ It is possible that early preventative campaigns were replaced by institutional care for sick consumptives. There was certainly an increasing number of sanatoria, but regardless of the exact nature of the campaign, tuberculosis was viewed as such a threat that a relatively extensive campaign was thought necessary.

As well as dealing with tuberculosis, the Department of Public Health faced two outbreaks of smallpox in the first few years of its existence. The responses to these outbreaks differed significantly from tuberculosis, for they were localised and there was little widespread public reaction. Although the public did not share the anxiety of the medical professionals, they seemed to view it as a significant enough threat. The first outbreak consisted of two cases in 1903 from the *Gracchus* which landed in Dunedin, infecting two others, and the second consisted of 14 cases in Christchurch.⁷² Before these outbreaks of smallpox there was a significant level of

⁶⁷ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.9.

⁶⁸ 'The Treatment of Consumptives', *Press*, 27 June 1905, p.4

⁶⁹ Bryder, 'If preventable, why not prevented?' p.112.

⁷⁰ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.12.

⁷¹ There is little evidence of the Department of Public Health's early work regarding tuberculosis at either National Archives or the Alexander Turnbull Library in the form of pamphlets or posters.

⁷² Maclean, pp.230-232.

fear because smallpox was often compared with the plague, and it was thought much more dangerous. The 1901 Annual Report of the Department of Public Health contained the following warning: 'Not from plague have we most to fear. Let but one case of small-pox escape the grasp of the inspecting officer, and within a few months there would be raised to that reaper, who plies his sickle without note of season, a harvest before which the number of victims of plague would pale in insignificance'.⁷³ This is an interesting statement because, as will be discussed later, there was nowhere near the level of public debate on these smallpox outbreaks even though they affected more people than the plague scare of 1900. There was also concern about the possibility of a smallpox outbreak in Maori communities because of their susceptibility to disease: 'Small-pox was a dreadful scourge, and once it got amongst us – especially amongst the Native race – it would carry off a great number of the people'.⁷⁴

Medical practitioners advocated vaccination as the best prevention for smallpox. Although parents were legally obliged to have their babies vaccinated within twelve months of their birth unless they had a conscientious objection, few children were vaccinated. The one exception to the poor rates of vaccination was in Christchurch in 1904. The news of a smallpox outbreak in the district led 15,417 people to be vaccinated in two weeks.⁷⁵ This, however, was not a nationwide phenomenon, for in 1904 the vaccination rates for the whole colony showed that only 10% of children born had been vaccinated.⁷⁶ Mason put some of the lack of motivation for vaccination down to the notion that because of the distance from other ports, there would be good warning before any outbreak. He argued that this was, however, a 'false sense of security'.⁷⁷ In reaction to the push for vaccination, Edwin Cox, a dentist and President of the Anti-Compulsory Vaccination League of New Zealand, led an anti-vaccination campaign which advocated sanitation over vaccination. Vaccination was viewed as dangerous and an infringement of human

⁷³ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.7. There is a similar comment in the Report of the Department of Public Health, *AJHR*, 1902, H.31, p.6.

⁷⁴ *NZPD*, 123 (1903), p.67 (W.D.H. Baillie).

⁷⁵ Maclean, p.232.

⁷⁶ Report of the Department of Public Health, *AJHR*, 1905, H.31, p.ii.

⁷⁷ Report of the Department of Public Health, *AJHR*, 1903, H.31, p.iv. Report of the Department of Public Health, *AJHR*, 1902, H.31, p.6.

rights. Cox's campaign included the petitioning of Members of Parliament and health officials and the distribution of pamphlets.⁷⁸

In both 1902 and 1904 the Annual Report for the Department of Public Health printed explicit pictures of smallpox victims. It was likely that such pictures were designed to shock and the 1904 pictures created a certain amount of debate in Parliament. The debates suggest the pictures were published as part of the push for compulsory vaccination. The Member for Napier, A.L.D. Fraser, said that 'the plates in the Public Health Statement might be objectionable to the eye, but as an object-lesson of the results of small-pox to the vaccinated and unvaccinated respectively they were essentially necessary and of scientific value'.⁷⁹ It was likely that debates such as this helped to heighten fears and awareness of smallpox.

The establishment of the Department of Public Health was a consequence of the convergence of both health and political factors. The threat of the bubonic plague created public awareness of health issues to an extent not previously seen in New Zealand. The possible internal weaknesses highlighted by the plague were met by a government reaction which involved creating a Department of Public Health and appointing a Minister of Public Health. Public anxiety reached a point where government intervention in health was seen as essential and met with little opposition. The political environment also provided an important context for what can be seen as an extension of the centralisation programme of the Liberal Party. The work of the Department brought health issues into the public spotlight, particularly with its campaigns against tuberculosis and smallpox. Maori health issues also received a greater recognition in the early years of the twentieth century, stimulated by the leaders of the Young Maori Party. The multi-faceted campaign to improve Maori health was essentially driven by them and that it was accepted by a primarily Pakeha government and Department of Public Health is further evidence of the growing importance of health issues. State intervention in health matters became acceptable

⁷⁸ Edwin Cox, 'The Protest of an Anti-Vaccinist', Cambridge, New Zealand, 1905. Edwin Cox, 'The Vaccination Coup d'Etat in New Zealand Whereby a Mercenary Imposture Usurped the Throne of Right.' Cambridge, New Zealand, September 1904. There is also correspondence between the Minister of Public Health, George Fowlds and Edwin Cox, see for example: Fowlds to Edwin Cox, Esq., Cambridge, 25th May 1910, Outwards Letters book 1/53 pp.180-181, and Inwards letters folder 2/39, November 1907, Fowlds Collection, MSS A-17, University of Auckland Library.

⁷⁹ *NZPD*, 131 (1904), p.149.

by the early stages of the twentieth century, and this growing popularity paved the way, in the following decade, for a more serious debate about the importance of health to a nation's strength and prosperity.

5 The Decay of a Nation?

In the early twentieth century concerns were raised in New Zealand about the standard of health of the general population. These concerns were related to the overall physical standard of the population. Infant mortality, tuberculosis, urbanisation, overcrowding, and disease were all seen as indicators of a declining race. Degeneration was a particular concern of the affluent elite who wanted a 'healthy society' free from the perceived evils of the old world. Anxieties present in New Zealand were influenced by and replicated those in Britain which followed publication of the report on the 'Deterioration of the Race'. Poor health reflected a declining nation and health was intrinsically connected to debates about national efficiency and national strength. If New Zealand's health was poor, the strength of the British Empire was weakened, at a time when there were growing fears about possible threats from the 'east' for both itself and its colonies. Closely tied in with concerns about a degenerating race was alarm at New Zealand's declining birth-rate. A strong efficient nation and empire needed a high birth-rate so its population could compete with other nations. These anxieties were also stimulated by British concerns about the future of its Empire.

The response to unease about degeneration focused on child health. In New Zealand the Plunket Society and the medical inspection of school children were programmes established to deal with child and infant health and to ensure the future

of a strong healthy British race. Health debates were not only driven by health related issues; arguments about degeneration and its possible effects had a very clear social and political agenda. Concerns about degeneration and a declining birth-rate were part of the growing anxiety about health in New Zealand and the growing importance of health in public debates.

This chapter will focus on ideas about degeneration. It was used in contemporary literature interchangeably with deterioration. Degeneration was a term with pessimistic connotations, used to explain a process of decline from what was nostalgically thought to be a better past. Degeneration was an emotive term, which, when used in the public sphere, could create or illustrate 'moral panic'. It was a judgemental term because it was used to criticise the way people lived and associate people's lives with degeneracy. Through concerns about physical decay degeneration became associated with health. A physically inferior nation was linked inextricably to a nation with poor health, and a nation with poor health was in the process of physical decay. Improving health was key to reversing the decline of a physically degenerating race. There are, of course, other aspects to the concept of degeneration, particularly in relation to psychological or moral decay. This thesis, however, will primarily focus on degeneration as a form of physical deterioration.

Degeneration as a concept had its roots in the biological sciences of the nineteenth century.¹ In one sense it may have been a response to Social Darwinian models of 'the survival of the fittest', and an adaptation of notions of biological improvement. Concerns about degeneration which emerged internationally in the late nineteenth and early twentieth centuries were, to a certain extent, a reaction against the belief that the nineteenth century was the era of progress.² The nineteenth century was thought to be a period of social and technological improvement and advancement; a time of supreme confidence about the western world. Norman Stone has written of the importance of health and medicine to this view:

One spectacular discovery or invention succeeded another. Medicine improved almost beyond recognition. In earlier times, most people died if they underwent an operation – not, usually, from a cause any more complicated than the simple shock of the pain. Now, hospitals became hygienic; people survived, rather than died, in

¹ J. Edward Chamberlain and Sander L. Gilman (eds.), *Degeneration, the Dark Side of Progress*, New York: Columbia University Press, 1985, p.290.

² Chamberlain and Gilman, p.290-294.

them; the death-rates were cut in half in most countries. There seemed to be no end to this process of improvement.³

There seemed to be a fear, however, that this exponential rate of 'progress' could not be sustained and was not 'improving' at all levels of society. The fear about possible degeneration was expressed in a number of ways internationally; this chapter will explore the impact of these fears on health debates in New Zealand.

Anxieties about degeneration, a factor in political debates in Britain at the turn of the century, were given greater urgency by British defeats in the Boer War.⁴ A prominent British General commented that 60% of Englishmen were unfit for service and this sparked major public debates over the strength of Britain and its Empire.⁵ The intensity of public concern was such that the British Parliament established an 'Inter-Departmental Committee on Physical Deterioration'. The Committee was established with the following terms of reference: 'To make a preliminary enquiry into the allegations concerning the deterioration of certain classes of the population as shown by the large percentage of rejections for physical causes of recruits for the Army'. These terms of reference were subsequently expanded:

1. To determine, with the aid of such counsel as the medical profession are able to give, the steps that should be taken to furnish the Government and the Nation at large with periodical data for an accurate comparative estimate of the health and physique of the people;
2. To indicate generally the causes of such physical deterioration as does exist in certain classes;
3. To point out the means by which it can be most effectually diminished.⁶

The terms of reference were based on the view that standards of health were representative of a deteriorating race. The Committee and the witnesses called focused on growing urbanisation and the associated evils of overcrowding, uncleanness, foul air and bad sanitation.⁷ The report focused on the condition of

³ Norman Stone, *Europe Transformed 1878-1919*, Fontana History of Europe Series, Glasgow, 1983, pp.14-15 quoted in Daniel Pick, *Faces of Degeneration, A European Disorder, c.1848-1918*, Cambridge: Cambridge University Press, 1989, pp.13-14.

⁴ For a discussion of New Zealand's contribution and reaction to the Boer War (which is now more commonly known as the South African War) see: John Crawford and Ian McGibbon (eds.), *One Flag, One Queen, One Tongue, New Zealand, the British Empire and the South African War, 1899-1902*, Auckland: Auckland University Press, 2003.

⁵ General Sir Frederick Maurice's comments were cited in an article in *Contemporary Review*, January 1902, in Samuel Hynes, *The Edwardian Turn of Mind*, Princeton: Princeton University Press, 1968, p.22

⁶ 'Report of the Inter-Departmental Committee on Physical Deterioration', Session 2, February 1904 – 15 August 1904: vol 1, Report and Index, *British Parliamentary Papers*, vol.32, Reports from Commissioners, Inspectors and Others, p.v.

⁷ *ibid*, pp.16-17.

children, the next generation of army recruits, and the part of the population in which it was easiest to address and reverse any decline. The Committee observed that:

In large classes of the community there has not been developed a desire for improvement commensurate with the opportunities offered to them. Laziness, want of thrift, ignorance of household management, and particularly of the choice and preparation of food, filth, indifference to parental obligations, drunkenness, largely infect adults of both sexes and press with terrible severity upon their children.⁸

Despite these comments and others by numerous witnesses, including doctors, that the British race was in a state of degeneration, the Committee came to the conclusion that there was insufficient evidence to support claims of this nature. 'The Committee hope that the facts and opinions they have collected will have some effect in allaying the apprehensions of those who, as it appears on insufficient grounds, have made up their minds that progressive deterioration is to be found among the people generally'.⁹ The Committee made a number of recommendations, many of which related to the health and care of children and infants, children being the next generation of possible recruits and employees. The first was more general and focused on the necessity of an anthropometric survey so that there was sufficient data to come to conclusions on any possible degeneracy. The Committee recommended programmes such as the medical inspection of school children, the importance of exercise for children, the establishment of children's clubs and cadet corps and teaching hygiene in schools.¹⁰ The report's conclusion noted that major legislative changes were not necessary, but rather 'Complacent optimism and administrative indifference must be attacked and overcome, and a large-hearted sentiment of public interest take the place of timorous counsels and sectional prejudice'.¹¹

Despite the Committee's downplaying of the existence of any physical deterioration, this issue still provoked public debate among politicians and in the press, which bordered on panic.¹² Samuel Hynes argued 'The very fact that a report on "Physical Deterioration" existed was enough to make the idea current; and deterioration quickly became interchangeable with degeneration or decadence, thus adding an implication of moral decline to the idea of physical worsening which the

⁸ *ibid.*, p.15.

⁹ *ibid.*, p.92.

¹⁰ *ibid.*, pp.84-92.

¹¹ *ibid.*, p.93.

¹² G. R. Searle, *The Quest for National Efficiency, A Study in British Politics and Political Thought, 1899-1914*, (2nd ed.), London: Ashfield Press, 1990, p.61.

report was in fact intended to refute'.¹³ One of the most important features of this debate was that anxiety about a decline in health standards became closely associated with concerns about national efficiency. The fear was that the British Empire may have reached its prime and was in a state of decline. There was concern that it would be unable to cope with threats from other nations. Asia was thought the most likely threat to the British Empire, although the reasons for this were vague. It is possible that Asia's proximity to some British colonies such as New Zealand and Australia was a factor. As will be discussed later in this chapter, Asia posed a threat in that it had, or was assumed to have, a high birth-rate, at a time when the rate in many European nations was in decline. There were also concerns that the public in Britain were beginning to lose enthusiasm for Britain's 'imperialistic greatness'.¹⁴ A code of 'National Efficiency' was adopted and there was an attempt to recreate the perceived greatness of the Victorian era.¹⁵

Debates about degeneration and national efficiency, like the report on degeneration discussed above, often focused on the health of children. They were the next generation of military recruits and the soldiers who would defend and expand the British Empire in the future. From these concerns the infant welfare movement was developed and a system of medical inspection of school children was established. The Girl Guide and Boy Scout movements were also a response to the need to instil positive feeling about the British Empire. It was thought they would encourage healthy outdoor activities for young boys and girls in an attempt to reverse any possible deterioration from unhealthy urban surroundings.¹⁶

A British pamphleteer used the opportunity of this public outcry to provide a satirical retort to concerns about national efficiency and degeneration. The pamphlet effectively represented many of the pertinent issues. The pamphlet, 'The Decline and Fall of the British Empire', purported to be published for the use of school children in Japan in 2005. It was described as 'a brief account of those causes which resulted in

¹³ Hynes, pp.23-24.

¹⁴ *ibid.*, p.29.

¹⁵ Robert A. Nye, 'Sociology and Degeneration: The Irony of Progress', in *Degeneration, the Dark Side of Progress*, J. Edward Chamberlain and Sander L. Gilman, p.65.

¹⁶ Hynes, p.29.

the destruction of our late Ally'. It listed the eight causes of British decline, including urbanisation, lack of defence and a decline in health.¹⁷

Little has been written of the impact of concerns about degeneration in Britain and its Empire on health debates and policies in New Zealand. This does not mean, however, that these same concerns did not exist in New Zealand. Unease over degeneration in New Zealand tended to be the anxiety of the affluent elite. There was a particular fear that New Zealand would replicate the evils of urbanisation and industrialisation which were present in Britain. Historians in New Zealand have briefly mentioned the Inter-Departmental Committee on the Deterioration of the Race, national efficiency and the decline of the birth-rate. These have almost all been in the context of discussions about the Plunket Society. Erik Olssen's article on Truby King and the ideology of the Plunket Society briefly commented on concerns by the middle class about declining birth-rates and possible degeneracy.¹⁸ Linda Bryder's history of the Plunket Society in Auckland referred to the Inter-Departmental Committee and the New South Wales report on the decline of the birth-rate. She has briefly discussed the significance of these documents regarding child health and the notion that healthy children were an investment in the future.¹⁹ Her more recent book, *A Voice for Mothers*, looked at the origins of the Plunket Society in the context of concerns about deterioration and national efficiency and the need for the British Empire to breed a healthy race. It provided a good starting point for the ideas discussed in this chapter as it included the most comprehensive discussion of ideas about national efficiency and deterioration. Bryder, however, has not drawn out, to the fullest extent, the parallels between these British concerns and possible anxieties in New Zealand. For example, she does not address directly, if and whether anxieties in Britain influenced concerns in New Zealand or if questions about infant health were just simultaneous.²⁰ In his history of eugenics, Philip Fleming also discussed the impact of ideas about the strength of the British Empire in the context of the establishment of Eugenics

¹⁷ *ibid.*, pp.24-26.

¹⁸ Erik Olssen, 'Truby King and the Plunket Society, An Analysis of a Prescriptive Ideology', *NZJH*, 15:1 (1981), pp.3-23.

¹⁹ Linda Bryder, *Not Just Weighing Babies, Plunket in Auckland, 1908-1998*, Auckland: Pyramid Press, 1998, p.1.

²⁰ Linda Bryder, *A Voice for Mothers, The Plunket Society and Infant Welfare, 1907-2000*, Auckland: Auckland University Press, 2003, pp.1-2.

Societies in New Zealand.²¹ None of these works, however, study these concerns in the context of growing anxieties about health matters. There has been little discussion of the significance these international concerns held for New Zealand and the impact these ideas had on public perceptions of health and the government's response.

British concerns about degeneration were replicated in very similar ways in New Zealand, which suggests that anxieties in Britain did influence notions of health in New Zealand. In an article on social policy in this period W.H. Oliver has argued that there was a co-existence of concern in Britain and New Zealand rather than a replication of issues.²² However, specifically in the field of health there is sufficient evidence to suggest that British concerns and events did influence New Zealand perceptions of health. The fact that the most significant doubts about the state of New Zealand's health as a nation were generally expressed after concerns were raised in Britain provides evidence for this suggestion. Direct references to the Inter-Departmental Committee's Report were made in Parliament and newspapers. Debates about degeneration, like those in Britain, also occurred, involving issues such as national efficiency, the strength of the Empire, urbanisation and child health. New Zealand's identity was still influenced, in many respects, by British values. Its good health was often defined in relation to health issues in Britain. In the nineteenth century New Zealand's standard of health was used as an argument to attract immigrants from Britain. When this standard was later questioned, it was suggested that factors which caused ill health in Britain were being replicated in New Zealand.

In New Zealand there were a number of direct references to the Inter-Departmental Committee's Report, which suggests people were aware of British concerns about degeneration. In Parliament, the Minister of Public Health, D. Buddo, was questioned on degeneration in New Zealand. W.H. Field raised a number of issues which were seen as signs of possible degeneration:

1. the recent medical examination for military purposes, which revealed the weakly constitution and physique of a great proportion of our youths, particularly in the cities and towns,
2. the poor birth-rate in the Dominion,
3. the lamentable infant mortality in our midst, especially among Maoris,

²¹ Philip J. Fleming, 'Eugenics in New Zealand, 1900-1940', MA Thesis in History, Massey University, 1981, p.9.

²² W.H. Oliver, 'Social Policy in the Liberal Period' *NZJH*, 13:1 (1979), p.26.

4. the fact that comparatively few mothers nourish their infants naturally,
5. the wretched condition of the teeth of even our young children,
6. the fact that tuberculosis is still rampant among us, notably so in the case of the Maori population.²³

These concerns were similar to those raised in the Inter-Departmental Committee's Report on the Deterioration of the Race. Field also asked that a Royal Commission be established to inquire into the 'evils above mentioned and other evils affecting the health of our people, and to recommend what course the State should pursue to remedy such evils, and so secure as far as possible our national health, and with it our national prosperity'.²⁴ Further acknowledgement of British concerns was given by Buddo in his answer. He referred to the British Inter-Departmental Committee on the Deterioration of the Race (calling it the Royal Commission on the physical degeneration of the race) and the New South Wales investigation into the decline of the birth-rate.²⁵ The very fact that Buddo thought the Committee investigated the 'degeneration of the race' illustrates the meanings and significance attached to the term 'degeneration'. He said that a commission in New Zealand was unnecessary because it was unlikely to uncover any new information. Buddo did not mention that the Committee in Britain came to the conclusion that there was no evidence of deterioration. The very fact that there was a Committee to investigate deterioration was enough to confirm any concerns. Buddo added that 'the reasons of most of these dangers to our national health and vitality as a nation are well known'.²⁶ These were words from the Minister of Public Health: degeneration, or at least the threat of degeneration, was a problem in New Zealand.

A report in the *Press* also referred to the establishment of a committee to investigate physical deterioration: 'The results of the British commission held after the Boer War showed that there was not only the inception of physical degeneration but some question as to the endurance and courage of the troops. This matter struck at the very root of the predominance of our race'.²⁷ Although the writer was quite wrong about the committee's findings, it demonstrates the extent to which the threat of degeneration drove public debates over health. Both these examples show that

²³ *NZPD*, 156 (1911), p.1041.

²⁴ *ibid.*, pp.1041-1042.

²⁵ *ibid.*, p.1042.

²⁶ *ibid.*, p.1042.

²⁷ 'Infant Life Preservation', *Press*, 13 September 1907, p.9.

although it was recognised that degeneration was a topical issue in Britain and that New Zealand was affected because it was part of the Empire, the actual findings of the Committee were almost unknown. It was assumed degeneration did exist in Britain and might be transferred to New Zealand like a communicable disease. As in many emotive public debates controversy clouded the reality of the evidence.

In Christchurch, comments regarding the rejection of candidates for military training were a particular cause of panic. This controversy mirrored concerns raised and issues debated in Britain and adds further weight to the suggestion that fears of degeneration in New Zealand were stimulated by events and debates in Britain. When a senior officer in the New Zealand Army referred to the high number of candidates rejected for military service, a public meeting was held in Christchurch.²⁸ Newspaper reports indicated that 61 of 111 recruits had been rejected and of these 26 had 'physical malformations'. It was suggested that 'the figures quoted showed the need for a thorough investigation of the causes of serious defects in our national physique'.²⁹ The officer involved, Colonel Blunt, recommended a system of 'medical inspection of school children and the inauguration of a national system of military and physical training' to identify children with physical weakness and combat any possible degeneration.³⁰ The origins of the system of medical examination of school children lie, to a certain extent, in the anxiety demonstrated in the early twentieth century about possible degeneration. This issue will be considered later in this chapter.

The issues highlighted by debates over degeneration in Britain were raised in similar debates in New Zealand. One of the most important themes was that, as in Britain, concerns about health became associated with national efficiency and New Zealand's role in the British Empire. Health was increasingly seen as a national asset, as the 1912 speech from the throne demonstrates: 'My Advisers recognize that the health of the community is a national asset, and should as far as possible be promoted and protected nationally'.³¹ The national importance of health represented a fundamental shift in philosophy to a point where it was seen as an essential

²⁸ 'Physique of New Zealanders', *Press*, 13 July 1909, p.6.

²⁹ 'Physique of New Zealanders', *Press*, 13 July 1909, p.8.

³⁰ 'Physique of New Zealanders', *Press*, 13 July 1909, p.6.

³¹ *NZPD*, 157 (1912), p.7.

component of a strong nation. The *NZMJ*, in 1911, reported the speech of the Association's President, who told his colleagues that 'Every healthy man or woman is or ought to be an asset of the State, hence the necessity for the preservation of individual health and the prevention and cure of disease by all means in our power'.³² Health, by the end of the first decade of the twentieth century, had become an important subject for public discourse in New Zealand.

Monetary value was frequently associated with health. A person in good health was an asset to a nation, and one in ill health a cost to a nation. The 1902 report of the Department of Public Health noted:

A nation's health is a nation's wealth; when we come to consider the relative capitalised values of all wealth as against the capitalised value of a people as a working machine;...it behoves us to inquire if it be not more profitable to expend money in order to keep our workmen well than allow them to drift into such a state of ill-health as will require the expenditure of all their energy and attention in order to prolong, it may be for years, a life which has little or no commercial value.³³

The report focused on national efficiency and the importance of good health to the success of a country's development. Because New Zealand was a relatively young nation, it was thought that the threat of a sick population was a major problem because it limited the development of a strong, competitive nation. In this context, poor health was thought to represent the end of the early pioneer population and the possibility that the evils of Britain could become established in New Zealand.

New Zealand's role in the British Empire was also an important theme in concerns raised about degeneration and showed the significant influence of British anxieties about the possible decline in the Empire. Many of these concerns were tied in with the declining birth-rate, a subject which will be dealt with in more detail later in this chapter. It is worthwhile at this point, however, to consider the significance of anxiety about the decline of the power of the British Empire. Fleming has argued that the eugenics movement was part of the reaction to anxiety about possible decline in the Empire. That is 'Eugenics was a reflection of the wider concern with the future of the Empire, a concern based on the neo-Darwinian beliefs which saw the white civilised races pitted against the rapidly multiplying hordes from the East. The preservation of the Empire, and hence of civilization, depended on meeting the

³² 'The President's Address, The Annual Meeting in Auckland', *NZMJ*, Series 2, 9:37 (1911), p.34.

³³ Report of the Department of Public Health, *AJHR*, 1901, H.31, p.14

challenge from the East'.³⁴ The eugenics movement reacted against the nineteenth century theme of progress. It was thought that the British Empire had reached its peak and was unable to sustain the expansion of the nineteenth century.

The major threat to the power of the British Empire was thought to come from Asia. It was thought that many Asian countries maintained high birth-rates when most European countries were suffering a decline. Comments in the *Press* illustrated the apparent threat Asia represented: 'A condition of things was being established that, in the long run, would land us in complete degeneracy and render it impossible for us to compete against the Asiatic who continued to rear his children in the natural way'.³⁵ Population issues were tied in with health, primarily through concerns about the decline in the birth-rate.

Asia played a key role in health ideas in New Zealand. Many infectious diseases were associated with Asia, or the 'east'. This led to a stigmatisation of Asian groups and when the British Empire's strength came under attack, this was driven by the apparent threat of Asian nations. The role of Asia in health anxieties was often based on very little evidence and was generally speculative. Although Asia was not located 'east' of New Zealand, fears about the 'east' in Britain were readily replicated in New Zealand. New Zealand's immigration policy also reflected the stigmatisation of Asian nations, particularly the Chinese. Until the latter stages of the twentieth century Chinese immigrants were regularly excluded in what Nigel Murphy has called the 'White New Zealand' policy.³⁶

The growth of cities which occurred in the late nineteenth century as a result of urbanisation and immigration was considered evidence of possible deterioration.³⁷ Urbanisation was a key theme in the statements of witnesses before the Inter-Departmental Committee on the Deterioration of the Race. One witness stated that 'overcrowding is the great cause of degeneracy', and another said that 'The condition

³⁴ Fleming, 'Eugenics in New Zealand', p.9.

³⁵ 'Infant Life Preservation', *Press*, 13 September 1907, p.9.

³⁶ Nigel Murphy, 'Joe Lum v. Attorney General, The Politics of Exclusion', in *Unfolding History, Evolving Identity, The Chinese in New Zealand*, Manying Ip (ed.), Auckland: Auckland University Press, 2003, p.52.

³⁷ This point has also been indicated by David Hamer in *New Towns in the New World, Images and Perceptions of the Nineteenth-Century Urban Frontier*, New York: Columbia University Press, 1990, p.122.

of the air by its direct effect on the lungs and skin is the cause of much disease and physical deterioration'.³⁸ Overcrowding, uncleanliness, foul air and bad sanitation were all thought to be problems exacerbated by urban living and contributors to degeneration. Similar views were articulated and conclusions reached about possible degeneration in New Zealand. The Minister of Public Health announced in Parliament that 'It will be found in New Zealand, as in other countries, that if any deterioration of the race exists it is principally due to the tendency of the population to flock to towns, and this tendency undoubtedly exists in New Zealand'.³⁹ Both politicians and the affluent in New Zealand strongly resisted any increases in urban population and usually did so with reference to Britain's large urban population. This was because urbanisation encouraged infectious disease and was thought to be a factor in a degenerating population. The Department of Public Health highlighted this concern when it reported that Wellington's population density was higher than that of some cities in Britain. The growth of cities was, however, of much wider concern: 'undoubtedly a matter which deserves the earnest consideration of all interested in the physical and moral welfare of the race'.⁴⁰ As discussed in Chapter Two, New Zealand's urban population grew rapidly in the late nineteenth and early twentieth century; between 1891 and 1921, the urban population in New Zealand doubled.⁴¹ This growth created a fear that the evils of British cities, overcrowding, poor sanitation and high rates of infectious disease were developing in New Zealand. In Britain, these trends were given as evidence for a degenerating population and it is not surprising that when population density began to rapidly increase in New Zealand, this was taken as a sign of possible degeneration.

Urbanisation challenged notions of New Zealand's identity as there was an increasing concern that the frontier society was either dead or dying. Questions were raised about what it meant to be a New Zealander and what kind of society was being developed in New Zealand. The development of a New Zealand identity may be seen in the context of the development of other 'new world' nations such as Australia and the United States of America. In the USA, Frederick Jackson Turner argued that the

³⁸ 'Report of the Inter-Departmental Committee on Physical Deterioration', pp.17, 20.

³⁹ *NZPD*, 156 (1911), p.1042.

⁴⁰ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.xi. This comment was also referred to in 'Density of Population', *New Zealand Mail*, 23 September 1904, p.22.

⁴¹ 'The Urban System, Cities, Towns and the Links Between Them, 1891-1961', in *New Zealand Historical Atlas*, Malcolm McKinnon (ed.), Bateman: Auckland, 1997, plate 65.

distinctive nature of Americans, their values, social structures and institutions, were a product of the frontier experience. Turner wrote that 'The existence of an area of free land, its continuous recession, and the advance of American settlement westward, explain American development'.⁴² The characteristics which the American frontier experience created were described by Turner: 'coarseness and strength combined with acuteness and inquisitiveness...masterful grasp of material things...dominant individualism, working for good and for evil, and withal that buoyancy and exuberance which comes with freedom'.⁴³ Turner strongly maintained that America was not a transplanted Europe; the frontier caused a shift away from Europe. A similar argument has been used to explain Australia's history and frontier experience. Russel Ward's *The Australian Legend* developed a similar interpretation in relation to Australia: 'a specifically Australian outlook grew up first and most clearly among the bush workers in the Australian pastoral industry, and that this group has had an influence, completely disproportionate to its numerical and economic strength, on the attitudes of the whole Australian community'.⁴⁴ He characterised Australia through the image of the bushman, the outback and the anti-authoritarian stance of the early European settlers. Jackson and Ward articulated an approach which argued that the frontier experience created a particular national identity. When these 'new' societies became more urban and experienced rapid population growth because of high immigration rates, there was growing concern that the advantages of the 'frontier' society were under threat.

New Zealand developed in different circumstances and produced, to an extent, a unique identity. J.O.C. Phillips argued that New Zealand developed a 'pioneer' myth, but distinguished it from the Australian pioneer. In New Zealand the heroes and heroines were 'respectable gentle folk...there was nothing very egalitarian...nor anything very anti-English'.⁴⁵ The characteristics of the New Zealand experience created a different form of national identity. There was a desire for a pastoral, arcadian life, with elements of a genteel society. The extensive pastoral runs in Canterbury were probably the best example of the idealised perception of an

⁴² Frederick Jackson Turner, 'The Significance of the Frontier in American History', in *Frontier and Section, Selected Essays of Frederick Jackson Turner*, New Jersey: Prentice-Hall, 1961, p.37.

⁴³ *ibid*, p.61.

⁴⁴ Russel Ward, *The Australian Legend*, Melbourne: Oxford University Press, 1958, p.v.

⁴⁵ J.O.C. Phillips, 'Musings in Maoriland – Or Was there a *Bulletin* School in New Zealand?', *Historical Studies*, 20:81 (1983), pp.524.

antipodean arcadia. Health benefits were also associated with a rural lifestyle. Whereas dirt and disease were associated with the city, the country had wide-open spaces and plenty of fresh air. In a society where environmental explanations for health were common the perceived benefits of the countryside influenced the construction of the town/country dichotomy. New Zealand was viewed in an idealised way: settlers thought it was possible to avoid the evils of mass urbanisation and industrialisation, class divisions and sectarian conflict, which had become so prominent in Britain. The best of Britain and British values could be replicated in this new, relatively untouched, nation. It was thought that New Zealand could then play an active part in the British Empire through the development of a strong, healthy population.

A growing urban society in the late nineteenth and early twentieth century threatened the arcadian notions of New Zealand's identity. The city was seen to be an 'old world' evil: it could spawn disease and overcrowding among other forms of physical, social and moral decadence. As Miles Fairburn has argued, 'the town became the city. It was then that New Zealanders grew alarmed about cancerous urban growth, and condemned this evil force that violated the purity of God's Own Country'.⁴⁶ In Britain, health anxieties often stemmed from the social problems of urbanisation and industrialisation. With the growth of cities in New Zealand there was increasing fear that these same evils would be replicated.

The predominance of tuberculosis was also seen to threaten New Zealand's health. The factors listed in Parliament as indicators of degeneration by Field included high infection rates of tuberculosis. Tuberculosis was not, however, a factor raised by the British Committee which reported on concerns about deterioration, so it is unclear exactly where the connection with degeneracy came from. Tuberculosis was thought to be a disease which attacked the weaker members of society. The logical consequence was that if there were a large number of cases it was thought that the society was weakened. From time to time concerns were raised about the high rate of tuberculosis in New Zealand. The Chief Health Officer, J.M. Mason, argued

⁴⁶ Miles Fairburn, 'The Rural Myth and the New Urban Frontier, An Approach to New Zealand Social History, 1870-1940', *NZJH*, 9:1 (1975), p.4. Hamer has also discussed the desire to avoid the evils of the old world cities in *New Towns in the New World*, p.68.

in the *Press* that: 'when it is remembered that New Zealand, from its climate, soil, and social conditions, is so much more favourably situated than England with regard to pulmonary disease, it is evident that consumption is a much more serious scourge in the colony than it ought to be'.⁴⁷ As stated in Chapter Four, much of the Department of Public Health's early work was directed at preventing and curing consumptives. Tuberculosis was seen as a significant threat to the settler population in New Zealand. High rates of infection were acknowledged. For example, a Departmental Report in 1905 stated that: 'Despite the excellence of our climate, it is disquieting to learn that 55 per cent. of the total deaths from consumption of the lungs occurred among New-Zealand born people'.⁴⁸ An article in the *NZMJ* also identified a relationship between tuberculosis and degeneration:

Let us attack in the most effective way possible those conditions which weaken and destroy our population. It has been said that no enemy ever destroyed a nation that had not suffered first from internal disintegration. In fighting against national degeneracy, as against national enemies, what is needed is a clear notion of the strength of the force we have to combat, and a steady, systematic application of all our energies against those forces.⁴⁹

Tuberculosis was characterised as a national enemy and degeneration, as represented by poor health, threatened the strength of a nation. The financial cost of tuberculosis to the nation was a further consideration. Mason, the Chief Health Officer, estimated that in 1903 the 800 deaths from tuberculosis cost the country £304,800.⁵⁰ The impact of tuberculosis on national efficiency and overall strength drove these debates in relation to degeneration.

In Parliament Field also spoke about high rates of infant mortality and tuberculosis in the Maori population, which were other signs of degeneration. It is significant that Field included Maori health concerns when expressing his anxiety about degeneration, because Maori health was generally viewed in isolation from the health of the wider population. Maori were thought to be susceptible to disease because of their inferior genetic makeup and insanitary living conditions. It does indicate that Maori were, to some extent, included in the campaign for a healthy productive nation. In this context at least, Maori health was viewed within the

⁴⁷ J.M. Mason, 'The Scourge of Consumption', *Press*, 26 October 1905, located within Dr James Malcolm Mason, 1864-1924, Private Papers, MS-77-075-2, WTU.

⁴⁸ Report of the Department of Public Health, *AJHR*, 1905, H.31, p.iii.

⁴⁹ 'On the Need for State Institutions for the Treatment of Inebriety, Epilepsy and Consumption', *NZMJ*, Series 2, 1:1, August 1900, p.21.

⁵⁰ Annual Report, Department of Public Health, *AJHR*, 1904, H.31, p.ix.

framework of broader health policy, a relatively new development in the twentieth century.

Another cause of growing concern about health, both in New Zealand and in other parts of the British Empire, was the declining birth-rate. A low birth-rate was further evidence of degeneration. The Inter-Departmental Report on the Deterioration of the Race in Britain highlighted the birth-rate. The 'alleged tendency of superior stocks in all classes towards a diminished rate of reproduction' was thought to be a possible cause. The Committee, however, did not have definite figures which could be used to clearly demonstrate this connection.⁵¹

New Zealand was not the only country where a declining birth-rate generated anxieties. In New South Wales, a Royal Commission was established to investigate the decline of the birth-rate and the mortality of infants.⁵² This report held particular significance for New Zealand, which had similar birth-rates to New South Wales and also played a similar role in the British Empire. The Commission found that the immediate cause of the decline of the birth-rate was 'deliberate interference with the function of procreation', that is, different forms of contraception.⁵³ The Commission concluded that 'Already we see, in the injury to health, the wrecking of life, which is manifesting itself, now nature has begun to avenge herself on those who oppose her laws'.⁵⁴ As with other official inquiries about degeneration, the strength of the British Empire was questioned, as were Australia's role and the perceived threat from Asia. The Commission's report noted that: 'With a decay of individual and social morality we must expect the loss of all those qualities which have made the British race predominant....public men...have referred hopefully to the day when Australia with her teeming millions will hold a commanding place among the peoples of the world'.⁵⁵ The moralising tone was a key feature of debates about the birth-rate. A healthy strong country was viewed as one which follows 'nature's laws' and removes any restriction on fertility. Population and thus health (for good health meant a larger

⁵¹ 'Report of the Inter-Departmental Committee on Physical Deterioration', pp.38-39.

⁵² 'Royal Commission on the Decline of the Birth-rate and on the Mortality of Infants in New South Wales', vol. 1, Report, 1904, *New South Wales, Joint Volumes of Papers Presented to the Legislative Council and Legislative Assembly*, vol. 4, Second Session, 1904.

⁵³ *ibid*, p.14.

⁵⁴ *ibid*, p.52.

⁵⁵ *ibid*, p.53.

and stronger population) became the focal points in debates about birth-rates in the early twentieth century.

Direct reference was made to this report in New Zealand, where similar issues were raised. In his annual report, the Chief Health Officer advised:

Not only do statistics show a serious diminution in the birth-rate of the United Kingdom, but also in the majority of her more important colonies. So serious is the diminution in the birth-rate regarded by authorities in New South Wales, that the Government of that colony recently appointed a Royal Commission to inquire into the decline of the birth-rate....There is unfortunately no reason to doubt that similar reasons are the causes of the diminution in the birth-rate of other parts of the British Empire, including, I regret to say, this colony.⁵⁶

The Royal Commission was also referred to in Parliament by the Minister of Public Health in response to a question about setting up a commission to investigate degeneration in New Zealand.⁵⁷ Such comments further show the extent to which anxieties in New Zealand were influenced by debates elsewhere in the British Empire. It reflects broader patterns in the growth of fears about degeneration in New Zealand, as much of the impetus for this anxiety was a consequence of events occurring in other parts of the British Empire.

A declining birth-rate, although it might be seen as a strictly population issue rather than as a health issue, was closely related to any debate about health and degeneration. In Parliament, 'The poor birth-rate in the Dominion' was given as one of the reasons that a commission to investigate degeneration in New Zealand might be needed.⁵⁸ A statement was also made in the Department of Public Health's Annual Report, which directly connected a decline in the birth-rate to degeneration: 'How many marriages are wilfully sterile? No other fact is a surer sign of the decay of a nation'.⁵⁹ As in Britain, debates about the declining birth-rate had a moralistic tone, which blamed the destruction of the European race on the immoral middle classes. Philippa Mein Smith has argued, in the context of Truby King and the Plunket

⁵⁶ Report of the Department of Public Health, *AJHR*, 1906, H.31, p.26.

⁵⁷ *NZPD*, 156 (1911), p.1042 (Buddo).

⁵⁸ *ibid.*, p.1041 (Field).

⁵⁹ Report of the Department of Public Health, *AJHR*, 1911, H.31, p.250.

Society, that the low birth-rate was seen as an imperial problem 'that exemplified racial decadence'.⁶⁰

New Zealand had both a low and a declining birth-rate. This was a trend throughout the British Empire; New Zealand's rates were generally at the lower end. In 1902 the birth-rate was 25.6 per thousand which was lower than the Australian colonies, England and Wales.⁶¹ Statistics produced in 1915 showed New Zealand's rate had declined from 37.32 per thousand in 1882 to 26.94 in 1904.⁶² If not for Victoria's low birth-rate, by 1912 New Zealand 'would have had the unenviable distinction of the lowest birth-rate in Australasia'.⁶³ There was no significant reduction in New Zealand's birth-rate in the first decade of the twentieth century, for the major decline had occurred in the 1880s and 1890s. Why then, were concerns about New Zealand's birth-rate not raised until the twentieth century? The most plausible answer to this question is that it took concerns in Britain and Australia about degeneration and the birth-rate to draw attention to New Zealand's low rate. In addition, for the first time statistics for birth-rates were collected and published by the newly formed Department of Public Health, and they were usually accompanied by explanations which emphasised the destructive consequences of low birth-rates. It is likely that once statistics were collected in a systematic way, authoritative evidence could be provided to back up what might previously have been mere speculation.

Birth-rate concerns were inextricably linked to population concerns and thus to national efficiency. A successful nation needed both a healthy population, free from degeneration, and a large population. The Prime Minister, Richard Seddon, wrote in a 'Memorandum on Child Preservation' that: 'In the younger colonies of the Empire population is essential, and if increased from the British stock the self-governing colonies will still further strengthen and buttress our great Empire. In British interests it is clearly undesirable that the colonies should become populated by

⁶⁰ Philippa Mein Smith, 'Truby King in Australia, A Revisionist View of Reduced Infant Mortality', *NZJH*, 22:1 (1988), p.27.

⁶¹ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.23.

⁶² Report of the Department of Public Health, *AJHR*, 1905, H.31, p.v.

⁶³ Report of the Department of Public Health, *AJHR*, 1912, H.31, p.3.

the inferior surplus of peoples of older and alien countries'.⁶⁴ He made it very clear that concerns about the strength of the British Empire, with its low birth-rate, were primarily about withstanding any long term threat from 'older and alien countries' which, it may be assumed, he meant Asia.

As part of the British Empire and as relatively new colonies, there was an expectation that New Zealand and Australia would contribute to the future strength and expansion of the British Empire. The future of this Empire rested, to a certain extent, with these new colonial nations. For this reason, the low birth-rate assumed special significance in debates about public health in New Zealand and Australia. As well as threatening the survival of the British Empire the declining birth-rate was a sign of what David Hamer has termed the 'passing of the pioneer phase of the country's development'.⁶⁵ Moreover, the declining and low birth-rate were evidence of yet another evil of urbanisation, in contrast to the early settler populations, which produced large families to meet their need for labour on the land.

The reaction to concerns about both the declining birth-rate and physical degeneration focused on child health. Since the future of the British Empire was doubted, it was not surprising that the response was targeted at the new generation. The future of the Empire was seen to rest in the hands of children. For example, the New Zealand Nursing Journal, *Kai Tiaki*, noted that 'The child is the main asset of the nation. He, and not the often doubtful product from across the seas, is our best immigrant'.⁶⁶ It was significant that in 1904, Seddon sent a memorandum on child preservation to newspapers stressing the importance of the survival of healthy children. This was accompanied by a letter which stated: 'The decreasing birth-rate, with its disastrous effects calls for instant and serious consideration in conjunction with what is of paramount importance – the death rate among infants in the colony'.⁶⁷ A similar view was articulated by the Editor of the *NZMJ*, 'It is absolutely necessary to the permanence of what we believe to be the finest race that the world has produced

⁶⁴ Seddon, Richard J., *Child-life Preservation*, No. 2, 1904. For a further discussion of Seddon's Memorandum see Louise J. Mattheus, "'This Leakage of Life'", Richard Seddon's Memorandum on Child-Life Preservation', *Research Exercise in History*, Massey University, 1988.

⁶⁵ David Hamer, 'Centralisation and Nationalism, 1891-1912', *The Oxford Illustrated History of New Zealand*, Keith Sinclair (ed.), Auckland: Auckland University Press, 1990, p.144.

⁶⁶ 'The Medical Inspection of Schools in Victoria, Australia', *Kai Tiaki*, 4:4 (1911), p.175.

⁶⁷ 'Infant Mortality', *New Zealand Mail*, 18 May 1904, p.61.

– we mean the Anglo-Saxon race – that the children that are born should survive, and should not only survive but be healthy and vigorous'.⁶⁸ These views all show the growing anxiety about the survival and continuing pre-eminence of the British Empire and the reaction to this anxiety was a response targeted at the health of children. A strong nation needed a high population of healthy children.

As in Britain, the origins of the infant welfare movement in New Zealand lay in this anxiety about the future of the British Empire and the place of Britons in New Zealand. The establishment of the Plunket Society provided an obvious and significant example of the reaction to this anxiety. The relationship between Plunket and concerns about national efficiency has been discussed briefly by a number of historians who have written about the Plunket Society, notably Olssen and Bryder.⁶⁹ It is still, however, worth discussing the Plunket Society in the broader context of the growing anxiety associated with degeneration and the influence of British concerns in New Zealand. The relationship between the latter, in particular, and debates in New Zealand has not been made entirely clear in this literature. The establishment of the Plunket Society was essentially a New Zealand reaction to the concerns about the continued viability of the British Empire. It was also a popular response, not one from the state or the medical profession. This was a significant characteristic of the Society's establishment. The fact that this was not a state programme but achieved a high degree of public support indicated that the public, to an extent, acknowledged concerns about the future of the British Empire.

There was substantial concern in Britain, New Zealand and Australia about the future strength of the British Empire. The new colonies, such as New Zealand and Australia, were characterised as the best hope to halt this possible decline. In Britain the infant welfare movement was sparked off by concerns about this deterioration of national strength.⁷⁰ Although some Australians also drew on fears about child health and the future of the Empire, the Plunket movement did not become established in

⁶⁸ 'Editorial', *NZMJ*, Series 2, 7:28 (1908), p.22.

⁶⁹ The Plunket Society published its own history. See Gordon Parry, *A Fence at the Top, The First 75 Years of the Plunket Society*, Royal New Zealand Plunket Society, 1982. Linda Bryder, *A Voice for Mothers*, p.2. Olssen, 'Truby King and the Plunket Society', p.9.

⁷⁰ Bryder, *A Voice for Mothers*, p.2.

Australia until the 1920s.⁷¹ Mein Smith has argued that many of the same anxieties about the declining birth-rate, infant welfare and the future of the British Empire were articulated in Australia. She argued that 'While they moved to shut the door on Asian immigration, public men in both countries (New Zealand and Australia) seized upon the prevention of infant mortality as the key to the problems of natural increase and the nation's – and Empire's – future productivity'.⁷² The establishment of the Plunket Society may be seen, therefore, in the context of a growing imperial and colonial emphasis on the importance of child health.

The Plunket Society was founded in 1907 by Truby King and called the Society for Promoting the Health of Women and Children.⁷³ It soon became known as the Plunket Society, however, after its benefactors, Lord and Lady Plunket. Olssen argued in 'Truby King and the Plunket Society, An Analysis of Prescriptive Ideology' that the Society was driven by King's ideology, which was concerned primarily with creating a certain type of regimented society.⁷⁴ This view has been challenged by Bryder, who emphasised the role of the Plunket Nurses in the operation of the Society.⁷⁵ This thesis does not challenge or support these views, rather it shows that the establishment of the Plunket Society was part of a growing anxiety about health and the strength of the British Empire. The Society defined two core tasks for itself. The first was the education of mothers to raise their children through breast feeding. The second was to instil values which would ensure continuing dominance of the British race. One pamphlet published by the Plunket Society, for example, stated that it existed 'For the sake of women and children, for the advancement of the Dominion, and for the honour of the Empire'.⁷⁶

⁷¹ Mein Smith, 'Truby King in Australia', pp.23-43.

⁷² Mein Smith, Philippa, *Mothers and King Baby, Infant Survival and Welfare in an Imperial World: Australia 1880-1950*, London: Macmillan, 1997, p.31.

⁷³ For biographies of King see: Lloyd Chapman, *In a Strange Garden: the Life and Times of Truby King*, Auckland: Penguin, 2003. Mary Truby King, *Truby King, the Man: A Biography*, London: Allen and Unwin, 1948.

⁷⁴ Olssen, 'Truby King and the Plunket Society', p.3-23.

⁷⁵ Linda Bryder, 'Perceptions of Plunket: Time to Review Historians' Interpretations?', in *New Countries and Old Medicine, Proceedings of an International Conference on the History of Medicine and Health*, Auckland Pyramid Press, 1995, pp.97-103.

⁷⁶ Royal New Zealand Society for the Health of Women and Children, *The Society for Promoting the Health of Women and Children, ("Lady Plunket Nurses"), What it is doing and why it is worthy of your support*, 1908.

That Plunket's supporters saw a key role for their organisation in stemming possible decay is obvious from its pamphlets. The Society argued:

The Plunket Society in New Zealand was one of the first organizations in our Empire to recognise the germ of degeneration that had begun to sap our own vitality. It saw that if we could not do anything in the meantime to check the falling birth-rate, we could do something locally to lower our infant death-rate, and to improve the mental and physical characteristics of our future generations.⁷⁷

The Society were anxious about possible degeneration, New Zealand's role in the Empire and the falling birth-rate. The importance of healthy children in the reversal of any degeneration was also obvious in their promotional material. The front cover of *Save the Babies* quoted Lloyd George's imperial rhetoric: 'The Race marches forward on the feet of little children'.⁷⁸ Thus, King's views were not an aberration: the Plunket Society addressed some significant popular concerns, especially those which have been addressed in this chapter.

The extent of concerns about national deterioration was shown in King's pamphlet, *The Story of the Teeth*. There was a tendency to connect any aspect of bad health to national efficiency and *The Story of the Teeth* was an example of this. King stressed the importance of teeth 'from the higher standpoint of Justice to the Children and Duty to the Community and the State – the duty of establishing Health and National Efficiency'.⁷⁹ Elsewhere breast feeding was promoted because it encouraged sucking. The physical exertion associated with chewing and sucking involved strengthening the teeth and jaws and this was characterised as a way to counter racial decadence. The teeth were viewed as gateways to health and disease and King wrote, 'The universal decay of weak and badly-built teeth is by far the gravest disease of the day, and is the main precursor and cause of unfitness and disease in general'.⁸⁰ Teeth were not just King's preoccupation; according to T.W.H. Brooking, dentists were also promoting the relationship between teeth and national strength: 'Improved dental health was unashamedly equated with greater national efficiency, and it was automatically assumed that the dentally fit would inevitably triumph over the dentally

⁷⁷ Royal New Zealand Society for the Health of Women and Children, *Save the Babies*, 1917, p.8

⁷⁸ *ibid*, p.1.

⁷⁹ F. Truby King, *The Story of the Teeth and How to Save them*, Auckland: Whitcombe and Tombs, 1917, p.3.

⁸⁰ *ibid*, p.32.

unfit. Dental decay was naturally symptomatic of national decline'.⁸¹ Good teeth led to a strong healthy population and a powerful nation.

The Plunket Society received support, including financial support, from middle class and wealthy colonial families. Olssen has argued that such families were intensely loyal to the British Empire and were concerned about its future.⁸² These classes saw their declining birth-rate as particularly concerning because the underprivileged of society were maintaining high birth-rates. It was speculated that this would cause an overall degeneration of the European race. This view was espoused by the Plunket Society in one of its pamphlets, 'The stock which we desire most to preserve - the most capable, cultured and intellectual - has for generations seen the most rapid decline, and we must face the fact that the present conditions favour the unfit so as to enable their increase in a disproportionate ratio'.⁸³ Moreover the inferior genetics of the poor were, as far as the affluent were concerned, exacerbated by incorrect child-rearing practices. An editorial in the *NZMJ* was unambiguous on this point: those whose 'hereditary tendencies increased by improper feeding, and crowding in unhealthy rooms - survive only to become a burden rather than a strength to their nation'.⁸⁴ Thus, to these wealthy families, the elite who were primarily concerned with degeneration and the declining birth-rate, the Plunket Society was a cause which would deal with the more obvious infant health problems as well as teaching 'appropriate virtues' to young mothers about the importance of healthy and strong children. *Kai Tiaki* summed up these objectives, so appealing to the middle classes, as 'really an attempt to rear a strong and healthy race by constructive, and not by restrictive means. The object was not primarily to eliminate the unfit, but to prevent their production by aiding in the full development of the healthy'.⁸⁵ Fit healthy children would provide a much better base for the future of the Empire. Such views confirm the very strong relationship which developed between health concerns and national concerns. Good health was an essential national asset.

⁸¹ T.W.H. Brooking, *A History of Dentistry in New Zealand*, New Zealand Dental Association, 1980, p.60.

⁸² Erik Olssen, *The Plunket Society and its Ideology, 1907-1942*, Dunedin, 1979, p.7.

⁸³ Royal New Zealand Society for the Health of Women and Children, *Save the Babies*, p.5.

⁸⁴ 'Editorial', *NZMJ*, Series 2, 7:28 (1908), p.22.

⁸⁵ 'Waste of Infant Life', *Kai Tiaki*, 7:3 (1914), p.119.

New Zealand, by the beginning of the twentieth century, had very low infant mortality rates compared with other nations. In the period 1894-1903 the infant mortality rate for New Zealand was 80 per 1,000 births, compared with 143 in Britain. However, concerns were still raised about the rate in cities. In Auckland it was 134.7, Christchurch 112.9, Wellington 105.6 and Dunedin 74.6.⁸⁶ These rates, particularly Auckland's, were considered too close to infant mortality rates in Britain. By 1912, however, the infant mortality rate had been reduced to 51 per 1000, which compared with 107 in Britain for 1909. It was a remarkable decrease. The major cities in New Zealand had rates between 38 and 60 per 1,000, and all showed substantial reductions. This decrease was widely attributed to the work of the Plunket Society.⁸⁷ As Mein Smith has pointed out, there are other possible factors such as falling fertility.⁸⁸ Public perception was, however, that the Plunket Society's work had caused this great reduction in infant mortality.

Despite public support for the Plunket Society, there seemed to be little government interest in its work during the early years. There was little reference to the Society's work in either the *Parliamentary Debates* or the reports of the Department of Public Health. The reasons for this silence are unclear and can only be speculated. The Department of Public Health did have its own agenda when it came to the provision of child healthcare: from 1912 the focus was on the medical inspection of school children. The government did, however, provide some financial support, which indicated marginal recognition of the importance of the Plunket Society's work. In 1908, according to a Plunket Society pamphlet, the government guaranteed donations of pound for pound up to £100 in the four major cities.⁸⁹ The Society also emphasised its independence from the government, maintaining that 'the Society knows that the particular work it has to do could not be as successfully carried out entirely by Government. The very fact that "Lady Plunket Nurses" are known not to be inspectors or compulsory visitors makes mothers far more ready to call them in'.⁹⁰ Bryder has argued, nevertheless, that both Prime Minister Ward and Chief

⁸⁶ Report of the Department of Public Health, *AJHR*, 1906, H.31, p.27.

⁸⁷ 'Waste of Infant Life', *Kai Tiaki*, 7:3 (1914), p.118.

⁸⁸ Mein Smith, 'Truby King in Australia', p.27.

⁸⁹ Royal New Zealand Society for the Health of Women and Children, *The Society for Promoting the Health of Women and Children*, ("Lady Plunket Nurses"), *What it is doing and why it is worthy of your support*.

⁹⁰ *ibid.*

Health Officer Mason were supportive of the Society's work. In 1909 T.H.A. Valintine replaced Mason as Chief Health Officer when the Department of Public Health and the Department of Hospitals and Charitable Institutions were amalgamated. Valintine thought that such a scheme was a waste of resources and should be amalgamated with the work of district nurses.⁹¹ Derek A. Dow has written about what he calls 'demarcation disputes' between the Plunket Society and the Department of Public Health in the 1910s and he maintains that 'it was not the last occasion on which the Department would take issue with Plunket ideology'.⁹² Dow does not make clear what the ideology of the Plunket Society was and how this differed from the Department's ideology regarding child health. This is an issue which will be considered in the next section of this chapter. Regardless of any disputes, in the early years the Plunket Society had little involvement with government, a relationship which apparently suited both parties equally well. What was more surprising was that the Plunket Society received little support from the medical profession. An *NZMJ* editorial noted that 'the general attitude of the profession towards the cause is one of chill indifference, if not absolute dislike'. It encouraged doctors to support the infant health crusade more strongly.⁹³

In contrast to the private establishment of the Plunket Society, the system of medical inspection of school children was a very definite government initiative. Although their establishment differed, the two schemes were both part of the reaction to concerns about degeneration which focused on the health of children. The history of the early years of what was officially called 'The School Medical Service' has been written by Margaret Tennant.⁹⁴ She has highlighted connections between British

⁹¹ Bryder, *A Voice for Mothers*, pp.32-33. It is interesting to note that by the early 1940s District Nurses completed Plunket nurse training as part of their preparation. This was possibly a hang over from the views of Valintine. (Interview with retired District Nurse, Mrs H. Griffin, 28 June 2002).

⁹² Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Health*, Wellington: Victoria University Press, 1995, pp.67, 80-81.

⁹³ 'Editorial', *NZMJ*, Series 2, 7:28 (1908), pp.23-4.

⁹⁴ Margaret Tennant, "'A Suitable Niche for Women": The Role of Women in the New Zealand School Medical Service', Pybus M. (ed.), *Fourth International Congress on Women's Health Issues, New Zealand Papers*, Massey University: Palmerston North, 1991, pp.398-404. Margaret Tennant, "'Missionaries of Health": The School Medical Service During the Inter-war Period', in *A Healthy Country, Essays on the Social History of Medicine in New Zealand*, Linda Bryder (ed.), Wellington: Bridget Williams Books, p.128-48. Tennant, Margaret, 'The Origins of the School Medical Service', *The Impact of the Past Upon the Present, Second National Conference of the Australian Society of the History of Medicine, Perth, July 1991*, Peter Winterton and Des Gurry (eds.), Canberra: Australian Society of the History of Medicine, 1992, pp.175-9.

concerns about degeneration and threats from Asia and the child health movement.⁹⁵ She also suggested that during the inter-war years, the service was part of a Health Department emphasis which focused on connecting personal well-being with racial vitality and national efficiency.⁹⁶ The origins of the School Medical Service will be looked at in this context but also in the context of other child health services, particularly the Plunket Society. These two programmes were both targeted at infant and child health and were a response to the same concerns but were the reactions of quite different socio-economic groups.

Calls for a system of school inspection from within the public service dated back at least as far as 1902. In the following years, before the system was established, there were many requests for the establishment of school inspections in Department of Public Health reports.⁹⁷ As will be shown, the main calls for such a system were from government officials and the medical profession. This may be compared to the establishment of the Plunket Society, which was essentially a private organisation with limited involvement from the medical profession. Many of the requests for a School Medical Service were based on the fact that many other nations had already established such a system. Mason, Chief Health Officer, said in the *NZMJ* in 1907 that Belgium, France, Germany, Japan and many states of America had already established a system.⁹⁸ Britain established a system in 1908, which set a precedent for New Zealand. In his private correspondence, G.M. Fowlds, the retired Minister of Public Health, wrote that 'Practically every country in the world has adopted some form of medical inspection of schools, and before long I have no doubt that we shall have to follow suit in New Zealand'.⁹⁹

Arguments about the importance of children to the development of a strong nation were also used by advocates of the scheme. The President of the New Zealand Branch of the *BMA* insisted that 'The medical profession...recognizes that from a national point of view the medical examination and treatment of school children

⁹⁵ Tennant, 'The Origins of the School Medical Service', p.175.

⁹⁶ Tennant, 'Missionaries of Health', p.131.

⁹⁷ See for example, Report of the Department of Public Health, *AJHR*, H.31, 1902, p.9, 1905, p.xxviii, 1906, p. iv, 1907, p.vii, 1908, p.44.

⁹⁸ 'Medical Inspection of School Children', *NZMJ*, Series 2, 5:22 (1907), p.24.

⁹⁹ Fowlds to Edwin Cox, Cambridge, 25th May 1910, Outwards Letters book 1/53 pp.180-181, MSS A-17, Fowlds Collection, Auckland University.

cannot be rejected by any people or country which is anxious to occupy a commanding position in either peace or war'.¹⁰⁰ These debates show that health was increasingly viewed as a national asset and New Zealand as having an important role in maintaining the strength of the British Empire. A report on the medical inspection of schools in Victoria, Australia, further supports this argument. It noted that 'the periodical stock-taking of the child-life of our community, which medical inspection represents, may be a most important factor in our national welfare'.¹⁰¹ The *NZMJ* even stated that the 'school is really the nursery of the nation'.¹⁰² It was thought that if healthy children could be 'moulded' at school, the future health of the nation would be assured, thus guaranteeing the future strength of the British Empire. Comments about degeneration were used bluntly as an argument for the need for school inspection in Australia and it was likely that similar views were an influence in New Zealand. Indeed *Kai Tiaki* observed 'a growing conviction that to secure a solution of the many grave problems of disease and degeneration in our community, the best and most economical method is, not to wait until the results have developed, and then provide for them in hospitals, asylums, gaols, and charities generally, but to attack these problems at the earliest possible moment'.¹⁰³

Nineteenth century myths about New Zealand's healthy climate were still present in the debates about the establishment of school inspection. Fowlds, as Minister of Public Health, wrote that 'I have had the matter before the Cabinet on several occasions, but the probable cost of, and lack of interest in, the proposal have so far prevented me from having it adopted. I hope, however to be successful before very long, though the need for such inspection cannot be as great here as it is in the Old World'.¹⁰⁴ It was thought by some health officials that because New Zealand's climate and environment were so favourable, inspection could be carried out by teachers, who could notify the education board of children with 'defects'.¹⁰⁵ This kind of system would placate those who were concerned about the probable cost. The

¹⁰⁰ 'President's Address' (Dr Purdy at annual meeting of BMA in NZ), *NZMJ*, Series 2, 8:33 (1910), p.5.

¹⁰¹ 'The Medical Inspection of Schools in Victoria, Australia', *Kai Tiaki*, 4:4 (1911), p.175.

¹⁰² 'President's Address' (Dr Purdy at annual meeting of BMA in NZ), *NZMJ*, Series 2, 8:33 (1910), p.6.

¹⁰³ 'The Medical Inspection of Schools in Victoria, Australia', *Kai Tiaki*, 4:4 (1911), p.174.

¹⁰⁴ Letter from Fowlds to the Rt. Hon. Sir John E. Gorst, England, 16 October 1907, Outwards letters book 1/19 pp.52-53, MSS A-17, Fowlds Collection, Auckland University.

¹⁰⁵ Report of the Department of Public Health, *AJHR*, 1911, H.31, p.220.

healthy country myths were, however, turned on their head by Mason in advocating a School Medical Service:

What interesting facts might not be disclosed as to the effects of our climatic and general economic conditions upon the race...which will in future years inhabit and control the destinies of this young country! It seems to me that here we have excellent opportunities of assessing those influences which follow a life under good climatic conditions and economic case.¹⁰⁶

His opinion demonstrates the importance which was increasingly attached to statistics in the development of medical programmes and the idea that statistics could prove the beneficial health advantages of climate.

Most of the work of the School Medical Service is outside the time frame of this thesis.¹⁰⁷ Some of the early work was, however, reported on in the *NZMJ* and in the annual reports printed in the *AJHR*. By 1914 four medical inspectors had been appointed to inspect standard two children. The early statistics gathered from the inspectors showed high rates of defective teeth, malnutrition, physical deformities and non-vaccination.¹⁰⁸ No evidence of a reaction to these statistics has been found and it is possible that they were not widely published. The debates concerning the establishment of this scheme, however, are significant in a discussion of concern about degeneration in New Zealand. They show that the medical profession and public health officials viewed health as a national asset and connected it to the strength of the British Empire. The School Medical Service was an official response to the threat of degeneration. It highlighted the importance of child health and the view that with these children lay the future strength of the British Empire.

In the first decade of the twentieth century there were significant debates about the possibility of degenerating health in New Zealand and internationally. In Britain, the very establishment of the Inter-Departmental Committee on the Deterioration of the Race was, in the popular mind, thought to be confirmation of degeneration, even though it found no evidence of physical deterioration. Concerns bordered on panic and health came to represent something much more significant than infectious disease or vaccination: it became central to debates about national efficiency. Health

¹⁰⁶ 'Medical Examination of School Children', *NZMJ*, Series 2, 5:22 (1907), p.26.

¹⁰⁷ On the work of the School Medical Service see for example: Margaret Tennant, 'Missionaries of Health', pp.128-148.

¹⁰⁸ Report of the Department of Public Health, *AJHR*, 1913, E.1, pp.10-11, 1914, E.1, p.13. 'Medical Inspection of School Children', *NZMJ*, Series 2, 13:57 (1914), pp.375.

represented the strength of a nation: a healthy nation was a strong nation. Degeneration was a threat to the British Empire and anxieties about the possible future of the Empire were common, especially in relation to Asia. These British concerns were replicated in New Zealand with calls for a Royal Commission to investigate the threat of degeneration. Urbanisation, child health, tuberculosis, a low birth-rate and poor Maori health were viewed as evidence of degeneration. New Zealand's role in the future of the British Empire was emphasised; a new colony could help determine the future of the Empire.

The New South Wales Royal Commission on the decline of the birth-rate also sparked concern about New Zealand's low birth-rate: further confirmation of a degenerating population. Although a population issue, it was central to health debates, concerns about national efficiency and the future strength of the Empire. The response to these threats was to focus on child health, the future of the nation and the Empire. The Plunket Society was a public response to the concerns of the British Empire, which stressed the importance of healthy babies. The response from the government and the medical profession was the system of medical inspection of school children. In the same period the government rapidly enacted wide ranging legislation in the areas of health, the control of medical practices, food supplies, immigrants and the movement of people when threatened by infectious disease.

6 Control to Protect

Growing anxiety about health together with the increasing importance of health issues stimulated a number of reforms, in the early twentieth century, which both restricted and controlled the New Zealand population and the types of medicine practiced. The growing importance of health as a public issue led the government to pass legislation designed to create a healthy society. There were many examples. In the early twentieth century there was an increasing reliance on doctors and their specialised knowledge and laws were passed defining acceptable forms of treatment. Both nurses and midwives required formal state registration to practice from 1901 and 1904 respectively. The registration of midwives was in response to concerns about infant health and the future population of New Zealand and the British Empire. The government also controlled the practice of medicine through the Tohunga Suppression Act and the Quackery Prevention Act. Both were deliberate measures to establish appropriate forms of medical treatment. They were about the protection of certain groups in society from medicine and treatments which were considered harmful to their health. Another example of the increasing involvement of the government in people's lives was the passing of legislation to control food and drink. Restrictions on immigrants, especially those with tuberculosis, was a further example of attempts to create a 'healthy society', cleansed of the evils of the 'old world'. Finally, travel restrictions on Maori during the smallpox epidemic in 1913 were designed primarily to limit Maori movements and protect Pakeha health. The growth of health as an

issue on the public agenda saw a government response which sought to control society for the sake of protecting what were thought to be its best interests.

In the early part of the twentieth century there was a definite trend towards a more 'medicalised society'. That is, health and medicine became more prominent on political and private agenda. This chapter highlights a number of themes raised throughout this thesis to show changing understandings of medicine and health and the way these were used by the government and health officials to create, through controls and restrictions, a 'healthy society'. A fundamental development during this period, which will be discussed in this chapter, was the increasing focus on acceptable forms of treatment.

The bio-medical revolution in the 1880s had a profound impact on early twentieth century public health programmes. These developments may also be considered in the context of a society increasingly concerned with health and medical issues. The discovery and isolation of various germs which caused infectious disease meant that public health policies were focused, initially at least, around sanitary activity designed to prevent the spread of germs. Doctors, particularly those trained in bacteriology, began to play an important role in public health. Only those with this specialist knowledge were able to determine, through scientific methods, whether or not particular bacteria were present. Public health policy was based around this official notification of infectious diseases. The increasing reliance on doctors and their expert knowledge meant that they acquired an important role in society generally and public health programmes specifically. Once health professionals were accepted as a necessary part of public health policy, they were, to a certain extent, able to pursue their own agenda, within the constraints of 'modern scientific medicine'. This agenda was one of control and restrictions on the types of medicine practiced. The outcome was supposed to be the protection of society.

Medical issues became more prominent in the early twentieth century as a result of the new medical developments. The growth in importance of these issues was stimulated by a number of international epidemics and, in New Zealand, the creation of a Department of Public Health. It was thought that degeneration and a declining birth-rate could be dealt with through medical intervention. The strength of

a nation was derived from the health of its population and good health could be achieved through health programmes.

New medical discoveries challenged many well established certainties about health and medical treatment and this new knowledge was controlled by the medical profession. The doctor's role in society moved towards one of power and control. Michel Foucault has discussed this development in *The Birth of the Clinic*.¹ The knowledge of doctors and health officials gave them a particular form of power in a society increasingly concerned with health issues. Foucault emphasised the 'clinical' or medical gaze as a form of power over patients through the way they viewed their bodies. The doctor was able to persuade individuals about appropriate ways of behaving and living their lives to promote good health, or alternatively, to fulfil the healthy role the state defined for them. It was in the government's best interests to promote forms of treatment and medicine which would establish and maintain healthy workers.

The growing emphasis on medical issues was also related to the changing role of hospitals in New Zealand. In the nineteenth century, the hospital situation was more accurately a poor law institution than a place of medical treatment. This shifted dramatically in the twentieth century. New biomedical developments helped to 'clean up' hospitals and developments in surgery and anaesthesia meant hospitals became safer places for medical treatment and were increasingly used by the middle classes. David Armstrong has suggested that there was another side of the relationship between doctors and biomedical developments:

The hospital provided a locus for a new relationship between the doctor and the patient, but it was this relationship that was instrumental in establishing the new biomedical model of medicine. During Bedside Medicine the patient was in the position to dictate (and define) the nature of illness: hence the existence of a symptom-based medicine. After the advent of the hospital the doctor's dominant role ensured the emergence of a medicine based on pathological lesions which were inaccessible to the patient without medical interpretation.²

The movement away from treatment in the home gave doctors and nurses a new form of power in an organisation which was run, at the grass roots level at least, by medical professionals. It also helped to entrench 'appropriate' forms of medicine. The role of

¹ Michel Foucault, *The Birth of the Clinic, An Archaeology of Medical Perception*, New York: Vintage Books, 1975, p.196.

² David Armstrong, 'Bodies of Knowledge/Knowledge of Bodies, in *Reassessing Foucault, Power, Medicine and the Body*, Colin Jones and Roy Porter (eds.), London: Routledge, 1994, p.19.

hospitals in local communities was strengthened by the growing urbanisation of the settler population. The development of the hospital as a medical institution and the associated rates, committees and organisational structures may be seen as a part of the move towards centralisation, characteristic of the early twentieth century. Nettleton stressed the relationship between the medicalisation process and an increasingly complex and bureaucratic system.³

In the early twentieth century there was a growing emphasis on acceptable forms of treatment. The *NZMA* became increasingly vocal in the 1890s and early twentieth century campaigning for the registration of nurses, midwives and reform of medical registration. The Association called for a system of registration through an independent Medical Board rather than through the Register-General. The government did not pass such an Act until 1914. There was, however, legislation in 1905 which placed limits on the registration of doctors with less than five years' training. It officially recognised those doctors who had been trained in New Zealand and Britain.⁴ The Association's arguments for a system of registration stressed the harm the 'charlatans' could do rather than the benefits of a system of registration.

New Zealand enjoys the wide-spread and unenviable reputation of being that country under the sun which best provides food, raiment, and something considerably more for those medical quacks and pretenders who favour the principal cities with periodical visitations, in the course of which they reap an abundant harvest out of the gullibility of the residents, and assist in the *exodus* of New Zealand capital, leaving no equivalent in return...it is calculated to affect the whole *morale* of a community by lowering the self-respect of its members.⁵

The registration of doctors was suggested as a way to protect the community from inappropriate forms of healthcare. Medicine was based on 'modern scientific' practice and any deviation from this was thought to be harmful for the patient. It was possible that the Association's arguments actually worked against their campaign for registration. The desire to prevent purported 'charlatans' from healthcare provision was legislated against in both the *Tohunga Suppression Act* and *Quackery Prevention Act*. Once the government had dealt with these possible threats to the public safety there was little benefit to be gained from a system of registration. Michael Belgrave, in his PhD thesis on the professionalisation of medicine in New Zealand, argued that

At the same time that politicians were wary of granting doctors professional control of New Zealand medicine, Parliament was passing a steady stream of legislation that

³ Sarah Nettleton, *The Sociology of Health and Illness*, Cambridge: Polity Press, 1995, p.27.

⁴ Medical Practitioners Registration Act, *NZS*, 1905, pp.197-198.

⁵ 'Editorial, The New Medical Bill', *NZMJ*, Series 1, 2 (1889), p.237.

gave doctors quite extensive social and judicial powers. Because of medicine's rising status, doctors were being placed in a position to provide scientific legitimacy to a whole series of legislative policies which combined humanitarian concerns with attempts to control social behaviour.⁶

The Medical Association also pressed for 'properly qualified' practitioners to hold public service positions. It was suggested that 'Each province requires the presence of a trained and expert medical officer of health'.⁷ Concerns were also raised when it was found that non-qualified persons held state medical positions such as public vaccinators: 'The appointment of laymen to be public vaccinators formed the subject of a correspondence between the Branch and the Colonial Secretary....that the appointment of laymen, where qualified practitioners are available and willing to act, is quite common in this country'.⁸ The government did acknowledge that only scientifically trained medical professionals should hold Department of Public Health positions. The Public Health Act 1900 required that both the Chief Health Officer and District Health Officers should 'in every case be a medical practitioner, with special knowledge of sanitary and bacteriological science'.⁹

The registration of nurses and midwives in the early years of the twentieth century were also part of the increasing state regulation of medical provision. The Nurses Registration Act was passed in 1901, the first of its kind internationally.¹⁰ The Act provided for the registration of qualified nurses.¹¹ In Parliament some objections were raised because the Act did not 'provide that only those who are qualified be allowed to nurse'.¹² Despite this criticism the Nurses Registration Act was a fundamental step towards state control and regulation of the nursing profession. Because nurses dealt with the sick, it was imperative that they had adequate training: 'In the most important matter of attending to the sick...no means are at present provided by the State to enable those engaged in this profession to produce evidence

⁶ Belgrave, 'Medical Men' and 'Lady Doctors', *The Making of a New Zealand Profession*, PhD Thesis, Victoria University, 1985, p.208.

⁷ 'The Sanitary Defence of New Zealand', *NZMJ*, Series 1, 5 (1892), p.155.

⁸ 'Our Auckland Letter', *NZMJ*, Series 1, 2 (1888), p.51.

⁹ Public Health Act 1900, *NZS*, 1900, p.108.

¹⁰ Mary I. Lambie, *Historical Development of Nursing in New Zealand, 1840-1950*, Wellington: Department of Health, 1950, p.6.

¹¹ Nurses Registration Act 1901, *NZS*, 1901, pp.22-24.

¹² *NZPD*, 117 (1901), p.388 (E.G. Allen).

of their ability to carry out their important duties'.¹³ The registration of nursing, as well as placing controls on the provision of nursing, was a way to protect the public.¹⁴

Several years after the Nurses Registration Act was passed, the regulation of midwifery was debated. To some extent this was stimulated by the registration of midwives in Britain. In Britain maternal and infant mortality and a decline in the birth-rate were the fundamental drivers in the development of officially sanctioned midwifery and the passage of the British Midwives Act 1902.¹⁵ The Midwives Act 1904 passed in New Zealand was derived from this British Act. The debates surrounding the introduction of this Act raise a number of issues relevant to this thesis.

The Act established a system of registration and of formal training through State Maternity Hospitals. The Midwives Act was much more restrictive than the Nurses Registration Act, for it only allowed registered midwives to practice.¹⁶ The debates in Parliament go some way to explaining why these restrictions were seen to be necessary. The object of the Bill, according to the Attorney-General, was 'to do something in the direction of the preservation of infant-life'.¹⁷ As was argued in Chapter Five, child health issues were some of the most significant health issues at the beginning of the twentieth century. The future of New Zealand and the British Empire was thought to rest in the hands of the children. A strong healthy generation of children was vital to the future success of the British Empire and her colonies. Midwives were important because childbirth was essentially controlled by midwives and they played a fundamental role in the lives of infants. The importance of scientific knowledge was stressed by Seddon in his speech on this Bill and the Act provided for State Maternity Hospitals so that midwives could learn correct scientific practices.¹⁸ Seddon referred to his Memorandum on Child-Life Preservation, where he had insisted 'Only those holding certificates should be allowed to practice

¹³ *ibid.*, p.387 (W. Hall-Jones).

¹⁴ *ibid.*, p.387 (Allen).

¹⁵ Marion A. Cooper, 'Towards the Professionalisation of New Zealand Midwifery, 1840-1921', M(Phil) Thesis in Midwifery, Massey University, 1998, p.27.

¹⁶ Midwives Act 1904, *NZS*, 1904, pp.189-192.

¹⁷ *NZPD*, 131 (1904), p.481 (A. Pitt).

¹⁸ *NZPD*, 129 (1904), p.70.

midwifery'.¹⁹ He also highlighted the significance of infant mortality for the strength of a nation when he told the House that 'if we lose our children we are losing our population, and I say that the loss of child-life or the want of child-life shows decadence in dealing with this question'.²⁰ The Midwives Act, although a part of the attempts to control the medical profession for the good of the public, raised a number of issues regarding the importance of child health and its relationship to the strength of a nation.

Another statute which needs to be understood in the same context was the Tohunga Suppression Act 1907. It has been cited as an instrument of colonial oppression, often alongside the prohibition of Maori language in Native Schools.²¹ This rather simplistic view fails to consider the broader framework of health reform in the early twentieth century. In the context of a number of other reforms in the health sector such as registration for doctors, nurses, midwives, the Quackery Prevention Act and the control of food supplies, the Tohunga Suppression Act can also be seen as a mechanism intended to control the practice of medicine. These two objectives, the control of medicine and the suppression of cultural elements, were not mutually exclusive: both worked together to create what was hoped would be a 'healthy society'. Although the medical role of tohunga is the focus here, the spiritual and leadership roles of tohunga were also fundamental components of traditional Maori notions of health.²²

There has been little substantial analysis of the Tohunga Suppression Act within a health history framework. The most comprehensive examination is Raeburn Lange's *May the People Live, A History of Maori Health Development, 1900-1920*. Lange does move away from the cultural oppression argument but does not look at the Act in the context of broader non-Maori health policy. He does, however, provide evidence which shows that medical issues were a real concern of the Bill's supporters.

¹⁹ Richard J. Seddon, *Child-life Preservation*, No. 2, 1904..

²⁰ *NZPD*, 129 (1904), p.71.

²¹ See, for example, David Williams, 'Matauranga Maori and Taonga', *Wai 262*, Waitangi Tribunal, p.124.

²² For a further discussion of the historical role of tohunga in Maori society see: Raeburn Lange, *May the People Live, A History of Maori Health Development 1900-1920*, Auckland: Auckland University Press, 1999, pp.10-15. Mason Durie, *Whairoa, A History of Maori Health Development*, 2nd ed., Auckland: Oxford University Press, 1998, pp.15-20.

Lange wrote that 'the clamour against tohunga was not necessarily because they were now more active than in previous times, but because their continued activity was now so obviously an obstacle to the health reforms, and because the Maori reformers spoke so strongly against them'.²³

The arguments developed by those who spoke in favour of the Bill in Parliament followed two main themes. First, they saw it as a way to restrict the practice of what they believed were unfavourable aspects of Maori culture, such as superstition and some traditional ways of living. In particular, Lange has stressed the influence of the fight against Rua Kenana and his community at Maungapohatu.²⁴ James Carroll, the Native Minister from Ngati Kahungunu, said in his speech on this Bill: 'This tohunga, Rua, assumed control over the major portion of those people, and persuaded them to part with their belongings, to sell their stock, to leave their cultivations, to withdraw their children from attendance at schools, and to pervert the good effect of all our laws'.²⁵ Essentially, the assimilationist programme of both the Young Maori Party and the Liberal Government emphasised breaking down traditional Maori customs, such as tohunga, so that Maori would become more like their Pakeha neighbours.

Medical issues were the second main theme in this debate on the Bill. They included suppressing the work of tohunga and promoting appropriate forms of treatment. There are references to the medical harm of tohunga and the need for their restriction at least as far back as 1900. The *Auckland Weekly News* termed the work of tohunga 'a growing evil, and required to be stayed. There was, unfortunately, no legislation on the question'.²⁶ There were many calls in Department of Public Health reports for the prohibition of tohunga, most by the Native Health Officers, Maui Pomare and Peter Buck. Pomare used medical metaphors in his call for suppression: 'the strong arm of the law is the only potent medicine that can cure this cancerous malady'.²⁷ Tohunga were one of the reasons for high Maori mortality rates: 'unless Parliament passes a stringent law prohibiting the practice of any kind of tohunga, we

²³ Lange, *May the People Live*, p.247.

²⁴ *ibid.*, p.249.

²⁵ *NZPD*, 139 (1907), p.511.

²⁶ 'Witchcraft Among the Maoris, A Growing Evil, A Tohunga Reprimanded', *Auckland Weekly News*, June 29 1900, p.23.

²⁷ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.64.

shall always have a great many Maoris dying from the effects of tohunga-ism'.²⁸ In Pomare's first report as Native Health Officer, he called tohunga 'Goliaths in the way of sanitary progress'.²⁹ The biggest campaign against the medical work of tohunga was led by these Young Maori Party doctors. To this end, it is difficult to see the implementation of this Act as solely a means of colonial oppression.

The words of the Tohunga Suppression Act are also a useful gauge of the objectives of this legislation. The Act provided for the fine of 'every person who gathers Maoris around him by practicing on their superstition or credulity, or who misleads or attempts to mislead any Maori by professing or pretending to possess supernatural powers in the treatment or cure of any disease, or in the foretelling of future events, or otherwise'.³⁰ Thus it was the work of the tohunga rather than the tohunga themselves which was being prohibited. The Attorney-General, J.G. Findlay, shed further light on the imperatives behind the Tohunga Suppression Act: 'I wish to emphasize the point, then, that while we are adding to our statute-book a law which to-day does not lie upon ourselves, it finds justification in this: that it aims at the protection, and in no sense at the oppression, of our Maori brothers'.³¹ Although the Act did, in a sense, control the medical services available to Maori, politicians and members of the Young Maori Party saw this legislation as a protective mechanism by which Maori health could be improved through European practices and medicine.

As part of the debate on the Tohunga Suppression Bill requests were made for medical services in remote Maori areas. It was argued that in isolated areas the tohunga was often the only alternative and Pomare demanded subsidies for doctors.³² Apirana Ngata laid some blame for the lack of European forms of medical care with the government: 'I think this is the proper place to point out a real grievance on the part of the Maori people, in the lack of enthusiasm displayed by successive Governments in the matter of medical attendance on the Maori sick'. He went on to argue that 'In spite of the fact that many have urged that the Maori should be placed on the same footing as the European in matters of this sort, there is still ground for

²⁸ Report of the Department of Public Health, *AJHR*, 1903, H.31, p.71.

²⁹ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.61

³⁰ Tohunga Suppression Act 1907, *NZS*, 1907, p.26.

³¹ *NZPD*, 140 (1907), p.404.

³² Report of the Department of Public Health, *AJHR*, 1903, H.31, p.71.

urging for special provision for Maoris', and pushed for a medical substitute trained at university.³³ The debates on the legislation highlighted the importance of medical issues for Maori and the need for protection against the so-called harmful consequences of tohunga. The approved alternative was 'scientifically' trained doctors. Concern about appropriate forms of medical treatment lay at the centre of the debates about the suppression of tohunga.

It was also suggested that the power of tohunga could be checked by the introduction of a system of compulsory registration of births and deaths. Pomare stressed that:

The non-registration of Maori deaths blinds us to all the causes of his decay. Death-certificates will have a wide and far-reaching effect: it will make the deceiving tohunga tremble, the money-seeking *toi-ora* think twice before he practises upon the unsuspecting and simple Maori mind; and, further, it will give us a thorough knowledge of the diseases which are sweeping away the race, and thus enable us to carry on a more perfect warfare in preventing the spread of epidemics and infectious diseases.³⁴

The Chief Health Officer, J.M. Mason, also emphasised the importance of death registration.³⁵ Ngata, however, recognised the complexity of this issue and the unwillingness of many Maori to allow their whanau to be subjected to post-mortem examinations and persuaded the government not to go ahead with a proposed registration bill in 1910.³⁶ Despite regulations providing for Maori registrars in 1912, the requirement for medical certificates was not made compulsory and few deaths were formally registered.³⁷ Attempts to register births and deaths, although never in formal operation, may be seen as another means through which medical provision could be controlled and limited to acceptable forms of treatment.

Buck's field notebooks provide a very significant perspective on the medicinal role of tohunga. This is particularly the case when the campaign against tohunga by Buck and his colleague, Pomare, is taken into consideration. Buck's notebooks include records of pa visited and of some of the cases seen. He drew attention to a number of cases where Maori patients were cured by tohunga. Some had first been

³³ NZPD, 139 (1907), p.520.

³⁴ Report of the Department of Public Health, *AJHR*, 1902, H.31, p.64.

³⁵ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.xv.

³⁶ Lange, *May the People Live*, p.237.

³⁷ *ibid.*, p.238.

seen by Pakeha doctors who had given up hope of cure.³⁸ The Young Maori Party members in particular often drew a distinction between true tohunga and charlatan. They believed the proper tohunga had died out and that those now claiming to be tohunga were by definition fraudsters. In a Department of Public Health report Buck argued:

The present-day aspirant to the tohunga's fame is only a sorry apology seeking to attain the cheap notoriety of an hour. The tohunga of the past was a man full of learning, skilled in the treatment of the few ills extant in those healthy days, and he was an absolute necessity in the stage in which the race existed. The present-day caricature, unskilled and unlearned, can only play upon the superstitions of minds in a transitional and unsettled state whereby he brings disgrace upon the once-honoured name of tohunga.³⁹

It is not clear, however, if Buck was suggesting that the tohunga referred to in his notebooks were the tohunga of 'the past'.

There was also strong concern over the prevalence of Pakeha tohunga. The medical harm of these tohunga was also highlighted. The Tohunga Suppression Act only provided for the prosecution of Maori tohunga. Buck and Pomare, Native Health Officers, continually stressed the importance of outlawing Pakeha tohunga.⁴⁰ In the debate on the Tohunga Suppression Bill, Ngata drew similarities between Maori and Pakeha tohunga: 'the only fault I have to find with this Bill is its want of provision for the suppression of the pakeha tohunga....I want legislation to suppress also such practices as are exercised by the pakeha tohungas, who manage to kill their patients in a very similar fashion'.⁴¹ Ngata's statements demonstrate that medical issues were an important part of the campaign against tohunga, which was, to a certain degree, about the protection of Maori health.

The passing of the Quackery Prevention Act in the year following the Tohunga Suppression Act highlighted the significant political context of these pieces of legislation. There has been only a limited discussion, however, of the important context of these Acts. Jennifer Gray has provided the most thorough analysis of quackery and the reasons for its suppression.⁴² Gray's main focus is the use and

³⁸ Sir Peter Buck, Field Notebooks on Maori life and customs, illustrated with drawings, 1907-1926, Micro - MS - 0599, WTU.

³⁹ Report of the Department of Public Health, *AJHR*, 1907, H.31, p.61.

⁴⁰ Report of the Department of Public Health, *AJHR*, 1907, H.31, p.55; 1908, H.31, p.119.

⁴¹ *NZPD*, 139 (1907), p.513.

⁴² Jennifer M. Gray, 'Potions, Pills and Poisons, Quackery in New Zealand, circa 1900-1915', BA (Hons) Essay, University of Otago, 1980.

popularity of quackery. However she does suggest that the prohibition of quackery was driven by the growing centralisation and entrenchment of appropriate scientific forms of medicine. She argued that the pressure for ‘national efficiency’, the threat of a declining birth-rate and deteriorating physique were key pressures in regulating medicine.⁴³ Few other historians have addressed this important link. Belgrave has argued that the Quackery Prevention Act was ‘part of an attempt to control advertising for patent remedies’, while Derek A. Dow discussed the Act within the context of Mason’s achievements as Chief Health Officer.⁴⁴

The Quackery Prevention Act was part of the response to the growing public awareness of health issues and the desire to regulate the forms of medical treatment readily available. The connection between the suppression of *tohunga* and the prevention of quackery was highlighted by Mason: ‘We must do what we can to check the illicit practice of the *tohunga*; but while we engage ourselves in this good work, let us not shut our eyes to the fact that we are every bit as superstitious and illogical in our actions as our poorer brothers whom we condemn, and whom we are so anxious to rescue from the hands of the charlatan’.⁴⁵ The Quackery Prevention Act, because it was directed at Pakeha and has received little attention from historians, has not been subjected to arguments about cultural suppression, and can be seen more clearly in its medical context.

The desire to control the availability of medication was obvious from the language of the Act:

Every person commits an offence who publishes or causes to be published any statement which is intended by the defendant or any other person to promote the sale of any article as a medicine, preparation, or appliance for the prevention, alleviation, or cure of material particular [sic] relating to the ingredients, composition, structure, nature, or operation of that article, or to the effects which have followed or may follow the use thereof.⁴⁶

It reflected the prevailing medical view that anything which had not been developed or tested by members of the medical profession was harmful, or at least could not be proved to be beneficial. The scientific revolution and the medical developments of

⁴³ *ibid.*, p.55a.

⁴⁴ Belgrave, ‘Medical Men’ and ‘Lady Doctors’, p.323. Derek A. Dow, *Safeguarding the Public Health, A History of the New Zealand Department of Health*, Wellington: Victoria University Press, 1995, p.65.

⁴⁵ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.xv.

⁴⁶ Quackery Prevention Act 1908, *NZS*, 1908, p.177.

the late nineteenth century helped to firmly entrench this perspective as well as increase the power of the medical profession. This kind of legislation helped to entrench this power by rendering other forms of medical treatment illegal.

Although a piece of regulatory legislation, the Quackery Suppression Act was also 'protectionist'. Politicians repeatedly spoke of charlatans 'preying' on members of the public. J.A. Hanan spoke of the Government's duty 'to put an end to these contemptible practices, and to protect the lives and health of our people against swindlers and charlatans who prey with impunity from punishment upon the weak-minded, the sick, and suffering'.⁴⁷ The debates indicate that politicians, at least, saw the activities of those without medical training as a real threat to the health of the entire community. The legislation was just as much about the protection of the health of 'the people' and 'the nation' as it was about the control of medical practices.

The false use of doctors' names was a particular concern raised because of the perceived authority that doctors had in relation to health. Hanan told the House that: 'Doctor's names are falsely attached or used in connection with certain medicines or food preparations in order to induce people to believe they have the approval or are the property of medical men'.⁴⁸ The authority, power and respect attached to medical practitioners indicated the growing importance of medical issues in the wider society.

Any brief survey of newspapers from the early twentieth century shows a multitude of quack remedies advertised - from skin creams for skin diseases to blood purification tablets. The Quackery Prevention Act specifically sought to prohibit advertisements of this kind 'in any newspaper printed and published in New Zealand, or is publicly exhibited in view of persons in any road, street, or other public place'.⁴⁹ Once the Act was in force, however, there was actually very little reduction in the numbers and scope of advertisements in the same papers.⁵⁰

The control of food was another issue which was raised in the early twentieth century as part of the push to regulate health. The debates over the control of food

⁴⁷ *NZPD*, 141 (1907), p.480.

⁴⁸ *NZPD*, 141 (1907), p.480.

⁴⁹ Quackery Prevention Act 1908, *NZS*, 1908, p.177.

⁵⁰ This is the writer's own impression as no statistical review has been undertaken.

supplies highlighted a number of issues relating to the health of children, the health of the nation, the influence of events in Britain and Australia and the role of the state in the regulation of health. Although much of the debate occurred from 1905 to 1907, the Medical Association was one of the first to raise concerns in the 1890s regarding the necessity of inspecting meat supplies.⁵¹ There were also calls for the regulation of food supplies in the Department of Public Health Annual Reports in 1905, 1906 and 1907 and in the *New Zealand Mail*.⁵² Calls for the regulation of food supplies cited examples of similar laws in Britain, Australia and the United States. Civilisation was a justification for the need for intervention: 'Every civilised country has attempted to secure better and purer food for its people, and probably there is no direction in which legislation is more required, or has proved, if properly drafted, to be more beneficial'.⁵³

The Sale of Food and Drugs Act 1907 embodied the government's desire to intervene, for the health of New Zealanders, in order to protect and control the quality of food. The Act operated alongside the Public Health Act and provided for the appointment of 'analysts' to inspect food and drug supplies. Food was contaminated 'If it contains or is mixed or diluted with any substance which diminishes in any manner its nutritive or other beneficial properties as compared with such article in a pure and normal state and in an undeteriorated and sound condition'. There were also specific regulations placed on the weight of bread.⁵⁴

In Parliament G.M. Fowlds, Minister of Public Health, argued that scientific and food production developments had created the necessity for the control of food supplies: 'great developments have taken place in the manufacture of food and drugs, and...men's conceptions have also altered as to the necessity for inspection and for investigation to see that the people are supplied with pure food'.⁵⁵ Moreover, although science had allowed the improvement of food supplies and the detection of

⁵¹ 'New Zealand Medical Association, Minutes of the 6th Annual Meeting', *NZMJ*, Series 1, 4, (1891), p.191.

⁵² Report of the Department of Public Health, *AJHR*, 1905, H.31, p.22; 1906, p.ii; 1907, pp.ix-x, 'Pure Food and the Public Health', *New Zealand Mail*, 4 July 1906, p.42.

⁵³ *NZPD*, 139 (1907), p.696, (Findlay).

⁵⁴ Sale of Food and Drugs Act 1908, *NZS*, 1908, pp.88-96.

⁵⁵ *NZPD*, 139 (1907), p.345.

impurities, science had also created the means with which to evade the law and regulation was needed to counter this fraud.⁵⁶

Debates about the regulation of food supplies raised issues about the importance of health and the capacity of the state to protect the health of its inhabitants. Hanan observed, in the debate on the Sale of Food and Drugs Bill, that ‘we recognise the fact that public health is one of the foremost concerns of a nation’.⁵⁷ Other politicians also spoke of the state’s role in protecting the public’s health: ‘it is a matter the State has a right to regulate, in order to prevent injury to the health of the community by the passing on of inferior qualities of food or drugs’.⁵⁸ It was becoming increasingly common for the health debate of the moment to be seen as the most important health issue facing the nation. An editorial in the *New Zealand Mail* laid some of the blame for sundry social problems on the ‘inattention to the soundness and cleanliness of food’, and for this reason ‘no measures which shall serve to secure greater cleanliness of a people’s food supply can be considered too stringent or too expensive’.⁵⁹

A key focus of the debate about food supplies was the emphasis placed on ‘pure milk’ for infants. This emphasis may be seen in the context of concerns about degeneration, the importance of children and the extent to which these anxieties influenced government policy. In calls for the regulation of food supplies, the health of children was tied to the quality of their food, ‘transforming an ideal food for children into a veritable agent for ill health and death...the value of pure milk-supply cannot be overestimated in its influence upon infantile mortality’.⁶⁰ The concern over milk supplies touched on the issue of the Empire because ‘milk is not only the necessary diet of infants, but is an ordinary aliment for all young children, the alarm caused by the report of the Royal Commission touches every family in the Empire’.⁶¹

⁵⁶ *ibid.*, p.696, (Findlay).

⁵⁷ *ibid.*, 139 (1907), p.349.

⁵⁸ *ibid.*, 139 (1907), p.345, (Fowlds).

⁵⁹ ‘Pure Food and the Public Health’, *New Zealand Mail*, 4 July 1906, p.42.

⁶⁰ Report of the Department of Public Health, *AJHR*, 1906, H.31, pp.ii-iii.

⁶¹ *NZPD*, 139 (1907), p.350, (Hanan). It is thought that the reference to the Royal Commission is referring to the Inter-Departmental Committee on the Deterioration of the Race held in Britain in 1904, which referred to the negative effects of a poor milk supply on infants.

Poor milk supplies were also related to the high incidence of consumption.⁶² Prevailing concerns about degeneration were further reinforced by the anxiety raised over the connection between white bread and physical deterioration. The flour used in white bread 'is bereft of a large portion of that which is most desirable for bread used in order to get it as white as possible; but in the interest of the public good, it is high time this was stopped'.⁶³

The Sale of Food and Drugs Act, also known as the Pure Food Act, may be seen in the context of growing anxiety about health and the government's reaction to this concern by passing legislation which, at the same time as protecting the public, controlled food supplies. The debate highlighted the growing importance of health issues and the way in which these issues moved from being strictly health and medicinal matters and were caught up in concerns about the health of the entire nation.

The government, as well as establishing a framework of 'appropriate' medicinal treatments and supplies, also sought to deal with anxiety in other health areas through policies designed to both restrict and protect the lives of the population. The suggestion that the government was concerned to restrict immigrants with diseases such as tuberculosis was raised in Chapter Two. The debate over the restriction of undesirable immigrants will be discussed in the context of the government's wish to control and restrict to create an idealised society. Immigrants infected with tuberculosis were most often targeted in calls to restrict immigration.

The debate over the restriction of immigrants was considered in some detail by the Wellington District Health Officer, and Assistant Chief Health Officer, T.H.A. Valentine. He reported that 'It is frequently said with more or less reason that the yearly influx of consumptives into the colony from the United Kingdom has a very decided influence on the spread of the disease'. Although Valentine thought these claims were often overstated he concluded that:

They [consumptives] are a source of some danger to the community, and hence the advisability of admitting them to the colony is to be questioned. Though it is very

⁶² *NZPD*, 139 (1907), p.350, (Hanan). Report of the Conference on the Administrative Control and Treatment of Tuberculosis, *AJHR*, 1913, H-31A, p.4.

⁶³ 'White Bread and Physical Deterioration', *Press*, 14 February 1906, p.8.

hard to deny anyone the advantage of this climate, I think it is time that the Legislature considered the advisability of refusing to allow consumptives – except under special conditions – to land in New Zealand. I must also take this opportunity to protest emphatically against the practice of some physicians at Home of sending out unfortunates...only to be sent back if the shipping company importing them fails to sign the necessary bond; or who, if successful in passing the Customs authorities, drift into our hospitals and swell our rates'.⁶⁴

Valentine's report clearly shows that policies were in place through the payment of bonds for those suffering from consumption, although Mason, in the following year's report, referred to the need for a 'working-rule' and greater candour on the part of shippers and surgeons to enforce the proper inspection of passengers.⁶⁵

There were also calls from the Medical Association for the restriction of 'undesirables'. The president, James Purdy, suggested that 'it would be worth while in the interests of the race, as suggested by Mr. Grey before the English Commission, to impose an anthropometric test for aliens to prevent the admission to the Dominion of people with degenerate physique'.⁶⁶ Purdy's view reflected the way New Zealand concerns about health were viewed in the context of British concerns: what was necessary for good health in Britain was also necessary for New Zealand. It was thought that, if practices such as these were adopted in New Zealand, a 'healthy society' could be created, free of the evils of the old world, including those with long term illnesses such as tuberculosis, which put them in the category of degenerate.

The eugenics movement also lobbied for restrictions and controls in health and welfare in the early twentieth century. G.R. Searle argued that 'the eugenics movement can be seen as a part of the wider quest for national efficiency, which so dominated British political thinking in the opening years of the twentieth century'.⁶⁷ Issues raised in Chapter Five over degeneration, a declining birth-rate, urbanisation, national efficiency and the future of the British Empire were all concerns of the eugenics movement. There were a number of contradictions within eugenist thought but most agreed that 'true progress could only be achieved through racial progress; the level of intelligence, health, energy or beauty could only be raised by breeding

⁶⁴ Report of the Department of Public Health, *AJHR*, 1904, H.31, p.22.

⁶⁵ Report of the Department of Public Health, *AJHR*, 1905, H.31, p.xxix.

⁶⁶ 'President's Address', *NZMJ*, Series 2, 8:33 (1910), p.3.

⁶⁷ G.R. Searle, *Eugenics and Politics in Britain, 1900-1914*, Leyden: Noordhoff International Publishing, 1976, p.34.

from the best stocks and controlling the fertility of the worst'.⁶⁸ In New Zealand the eugenics movement was popular among the middle classes and the wealthy elite and a number of health professionals were members: W.H. Symes (Christchurch Chief Health Officer), Truby King (founder of the Plunket Society), F. Hay (Inspector-General of Mental Hospitals), and Mason (Chief Health Officer).⁶⁹ Philip Fleming argued that 'the duty of the State to involve itself in matters pertaining to the health and welfare of the community was an established principle and eugenists saw their calls for the State to involve itself in the fields of procreation and marriage as merely a continuation of this principle'.⁷⁰ Control and restriction of the population were viewed as the means by which a healthy and strong society could be created to avoid the evils of the old world. This was a constant concern of the elite in New Zealand.

Another form of control designed to protect the health of the nation was the travel restrictions placed upon Maori during the smallpox epidemic in 1913. Alison Day, in a thesis on the 1913 smallpox outbreak, has argued that 'The discriminatory enforcement of restrictions to control smallpox exposed deep prejudice within the European community over and above the fear of smallpox'.⁷¹ The smallpox epidemic became, on one level, a race issue. Almost all those infected were Maori and of the few Pakeha who did contract the disease, none died. For this reason it was regularly referred to as the 'Maori epidemic'.⁷² As the *Auckland Weekly News* reported: 'Everybody knows that the disease is a "Maori epidemic" of some kind or other and that it is being spread by the Maoris and by nobody else'.⁷³

The government's reaction to the 'Maori' aspect of the smallpox epidemic was to impose travel restrictions on Maori from infected areas. The Minister of Public Health in the Reform Government, Heaton Rhodes, said in Parliament that: 'it has been deemed necessary to put some restriction on Natives travelling in the Auckland District, and from the Auckland District to the Wellington District'. The trams, shipping and railways were all asked to prevent any Maori from travelling who did

⁶⁸ *ibid.*, pp.6-7.

⁶⁹ Fleming, 'Eugenics in New Zealand, 1900-1940', MA Thesis in History, Massey University, 1981, p.74.

⁷⁰ *ibid.*, p.28.

⁷¹ Alison Suzanne Day, 'The Maori Malady', the 1913 Smallpox Epidemic and its 19th Century Background', MA Thesis in History, University of Auckland, 1998, p.81a.

⁷² See for example: *Auckland Weekly News*, 17 July 1913, p.23, 24 July 1913, p.23.

⁷³ 'Editorial: Epidemics and the Health Department', *Auckland Weekly News*, 24 July 1913, p.55.

not have a permit from a public vaccinator.⁷⁴ It is difficult to come to a firm conclusion on the extent to which the push for restrictive measures was about stopping the spread of smallpox into other Maori communities or about protecting and safeguarding the Pakeha population. Those with a particular concern about Maori health, however, stressed the tragedy smallpox would create in Maori areas. Ngata was alarmed about a rumour that Pakeha were being vaccinated before Maori. He maintained 'that every step should be taken as rapidly as possible to vaccinate the Maori population, because they were more liable to take the disease, and that the Health authorities should be asked by the Health Department to give them preference at this juncture'.⁷⁵ Other politicians raised concerns over ineffective vaccine and the threat this posed to the rest of the community when those Maori vaccinated with the ineffective vaccine travelled.⁷⁶ The effect of a possible smallpox outbreak was also referred to in relation to economic issues and the security of New Zealand as a nation: 'No member should ridicule the situation, because if it became worse it would seriously affect the interests of the whole country. It would affect business generally, both in town and country. It was in the interests of the State that the House should assist the Health authorities in every possible and reasonable manner, irrespective of expense'.⁷⁷

The desire to protect both Maori and Pakeha through restrictions on travel had a serious economic effect on many Maori communities, who were unable to travel into the towns for food supplies, medical assistance or work. The restrictions were not fully lifted until July 1914, a year after the first travel restrictions were put in place. The outbreak of smallpox showed the extent to which the Reform Government viewed the importance of such 'draconian' measures, which imposed restrictions on Maori to protect the rest of the country. Health issues had become, by the beginning of the First World War, an area in which the government saw itself as taking a strong responsibility, particularly when the lives of the population were threatened.

The early years of the twentieth century saw a large number of statutes relating to health enacted which increasingly restricted and controlled society. The

⁷⁴ *NZPD*, 162 (1913), p.454.

⁷⁵ *NZPD*, 163 (1913), p.443.

⁷⁶ *ibid.*, p.15 (G.V. Pearce).

⁷⁷ *ibid.*, p.19 (J.A. Young).

medicalisation of society meant medical issues were more prominent on the public agenda. The government attempted to use medicine to create a healthy society. The legislation was also a response to increasing popular anxiety about health issues. The government promoted treatment by doctors, nurses and midwives and legislated against tohunga and quacks. The Tohunga Suppression Act and Quackery Prevention Act sought to protect society by controlling the practice of medicine. Along with the promotion of 'appropriate' medicine, the government tried to control the production and distribution of food and drink with the aim of protecting society and maintaining good health. In the process of attempting to create a 'healthy society' the government limited the number of immigrants and imposed restrictions on those who did arrive, especially if they suffered from 'old world' diseases. Moreover, during epidemics the movements of particular sectors of the population, particularly Maori, were restricted. These policies were a reaction to concerns about New Zealand's health and an attempt to ensure a good standard of national health. Good health was, after all, an essential national asset.

Conclusion

This is a study of perceptions of health in New Zealand from 1890 to 1914. It investigates the way in which these views changed and the manner in which they were reflected in health policies and programmes. Through the study of changing perceptions of health, broader themes emerge relating to the construction of a New Zealand identity, the role of the state, and the importance of health to national development. Histories of health must recognise that perceptions of health have a social, political and cultural context. It is important that any analysis of these ideas is undertaken in a way which both understands and acknowledges these contexts. A holistic view of the history of health recognises not just the medical context in which debates occurred but the socio-political environment too.

The study of New Zealand health issues in the late nineteenth and early twentieth centuries highlights anxieties about health and physical degeneration. This was a new development which reflected the growing importance of health issues on the public agenda. There were a number of reasons for perceptions of health changing. In the period from 1890 to 1914 there was a shift from explaining poor health and disease in environmental terms to explanations which increasingly emphasised human intervention. In the nineteenth century, for Pakeha at least, environmental factors were thought to be the primary determinant of health. The inherently healthy climate of New Zealand would breed a strong, healthy population.

This meant that health was not so prominent on the public agenda. Health was not a popular issue, though it was still of concern to specific individuals. There was no need for government intervention because the climate itself was sufficient 'medication' for a healthy population. Despite the calls of some prominent Maori, Maori health basically went unchecked in the nineteenth century. In pre-European times, Maori were thought to have been a strong, healthy, war-like race. Their alleged poor health and declining numbers in the nineteenth century, however, were viewed as a failure to compete with the stronger, more civilised British immigrants. In a sense there was a contradiction in understandings of health: although health was believed to be determined by environmental factors, when it came to a comparison between Maori and Pakeha health, these understandings were reversed. Maori were a race in decline because of their failure to adapt and compete with a new culture.

One of the reasons for the shift towards public intervention to improve health standards was the important medical developments of the 1880s. The revolution in bio-medicine meant the causes of diseases were known, vaccination proved more effective, and the means for improving sanitation and reducing infectious disease were becoming increasingly successful. The increasing medicalisation of society meant that conditions were right for a transformation in perceptions. Medical science could significantly improve the health of a population. The role of the doctor as the mediator of specialised knowledge about health, ill health and its causes was more important, especially as doctors often had a monopoly on such knowledge.

The centralisation programme of the Liberal Government and the more interventionist role of the state had special significance for health. During the period examined in this thesis the Liberal Government established a centralised bureaucratic state. With health issues now on the public agenda, the state was expected to provide for and protect the public's health. The Liberals responded with a programme of state centralisation of health services, including a Department of Public Health and other health initiatives. The very existence of the Department stimulated debate and anxieties about health concerns by officially placing health in the public sphere. The Department's work in communities created more public awareness of health issues. The health promotion and health education work undertaken by the Department, particularly in areas of infant health, tuberculosis and Maori health, also helped to

create public consciousness about health. Acceptance of the state's role in relation to health saw another shift in perception so that health was viewed as a national asset. The government also sought to cope with health anxieties by placing controls on the practice of medicine designed to protect society. The registration of midwives, nurses and doctors, together with the Tohunga Suppression and Quackery Prevention Acts provided a system for regulating the provision of medical services. Other controls were established to regulate and protect society, including policies relating to food supplies, the kinds of immigrants and the movements of Maori during epidemics.

Increasing state involvement and concerns about health were in part a reaction to the concern that New Zealand was becoming an increasingly post-frontier urban society, associated with poor health. The frontier in New Zealand was based on the myth of an arcadian, pastoral lifestyle and landscape, one which also had health benefits: fresh air, no overcrowding and an outdoor lifestyle. The demographic shift which saw the majority of the population living in urban centres challenged this identity. Cities were viewed as an evil of the 'old world': they bred dirt, disease and degenerate and immoral populations. Concerns were regularly raised by members of the public, health professionals and politicians about the sanitary standards in the cities and the need for intervention by local and central authorities. As a result, much of the public health work in the early twentieth century was directed at sanitation in the major cities.

International events and concerns, particularly those in Britain and in other parts of the British Empire, had a profound effect on the way health was perceived in New Zealand. In the late nineteenth century international epidemics had a significant impact on the direction of public health policies, particularly on sanitation and vaccination. The steamship removed, to some extent, New Zealand's isolation. Infectious diseases could travel rapidly from country to country. Awareness of the threat these diseases represented was heightened by the use of the telegraph to quickly transmit information about the spread of a disease through other countries. This meant that the progress of disease could be charted 'on its way' to New Zealand. In the early years of the twentieth century New Zealand was threatened both by plague and smallpox, probably the two most feared diseases, and there was a great deal of public panic and anxiety about their possible arrival. The influenza epidemic of 1918,

although beyond the period of this thesis, caused a considerable public outcry and provoked an intense examination of New Zealand's health.

From about 1904 concerns were raised about the possibility that the population was degenerating. These ideas became popular because of both the public importance of health issues and the influence of concerns in Britain. There were fears over the possibility that British evils could be replicated in New Zealand. Debates in Britain, meanwhile, were fixated on the possible deterioration of Europeans. The future of the British Empire became central to health debates in New Zealand as a consequence. Health was bound up with debates about national efficiency and national strength. A nation with poor health was seen to be a nation in decline. Related to concerns about degeneration were anxieties about a declining birth-rate – supposedly convincing evidence of a race in decline. A nation or an empire with a small population could not compete with threats from abroad, especially those from Asia. These were primarily the anxieties of the affluent elite and those who were concerned about the contamination of the paradise, free from the dirt, disease and impoverishment of Britain, they believed they were creating in New Zealand. The significance of these threats may be gauged by the political responses which generally targeted child and infant health as children were the future population of the nation and the Empire.

Perceptions of Maori and Pakeha health cannot be analysed in isolation from one another. The view that New Zealand was a healthy nation was founded on the first impressions of Maori. Concerns about Maori health also helped to bring health issues onto the public agenda around the turn of the century. Many Maori health issues pre-empted concerns raised about Pakeha health. Questions about sanitary standards in Maori communities and concerns about the decay and decline of Maori were both raised in the nineteenth century. Similar concerns were raised about Pakeha health in the early twentieth century. There was little work directed at Maori health until the early twentieth century, but from this point the burst of activity paralleled similar events in other health policies.

Maori health at the time did, however, show some characteristics independent of Pakeha health. Maori were thought, in the nineteenth century and early twentieth

century, to be a 'dying race', both culturally and physically: only Pakeha health practices and 'civilisation' could save them. The Young Maori Party was particularly strong in advocating assimilation to ensure the survival of Maori. Most of the policies to address Maori health came from members of the Young Maori Party, particularly Maui Pomare and Peter Buck. Native Health Officers appointed under the Public Health Act carried out significant health promotion work among Maori communities. Although their overall contribution to the improvement of Maori health is difficult to quantify, they helped to highlight fundamental issues and Pakeha, at least, perceived their role as one of bringing the 'gospel of health' to Maori.

This thesis articulates a different view from that argued in much health history in New Zealand. This is because it looks at policies in their broader socio-political context and alongside similar policies overseas and nationally. Medical issues are examined along with broader social issues in order to give a holistic view of health history. From this kind of analysis new conclusions may be drawn about what drove policy and how it reflects developments and trends in the wider society.

Using this new approach, this thesis highlights a number of key themes in relation to New Zealand's health history and also to broader social history. In the area of health history specifically, these themes include the changing role of medicine and even concepts of 'health', the need and demand for government intervention, concerns about declining standards of health and the relationship between Maori and Pakeha health. More general anxieties and public issues are also visible through the study of perceptions of health. They include the articulation of national concerns and the development of national identity, the emergence of an urban society and New Zealand's relationship with Britain. By 1914 perceptions had shifted to such an extent that the maintenance of good health was seen as an essential component for the future prosperity and security of a new New Zealand nation. This fundamental transformation in values paved the way for perhaps the most significant self-examination of all when, in 1918, the influenza epidemic struck New Zealand's shores.

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