

Central state initiative and local self-government in public health reform: Late-Victorian England and Meiji Japan in a comparative perspective

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In 1891, George Sclater-Booth (Lord Basing), who had been the President of the English Local Government Board (LGB) from 1874 to 81, attended the seventh International Congress of Hygiene and Demography, which was held in London. He chaired Section IX of the Congress, which dealt with 'State Hygiene'. In his opening address, Sclater-Booth justified his own capacity for the chairmanship, saying that England had 'in the President of the Local Government Board a Minister of Health in spirit if not in name, assisted by a body of able experts'. In fact, the LGB was an antecedent of the Ministry of Health¹, and some important public health statutes, including the Public Health Act of 1875, were established under his presidency, assisted by the Board's Medical Officer Sir John Simon² and his staff.

What Sclater-Booth was particularly proud of, regarding the development of public health administration in England, was that:

our system had grown and ripened from experience, beginning with the grant of special powers to the greater municipal authorities, and ending with general Acts conferring like powers on all local

¹ The Ministry of Health: Founded in 1919, amalgamating the LGB with the National Insurance Commissions.

² John Simon (1816-1904): Surgeon to St. Thomas's Hospital, London. Simon led the mid-Victorian public health movement, as the first Medical Officer to the City of London (1847-55), to the Privy Council (1858-71) and then to the LGB (1871-76).

authorities.

Pointing out both the English public's dislike of 'anything that savoured of bureaucracy' and the desirability of some central intervention in order to put pressure on reluctant local councils, Sclater-Booth supported a compromise between decentralization and centralization, which was, according to him, an important feature of the English public health administration at that time.³

In this paper, I would like to explore this compromise between central and local government in late-Victorian and Edwardian public health administration, first, by seeing how the issue was observed by the contemporary critics, Sidney and Beatrice Webb.⁴ Then, views of some Japanese senior public health administrators on the same issue will also be examined, so that we are able to convey a comparative perspective.

The 1870s system of English public health administration

The administrative machinery for public health in England, which was advocated by Sclater-Booth, had been established under the provisions of the Local Government Act, 1871, and the Public Health Acts of 1872 and 1875, following the recommendations of the Royal Sanitary Commission, 1869-71. It consisted of local 'sanitary authorities', and the LGB as the central supervising department.⁵

At the local level, county borough or borough councils (in large towns)

³ *Transactions of the Seventh International Congress of Hygiene and Demography, London, August, 10th-17th* (1891), vol. IX, pp.7-9; *British Medical Journal* (1891), i, p.374.

⁴ Webb, Sidney (1859-1947) & Beatrice (1858-1943): Fabian social reformers. Beatrice was appointed a member of the Royal Commission on Poor Laws, 1905-09 and, assisted by her husband Sidney, played a central role in the publication of the 'Minority Report' proposing more radical reforms for social welfare systems than the 'Majority Report' of the Commission.

⁵ For a general account of the development of Victorian public health policies, see A. Wohl, *Endangered Lives: Public Health in Victorian Britain* (1983), esp. Chapters 6,7.

and urban or rural district councils (in the country) were designated as local 'sanitary authorities' and assigned to deal with public health problems. In theory these local councils were representative bodies of local communities, whose members (councillors) were to be elected by local rate-payers. It was expected that different opinions and interests over how to deal with difficulties relating to public health should be coordinated democratically in the local councils. In proposing this administrative machinery, the Royal Commission was committed to the notion of local self-government, which was 'generally recognized as the essence' of England's national vigour, and as 'the distinguishing feature' of government in England.⁶

One of the important elements in these administrative developments in the 1870s was that every local sanitary authority was required to appoint a Medical Officer of Health (MOH) as the administrative head and expert advisor to the local council. The MOHs of the local sanitary authorities became increasingly professional through the late-Victorian and Edwardian periods, as specialist knowledge of preventive medicine increased due to developments in bacteriology and epidemiology, and due to the accumulation of practical experience in their work.⁷ It should be noted that they were employees (salaried officers), and not members, of the local councils. They were subject to the councils' decisions.

The Public Health Acts of the 1870s prescribed not only duties to be fulfilled by the local authorities, but also permissive powers which the local council could decide whether they should or should not adopt. And

⁶ *Second Report of the Royal Sanitary Commission*, in *British Parliamentary Papers*, 1871, XXXV, p.16. For a general account of the notions of government in modern England, see P. Thane, 'Government and society in England and Wales, 1750-1914', in F.M.L. Thompson (ed.), *The Cambridge Social History of Britain 1750-1950* (1990), vol.3, pp.1-62

⁷ D. Porter, 'Enemies of the race: biologism, environmentalism, and public health in Edwardian England', *Victorian Studies*, 34 (1991), pp.171-2; D. Porter, *Health, Civilization and the State* (1999), p.205

most statutes relating to public health during the Victorian era were permissive Acts. Thus, large discretion was left to local government: basically local councils in each locality could decide, on the basis of local needs and local political consensus, how and to what extent public health policy should be implemented, by using permissive powers.

At the central level, the LGB was set up in 1871. It was expected, by the Royal Sanitary Commission, to be a 'Central Authority, ... not to centralise administration, but ... to set local life in motion'.⁸ Thus, the LGB was assigned a tricky task: while expected to be an efficient central supervising body, it was not desirable to interfere too much with what the local authority was doing, or not doing, in deference to local self-government. One of the important powers which were given to the LGB was the power of granting sanctions to the local authority, particularly in relation to low-interest public loans for local undertakings for public health.

The Webbs' views on the English system

The Webbs basically supported the idea of compromise between central and local government. It is noticeable from their writings that they were sympathetic to the notion of local self-government, which had been advocated by the Royal Sanitary Commission.⁹ But their views were not exactly the same as that of Sclater-Booth. Unlike the former President of the LGB, they were actually highly critical of the present situation, in particular, of the performance of the LGB. They were concerned particularly about the LGB officials' red-tape and their unimaginative way of proceeding with social reforms.

In the mid-1900s, the Webbs got acquainted with some leading local

⁸ *Second Report of the Royal Sanitary Commission*, pp.30-1.

⁹ S. Webb and B. Webb, *English Poor Law History*, II, *The Last Hundred Years* (1929), p.622.

MOHs. This increased their criticism of the LGB. One of the important tasks of the local MOHs was to propose to their local councils what public health measures should be taken (e.g. proposals for modern sewerage systems, slum-clearance, municipal housing provision, enforcement of sanitary inspection, compulsory notification and isolation of the infected, municipal hospital provision). But local councillors did not always agree with their proposals. It was usual that MOHs confronted fierce opposition from local councillors who were worried about an excess of public intervention in the private sector and a waste of rate-payers' money. While the LGB as a central health authority were to promote public health measures supporting the MOHs, they also had to address the voice of local councillors and rate-payers.¹⁰ Thus, in sanctioning measures, the LGB often imposed conditions, in order to prevent the measure from becoming a waste of rate-payers' money. Understandably, however, such intervention by the LGB sometimes seemed to local MOHs to be obstructive and timid. The Webbs' low opinion of the LGB seems to have been enhanced through their findings from the MOHs.¹¹

In referring to the merits of local government in the public health administration, the Webbs tended to place more stress on the role of the MOHs (appointed officials) than on that of local councillors (elected politicians), since, in their view, the former were scientific and progressive, while the latter were often possessed with local vested interests. It is well-known that the Webbs' idea of the 'framework of prevention' was derived from their association with the MOHs.¹²

The 'framework of prevention' was the basis for their proposals in the

¹⁰ C. Bellamy, *Administering Central-Local Relations 1871-1919: The Local Government Board in its Fiscal and Cultural Context* (1988), pp.111-2, 233.

¹¹ For Beatrice's exchange with the Medical Officers, see B. Webb, 'The relation of poor-law medical relief to the public health authorities', *Public Health*, 19 (1906-07), pp.129-38.

¹² Porter, *Health, Civilization and the State*, p.205; J.M. Eyler, *Sir Arthur Newsholme and State Medicine 1885-1935* (1997), pp.218-9, 224-6.

famous Minority Report of the Royal Commission on Poor Laws of 1909. In this, they proposed to break up poor laws, and to reorganize local administration. Under the new system, all the social services were to be managed by expert officers of the local councils who should have the standpoint of prevention. In the sphere of public health, they proposed to establish a comprehensive state medical service by integrating existing public health and poor law medical services and putting it under the management of local MOHs. Poverty due to ill-health and other related causes could be prevented by establishing such a comprehensive set of social services based on the principle of prevention all over the country. Thus, in their view, poor laws were no longer necessary. At that time, poor laws were administered by boards of guardians at the local level, separately from the local councils. The Webbs' proposal for abolition of poor laws implicated a unification of local administration under the local councils¹³

But their proposals were not implemented. The LGB, which were in charge not only of public health but also of poor law administration, failed to adopt not only the Webbs' Minority proposals, but also the Majority Report of the Royal Commission. Since there was strong opposition to an expansion of the local councils' work both at the central and local level, LGB officials were cautious in making drastic moves. This event definitely increased the Webbs' irritation with the LGB. Actually, not only the Webbs but also many other contemporary critics and later historians have seen the LGB as a main cause of delay in progressive social policy innovations.¹⁴

We notice here that the Webbs expected that their proposals should

¹³ S. Webb and B. Webb, *The Break-up of the Poor Law: Being Part One of the Minority Report of the Poor Law Commission* (1909), pp.291-2.

¹⁴ J.L. Brand, *Doctors and the State: British Medical Profession and Government Action in Public Health, 1870-1912* (1965), p.82; F. Honigsbaum, *The Struggle for the Ministry of Health* (1970).

be implemented all at once under strong initiative from a central department (in this case, the LGB). The purpose of their reform was to make the most of the working of local government, but in order promptly to proceed with the reform all over the country, they expected that central government should act decisively without worrying about various local interests.

Some historians of political thought have debated whether the Webbs were 'centralists' or 'localists'. It has been pointed out that there was a tension between centralist and localist elements in their views, while there were some differences between Beatrice and Sidney.¹⁵

The Webbs acknowledged the important role to be played by the local councils and their officers. Thus, by breaking up poor law administration, they aimed to introduce a nationally uniform local government system under which the local council should provide social services, on the basis of local needs and local political consensus, under the supervision of experts like MOHs. The Webbs fought hard at the central level for the new system to be introduced at once under the strong initiative of central government, so the centralist elements in their thought apparently came to the fore, during their anti-poor law campaign.

I would like to distinguish here between a localist/centralist approach to reforming *outcomes* on the one hand, and to reforming *process* on the other. In the case of the Webbs, it can be argued that they envisaged fairly localist ideas for reform *outcomes*, but tended to assume a centralist approach to the reform *process*.¹⁶

The Webbs' views on the Japanese bureaucracy

The Webbs visited Japan in 1911, just after their anti-poor law

¹⁵ J. Stapleton, 'Localism versus centralism in the Webbs' political thought', *History of Political Thought*, 12 (1991), pp.147-65.

¹⁶ T. Nagashima, 'A veteran public health reformer planning for an NHS', *Keio Economic Studies*, 39 (2002), pp.51-2.

campaign came to a deadlock.

It is well-known that the Webbs were impressed by ‘the alert and open-minded Japanese bureaucracy’, which could, in their view, provide a significant advantage for the country’s pursuit of social reform. Mrs. Webb’s admiration for Japan as the paragon of national efficiency originated in Japan’s military victory over Russia in 1905. In view of Japan’s strong centralized government which was ‘in favour of organization, collective regulation, scientific education, physical and mental training’, she thought that Japan’s development helped to ‘bear out the Collectivist as against the individualist theory of the Political State’.¹⁷ It seems that Beatrice’s earlier expectation was endorsed by some ‘highly intelligent’ Japanese government officials whom they met during the visit. The Webbs implied that the Japanese bureaucracy might be the key to Japan’s making up arrears in social, as well as military and industrial, affairs.¹⁸

Their ultimate concern was of course not about Japan but about England. It seems that they brought up the example of Japan’s disciplined bureaucracy to clarify England’s relatively incoherent administration. They hoped that, in pursuit of collective policy, a group of able central government officials would display decisive leadership in England, as in Japan. As we have seen, LGB officials had failed to meet their expectations.

It should be noted however that the advantage of a centralist bureaucratic state was not the only point the Webbs wanted to make. In their article titled ‘The social crisis in Japan’ which appeared in the journal *Crusade* in 1912, they paid much attention also to defects due to fragile local self-government, pointing out the lack of ‘driving power of a

¹⁷ Quoted in J. Winter, *Socialism and the Challenge of War; Ideas and Politics in Britain 1912-18* (1974), pp.45-6.

¹⁸ S. Webb and B. Webb, ‘The social crisis in Japan’, *Crusade*, vol.3 (1912), p.19.

politically active democracy' in Japan.

. . . the Japanese Central Government has not yet learnt how to call to its aid, in administration as well as in finance, the indefinitely expansible force of local self-government. In its eagerness for efficiency, the Japanese Cabinet has adopted a bureaucratically controlled and minutely supervised system of local administration, partly German and partly French in its structure; and has failed, as yet, to learn from England how to create really independent centres of local initiative and local administration. . . .¹⁹

Once again, we see a mixture of centralist and localist elements in the Webbs' thought. They pointed out the importance of local democracy and advocated a locally-administered system as an *outcome*. But in the *process* of achieving this outcome, they expected that the Japanese central bureaucrats should exert their strong powers.

The development of public health administration in Meiji Japan

It was true that, in theory, Japanese central bureaucrats could exert much influence from above. In the public health sphere, a hierarchical administrative machinery was established under the initiative of the Sanitary Bureau of the Home Ministry, within a relatively short period of time during the last quarter of the 19th century.

The early years of modern Japanese public health administration was preoccupied with the control of acute infectious diseases, particularly cholera. The cholera epidemic in 1875 made the Home Ministry urgently issue the Provisional Regulations for the Prevention of Cholera. In 1880, this was transformed into a permanent and more comprehensive set of regulations: the Regulations for the Prevention of Infectious Diseases.

¹⁹ *Ibid.*, p.17.

This prescribed compulsory notification and isolation of six major infectious diseases. Thus, as early as 1880, Japan came to have a nation-wide system of compulsory notification of chief infectious diseases.

This constitutes a striking contrast with the deliberate pattern of policy innovation to which the English LGB adhered. It was in 1889 that a law prescribing compulsory notification passed Parliament in England: the Infectious Disease (Notification) Act. And like many of other public health statutes at that time, it was a permissive Act. Therefore, notification of infectious disease was made compulsory only in the localities where the local council agreed to adopt the measure. Actually, many local authorities hesitated to adopt it, since there were concerns about possible defects of the measure, such as public intrusion into the patient-doctor relationship and the stigmatization of patients and their families. It was in 1899 that the LGB proposed to make the Notification Act mandatory, because the experience of the local authorities which had adopted the Act proved to be successful. We can see here a good instance of the gradual pattern of policy innovation in England's public health administration, which was pointed out by Sclater-Booth.

Thus, thanks to its stronger inclination to centralism, Japan succeeded in establishing a nation-wide system of compulsory notification 19 years earlier than England.

The English system as a model for Meiji Japan

It should be noted, however, that centralization was not necessarily an aim that public health administrators in the Meiji government envisaged. Let us examine here views of two Japanese senior public health officials: Sensai Nagayo²⁰ and Shimpei Goto.²¹

²⁰ Sensai Nagayo (1838-1912): studied medicine in Nagasaki under Dutch physicians J.L.C. Pompe and C.G. Mansvelt. The first Director of the Medical Affairs Bureau of the Education Ministry (1873-75) and then of the Sanitary

Sensai Nagayo was the first Director of the Sanitary Bureau of the Home Ministry. The Meiji government's plan for public health administration was, to a large extent, designed by Nagayo himself, based on his experience of a 3-year visitation to Western countries (USA, England, Holland, France, and Germany) in the early 1870s.

In 1888, Nagayo delivered a paper, titled 'Public health and self-government', at a meeting of the Japan Sanitary Society. Outlining the development of the public health movement in England, he pointed out that initiatives for reform often arose at the local level, and that the role of central government was merely to co-ordinate uneven developments between localities. Thus, England was regarded as 'the home of local self-government'. France, 'on the contrary', had a well-centralized administrative system. However, public health reform in France seemed to him to be inactive, due to lack of 'the spirit of self-government'. He acknowledged the diversity in German public health due to the federal polity. While the Prussian State developed the autocratic 'medical police', some parts of Germany had traditions of local autonomy. Thus, he placed Germany somewhere between England and France.²²

This international comparison, if too simplistic, provided the basis for

Bureau of the Home Ministry (1875-91). He drafted the *Isei* (1874), a comprehensive law providing ground rules for public health administration, medical provision, education and qualifications, and pharmaceutical affairs.

²¹ Shimpei Goto (1857-1929): After serving as a physician to the Aichi Prefectural Hospital in Nagoya, Goto joined the Sanitary Bureau of the Home Ministry in 1883; studied hygiene in Germany (1890-92), and received his M.D. from the University of Munich; the Director of the Sanitary Bureau (1892, 1895-97); Chief civil administrator to the Colonial Government of Taiwan (1898-1906); President of the South Manchurian Railway Company (1906-08); Cabinet Minister of State for Communications (1908-11, 12-13), for Home Affairs (1916-18, 23-24), and for Foreign Affairs (1918); Mayor of Tokyo (1920-23).

²² S. Nagayo, 'Eisei to jichi no kankei', *Dai-Nihon Shiritsu Eiseikai Zasshi* (Journal of the Japan Sanitary Society. Hereafter, cited as *Eiseikai Zasshi*), vol.6 (1888), pp.260-74.

Nagayo's discussion over what sort of administrative machinery should be developed in Japan. He was apparently in favour of the English system. Historians have often stressed the German influence on Japan's modern medicine. In the sphere of public health, however, the British influence was thus not negligible.

A similar admiration for English public health reform was also held by Shimpei Goto, Nagayo's successor as the Head of the Sanitary Bureau. In 1891, Goto attended the seventh International Congress of Hygiene and Demography in London, mentioned at the beginning of this paper. It seems that Goto was impressed very much by Sclater-Booth's address, in particular his remark on the mixture of local self-government and central state intervention in England. Goto expressed his admiration for the way in which the LGB was proceeding with health policy innovation by leaving some space for local self-government. He remarked that, although its 'decentralist' approach was seemingly weak in comparison with the 'centralist' approach in other European countries, England's public health administration was effective, because it assumed the penetration of public health ideas into the general public, which could not be attained by one-sided enforcement from central government. He recognized the advantage of interactions between individual and state efforts through the medium of local government and voluntary organizations.²³

The Japanese central public health officials had once attempted to introduce a system of public health administration based on local self-government. In 1879, under Nagayo's initiative, elective sanitary committees were set up at each small unit of local administration. This was to let the local committees, which were, if limited, subject to

²³ S. Goto, 'Dai-7-kai Bankoku Eisei-kai ni okeru Kokka Eiseigaku bu kaigi no taiyo'(A report on the section of state hygiene, the seventh International Congress of Hygiene), *Eiseikai Zasshi*, vol.10 (1892), pp.509-41. For an account of Goto's views, see also K. Ozaki, 'Goto Shimpei no eisei kokka shiso ni tsuite', *Historia*, 153 (1996), pp.199-219.

democratic procedure, deal with local health matters.

However, things did not go afterwards as Nagayo had intended. In 1885, the elective sanitary committee system was abolished, for the reason that it proved to be difficult to secure suitable candidates for the committees. This action was part of the local government reform which was undertaken in the mid-1880s and early 90s, under the direction of successive Home Ministers. Meiji political leaders wanted a local government system which would faithfully implement the interests of the state, thinking that local authorities should merely be agencies of central government.²⁴ It was through this reform that a highly bureaucratic, hierarchical local government system emerged. In 1893, at a later stage of the reform, the administration of public health regulations was put under the jurisdiction of the police forces at the local level. This was intended for an efficient execution of 'medical police' work, including compulsory notification, inspection and isolation of the infected.

In 1898, Goto expressed his regret that there were few local authorities whose performance in the prevention of infectious disease was satisfactory. He saw its cause in the lack of cooperation between local police officials and the local public. The oppressive character which was inherent in the police tended to fail at obtaining local people's cooperation. He warned that one-sided enforcement of measures from the central state could result in 'the general public's neglect of public amenity'. Goto felt what Japan lacked were movements from the local grass-roots upwards involving not only officials and but also local lay citizens.²⁵

Thus the Japanese public health reformers struggled in promoting a locally-initiated public health reform by central bureaucratic means. They certainly had a centralized administrative system but the

²⁴ K. Steiner, *Local Government in Japan* (1965), pp.32-43.

²⁵ S. Goto, 'Shi-cho-son jichi-tai to densenbyo yobo jimu'(Local authorities and the prevention of infectious diseases), *Eiseikai Zasshi*, vol.16 (1898), pp.675-704.

establishment of such a system did not automatically promise satisfactory implementation of public health reform. Basically, public health was compatible with Meiji Japan's national slogan, 'enrich the country, strengthen the military', because elimination of ill-health would constitute the basis for the pursuit of a powerful nation. In practice, however, there were a lot of difficulties. Finance was an obvious problem.²⁶ In addition, what Goto was especially concerned about was the absence of local people's subjective involvement in public health matters and the absence of local experts who would guide the local people with specialist knowledge of preventive medicine. It was, however, impossible for him to dispose well-trained preventive medical experts overnight and to establish mutual cooperation between local people and those officials.

Conclusion

This paper aims to rethink the simplistic assumption that centralization was efficient and decentralization was inefficient in public health administration. England, after the late-1870s, lacked powerful central bureaucrats such as Sir Edwin Chadwick.²⁷ It was the LGB which was assigned the difficult task of balancing central state intervention and local self-government. As we have seen in the case of infectious disease notification, the LGB was cautious in enforcing measures as long as opposition existed at the local level, and it waited until most of the country had become ready for mandatory measures. This time lag between the permissive and mandatory measures had an important

²⁶ Financial aspects of central/local relations are left for further research.

²⁷ Edwin Chadwick (1800-90): The author of the *Report on the Sanitary Conditions of the Labouring Population of Great Britain* (1842). Chadwick played a central role in the establishment of the first Public Health Act of 1848. But his centralist temperament aroused fierce criticisms, and he was obliged to retire from central government in 1854. See A. Brundage, *England's "Prussian Minister": Edwin Chadwick and the Politics of Government Growth, 1832-1854* (1988).

implication: this let local communities discuss public health issues as their own problems. Such a localist approach to the reform process, however, sometimes attracted criticisms from a progressive point of view, as the LGB seemed to lack the decisive sense of initiative.

The Webbs basically supported a localized system of administration. But they insisted that there were occasions on which central officials should act decisively for reform even if they confronted opposition from local vested interests. Thus, in 1909, they urged LGB officials to exert central initiatives in establishing a locally managed comprehensive state medical system by dismantling poor laws. But the approach the LGB actually adopted in the *process* of establishing such a system was a deliberate one as ever. Instead of dismantling poor laws and establishing a nationally uniform local-council-based public medical system all at once, the LGB officials advised local councils to make partial, practical arrangements, starting with provision for tuberculosis patients, by coordinating their public health services with poor law medical and other voluntary and private health services, corresponding to local circumstances, within the range of political consensus, in each locality. Sticking to the existing late-Victorian system of administration, the LGB as the central department sought a localist approach not only to reform *outcomes* but also to the reform *process*.²⁸

Thus, public health services were extended only gradually, partially and unevenly, due to a degree of decentralization, during the late-Victorian and Edwardian periods. But it would be misleading automatically to assert that reforms were 'delayed' because of the lack of strong initiatives from central government. It is questionable whether it was desirable and possible that central government assumed such an exclusive influence on health policy. After all, public health was basically

²⁸ Nagashima, *op.cit.*, pp.42-3.

about local problems, and there were a variety of practical difficulties. It was (and still is) not always self-evident what measures should be taken and how. The process of forming consensus among local people by coordinating various opinions and interests in each locality was important.

Of course, this is not to say that the LGB and the local councils were without defects, but only to point out that the deliberate pattern of policy innovation, which was derived from a compromise between central intervention and local self-government in the late-Victorian and Edwardian public health administration, had its advantages. At least, the advantages seemed clear to the architects of public health administration, Nagayo and Goto, in Meiji Japan. They had no choice but to assume a centralist approach to the reform process, but they struggled to secure effective public health reform at the local level at which local people should take an active part.