through shame or emulation, to the more backward authorities to increase their efforts.[1]

REGISTER OF COMMON LODGING-HOUSES

No.	Date of Registration.	Name of Keeper of Lodging-house.	Name of Deputy-Keeper.	Residence of Keeper.	Situation of Lodging-house.	No. of Rooms set apart as Bedrooms.	Cubical Contents of Bedrooms.	No. of Lodgers allowed in each Bedroom.	Whether whole or part of such House (and what part) is used as Common Lodging-house.	Name of Officer by whom House was Inspected.	Date of Inspection.	Date of Approval.	Date of Certificate of Character	Names of Ratepayers by whom Certificate was signed.	Condition.	Remarks.

REGISTER OF WHOLESALE DEALERS IN MARGARINE AND MARGARINE CHEESE AND MILK BLENDED BUTTER

No.	Date of Registration.	Name and Address of Applicant for Registration.	Situation of Premises on which business of Wholesale Dealer is carried on.	Name and Address of Owner or Occupier carrying on Business.

[1] For more detailed information on this subject, see Public Health section of *Municipal Office Organisation and Management*, W. Bateson (Ed.), and *Organisation and Administration of the Public Health Department*, by W. A. Leonard.

CHAPTER XXII

TOWN PLANNING AND IMPROVEMENT

As a unit of the local administration the public health department is engaged in the discovery and abatement of nuisances, the regulation of particular trades and premises, the investigation into and isolation and treatment of infectious disease, the provision of various services for the welfare of mothers and children, and the protection of the food supply. These functions are, as a rule, peculiarly personal; they bring the department into relation, not with the community as a whole, but with individuals or small groups of individuals. It is for this reason that the possession of courtesy, tact and a wide knowledge of men and affairs is particularly essential for officials of the department.

The sanitary authority is, however, endowed with other powers and duties which involve complex engineering and architectural questions, the construction of various works and buildings, and often the establishment of special departments with officials equipped with experience, knowledge and skill peculiar to the service in which they are engaged. Such subjects of sanitary administration as the regulation of streets and buildings, the provision of houses for the working classes, town planning, sewerage and sewage and refuse disposal works, water supply, and the provision of public abattoirs, markets, baths and washhouses, burial grounds and crematoria, are, as a rule, matters with which the surveyor or engineer has to deal, at least until they are handed over to the special department into the care of which some of them are usually placed. But all of them affect the public health, and several are, either by order of the

Ministry of Health or on the initiative of the medical officer of health, dealt with in his annual report; and, in the case of many of them, proposals for the performance of the duties or the establishment of the services or institutions, usually originate in the public health department. Upon the medical officer of health falls the duty of advising his authority when such duties and works are necessary for the public health, and by his staff are gathered the data upon which his advice is based. Hence, although the work, service or institution generally passes out of the domain of the public health department, the responsibility of the medical officer of health in the initial stages is very onerous.

In the early years of the nineteenth century the new towns which arose as a result of the concentration of population due to the industrial revolution were constructed without plan, streets were made without regulation and houses were built without supervision; out of these circumstances developed many of the sanitary difficulties and problems with which later generations had to grapple. That day is passed, and local authorities now possess extensive powers for regulating the development of estates, defining conditions with which new streets and buildings must comply, and improving conditions which have developed in the absence of supervision and control.

The Public Health Act, 1875,[1] vested all streets repairable by the inhabitants at large of urban districts in the local authorities, who were empowered to make up, repair, or alter them at their discretion. They were also given powers,[2] extended some years later,[3] to compel owners or occupiers of premises fronting, adjoining, or abutting on private streets, to sewer, level, pave, metal, flag, channel, make good, or light such streets to the satisfaction of the authority, after which they might be declared to be public highways repairable by the inhabitants at large. Failure to comply with the notice can be met by the authority

[1] Section 149.
[2] Public Health Act, 1875, ss. 150 to 152.
[3] Private Street Works Act, 1892.

carrying out the necessary work and recovering the expenses incurred. An urban authority may also deal with the naming of streets and the numbering of houses, take steps to improve the line of streets, remove obstructions, deal with ruinous or dangerous buildings, and prescribe precautions to be taken during the construction or repair of sewers, streets and houses.[1] It is also empowered to purchase any premises for improving any street, or, with the sanction of the Ministry of Health, for making any new street,[2] and may regulate the building line where the whole or front of any house or building has been taken down.[3]

As regards new streets and buildings, the important power of making bye-laws has been placed in the hands of urban authorities.[4] These may be made in respect of the level, width, sewerage and construction of new streets, the structure, drainage and sanitary arrangements of and air space about new buildings, and for closing and prohibiting the habitation of buildings unfit for human habitation. These powers were extended fifteen years later, and rural authorities were empowered to make similar bye-laws, but for buildings only.[5] Building bye-laws are, in the larger districts, administered from the surveyor's or engineer's department, building inspectors being employed for the purpose, but in many of the smaller areas the duties are added to those of the sanitary inspector.

County councils and other highway authorities are empowered to prescribe building lines along highways repairable by them, provision for compensation or betterment being made.[6] They may control height and character of walls, hedges, etc., and restrict the erection of new buildings at corners or bends,[7] and may plant and maintain trees, shrubs and grass margins along the highway.[8] The

[1] Public Health Act, 1875, s. 160.
[2] *Ibid.*, s. 154.
[3] *Ibid.*, s. 155. See also Public Health Acts Amendment Act, 1890, ss. 33 to 43.
[4] *Ibid.*, s. 157.
[5] Public Health Acts Amendment Act, 1890, s. 23; see also Public Health Acts Amendment Act, 1907, ss. 13 to 33.
[6] Roads Improvement Act, 1925, s. 5.
[7] *Ibid.*, s. 4.
[8] *Ibid.*, s. 1.

Public Health Act, 1925 (Part II), which is adoptive,[1] enables the same authorities to prescribe "improvement lines" preventing the erection of buildings upon land which may be required for street widening,[2] and gives other powers in enlargement or addition to those already possessed for the regulation of highways.

Previous to 1909, although local authorities could regulate the construction of new streets and buildings and take action to remove certain obstacles or dangers to the use of such places, they had no power to take a broad survey of the general conditions of their area with a view to its development on lines at once healthy, artistic and convenient. The Housing and Town Planning Act of 1909, which altered this condition of affairs, was followed by several other Acts, the bulk of the provisions of which have been consolidated in the Town Planning Act of 1925. By this Act the London County Council and borough and urban and rural district councils may make town-planning schemes in respect to any land which is in course of development or appears likely to be used for building purposes, with the general object of securing proper sanitary conditions, amenity, and convenience in connection with the laying out and use of the land, and of any neighbouring lands ;[3] and the council of every borough or urban district having a population of more than 20,000 at the census of 1921, must prepare and submit to the Minister of Health such a scheme before January 1, 1929.[4] In the performance of this function they are subject to a rigorous control by the Ministry who have issued regulations prescribing the procedure necessary to secure their consent to the schemes and for carrying them out. The Ministry's decision is final, but, permission obtained, the next step is to prepare the scheme, which may include land already built upon, and submit it, together with all the necessary plans and information, to the Ministry of Health, who may subject it to modifications and conditions. A scheme may be

[1] Applicable to county councils without adoption.
[2] Sections 33–4. [3] Sections 1 and 2. [4] Sections 3.

revoked or varied by similar procedure,[1] but otherwise it may be enforced against a defaulting authority by an order of the Ministry of Health, made after inquiry and enforceable by *mandamus*.[2] The Ministry may, in a similar way, compel a local authority to prepare and submit a scheme, to adopt any scheme proposed and presented by the owners of any land, or to consent to any modifications or conditions imposed by the Ministry in respect of a scheme prepared by the authority.[3] Provision is made for compensation either by the authority to owners of property injuriously affected by such a scheme or to the authority by owners of property which is increased in value by the scheme, the expenses incurred being considered as expenses under the Public Health Act, but money borrowed is not subject to the limitations imposed by that Act.[4] In the metropolis the expenses are defrayed out of the county rate, and loans are raised in the same manner as for general county expenses.[5]

The preparation of town-planning schemes needs very careful consideration and the collection of a great deal of data, so that, having in mind the unprecedented nature of the work, it may be considered satisfactory to find that at March 31, 1926, 324 local authorities had submitted 498 schemes covering an area of 2,181,266 acres.[6] At the same date there were thirty-four joint Town Planning Committees, formed under the provisions of Section 2 (3) of the Act, which included 537 local authorities, covering a total area of $5\frac{3}{4}$ million acres, with a population of 17 millions, and a combined rateable value of £88 millions.[7]

For the improvement of areas already built upon powers are given in the Housing Act, 1925, which repealed a whole series of previous Acts and consolidated and amended their provisions. Part II deals with unhealthy areas which are represented to the local authority by the medical officer of health as needing an improvement scheme for the

[1] Town Planning Act, 1925, s. 2. [2] *Ibid.*, s. 14 (2–3).
[3] *Ibid.*, s. 14 (1). [4] *Ibid.*, s. 20 (2). [5] *Ibid.*, s. 20 (3–4).
[6] Seventh Annual Report of the Ministry of Health, pp. 181–5.
[7] *Ibid.*, p. 75.

rearrangement and reconstruction of the streets and houses within such area, or of some such streets and houses. It is the duty of a medical officer of health to make such representation when he discovers such an area, if his attention is drawn to it by a local justice of the peace or four or more local ratepayers. If on receipt of such a complaint the medical officer of health fails to inspect the area an appeal may be made to the Ministry of Health, who may send an inspector, and, if satisfied that the area is unhealthy, must make a representation to that effect to the local authority. As a rule the preparation of an improvement scheme as well as schemes of town-planning and reconstruction become matters for the surveyor or engineer, who consults with the medical officer of health. In the county or city of London the scheme must include the provision of dwelling accommodation for at least half the number of persons displaced, although this need not always be upon the same site; in the provinces the Ministry of Health may require the provision of such accommodation as the local inquiry shows to be necessary. After complying with the preliminary procedure, which includes the publication of the scheme in a local newspaper and the service of notices upon every owner or reputed owner, lessee or reputed lessee, and occupier of lands proposed to be compulsorily taken, the Ministry of Health must be petitioned for an order confirming the scheme. The Ministry may first direct a local inquiry, but their order when made has effect as if enacted in the Act and is enforceable upon a neglectful authority by *mandamus*.[1]

Many notoriously unhealthy areas in different parts of the country have been improved by the use of these powers, by virtue of which seventy-three local authorities submitted ninety-five improvement schemes between 1919 and the 31st of March, 1926, fifteen of such schemes, involving the demolition of 1,597 houses and other buildings, being confirmed during the year then current.[2]

[1] Housing Act, 1925, ss. 50–1.
[2] Seventh Annual Report of the Ministry of Health, p. 62.

Part I of the Act of 1925 relates to unhealthy dwelling-houses or obstructive buildings of which complaint may be made to the local authority by any four or more local government electors or a justice of the peace.[1] The medical officer of health is required to represent such houses and buildings to his authority.[2] If the authority fail to exercise their powers where necessary, complaint may be made to the Ministry of Health as respects a rural district council by the county council, the parish council or meeting of any parish within the district, by a justice of the peace or by four local government electors; as respects county boroughs by a justice or four electors and as respects other urban districts by the county council, a justice or four electors.[3] The Ministry, after inquiry, may order the local authority to take the necessary proceedings and may enforce their order by *mandamus*, but in the case of county districts they have the alternative, if the county council consents, of issuing the order to the county council. The power of local authorities to make closing orders in respect of houses certified as unfit for human habitation, and demolition orders where they have not been rendered fit has been already referred to,[4] but the local authority, upon the representation of the medical officer of health or county council, may deal with buildings which, whilst not themselves being unfit for habitation, are so obstructive as to render others unfit. Such a building may be ordered to be demolished, failure to do which may be met by the local authority acquiring the property and doing the necessary work, compensation to the owner, in case of difference, being settled by arbitration.

For dealing with cases intermediate between single houses and large insanitary areas the local authority is empowered to purchase by agreement or compulsorily, subject in both cases to the consent of the Ministry of Health, any property required for a reconstruction scheme. The object of such a scheme may be either to dedicate the land

[1] Housing Act, 1925, ss. 10 and 19 (2).
[2] *Ibid.*, ss. 9 and 19. [3] See Chapter XX. [4] *Ibid.*, s. 23.

as a highway or open space, use it or exchange it for land to be used for the erection of houses for the working classes, or to remedy the bad arrangement or condition or the sanitary defects of any buildings where the site is too small to be dealt with by an improvement scheme.[1] After the usual resolution of the council and notices to owners and occupiers, the Ministry of Health must be petitioned to make an order sanctioning the scheme, a local inquiry being held if the Ministry think fit, the usual means of compulsion being available in case of default. This power is a very useful one, and the objects of an improvement scheme may often be attained by its judicious use without the great expenditure involved in such a scheme.

It had long been felt before the War intervened that the crux of the housing problem is the provision of adequate and healthy housing accommodation; it is not sufficient to pull down insanitary houses—healthy houses must be provided. The War placed a rigorous check upon the building of houses—privately and by public authorities—and housing accommodation became not only more defective in quality but deficient in quantity. As so often happens, economic considerations enter here; it is a truism that so long as we have the poor they will be poorly housed unless low or irregular wages are supplemented by the provision of houses at rents which fail to be sufficient to cover cost of construction and maintenance. To the objection that such a policy creates a privileged and pauperized class it may well be urged as a valid argument that the considerations of public health are worth the expense incurred, and that the effect of decent housing will be to raise the standard of life of those housed, especially the children, improve their economic value as productive agents, and ultimately result in an increase of their remuneration. This is not intended to beg the question against proposals to directly increase or regularize earnings, which is by far the superior method of dealing with the problem, but until this is generally

[1] Housing Act, 1925, s. 37.

achieved the health of the people must not be sacrificed to the exigencies of economic theory.

Post-war conditions converted all shades of political opinion to the recognition of the fact that without public assistance housing conditions would go from bad to worse. A series of Acts provided such assistance in the form of subsidies to local authorities, public utility societies and private builders to encourage the building of houses of an approved type, and from the Armistice to March 31, 1926, over £45½ millions had been paid by the Exchequer as subsidies in respect of housing,[1] and two years later the Minister of Health could boast that no less than 1,102,000 houses had been built, 412,000 by local authorities.[2]

Local authorities are, to an increasing extent, utilizing their powers of acquiring land within or without their districts, and providing thereon "housing accommodation," a term which includes "lodging-houses and separate houses or cottages containing one or several tenements," and a cottage may include a garden not exceeding an acre in extent.[3] Land may be acquired by agreement or leased, with the consent of the Ministry of Health, and houses may also be acquired, roads may be laid out and part of the land may be used for all purposes for the convenience of persons belonging to the working classes and other persons.[4] Complaint of default may be made in the same way and the Ministry have the same powers of compulsion as in the case of Part I, but they must take into consideration the necessity for further accommodation for the housing of the working classes, the probability that such accommodation will not be otherwise provided, and the prudence of placing increased liability upon the rates.[5] In the case of rural districts, the county council, if satisfied that a complaint of default is justified, may resolve that the powers of the district council be transferred to them, notice of such intention being given to the council concerned, after which

[1] Seventh Annual Report of the Ministry of Health, p. 60.
[2] House of Commons, May 15, 1928.
[3] Housing Act, 1925, s. 57.
[4] *Ibid.*, s. 58.
[5] *Ibid.*, s. 73.

application must be made to the Ministry of Health for an order transferring the necessary powers.[1]

The lack of housing accommodation has hampered the closing and demolition of houses very considerably, but a reference to the figures of work done in this direction shows that where opportunity offers many local authorities are alert to their responsibilities.[2] Mention must be made of the Housing (Rural Workers) Act of 1926, which enabled, within limits, rural authorities to aid the owners of dilapidated cottages to recondition them, without an increase of rent. Progress has been "disappointingly slow,"[3] but when the possibilities of the Act are better realized much useful remedial work will probably be done.

Although not properly within the province of the public health department, the powers given by the Small Dwellings Acquisition Acts of 1899 and 1923 are important as being a useful factor in the solution of the housing problem. By these Acts local authorities are empowered to lend on mortgage to the occupiers of small houses up to 90 per cent. of the approved purchase price to enable them to own the house in which they dwell. It was the latter Act which extended the amount which might be advanced; and its popularity and value may be gauged by the fact that since its passing local authorities have advanced £54½ millions whilst building societies have contributed to the solution of the problem £172 millions in aid of the purchase of small houses.[4]

Progress in housing still appears to many to be painfully slow; all public health officials are alive to its urgency, but considering the complex economic and social factors involved the advance made must appear to the unprejudiced observer to be a very remarkable testimony to the value of the co-operation of national and local authorities, co-operative enterprise and private effort.

[1] Housing Act, 1925, s. 77.
[2] See page 149.
[3] The Minister of Health in the House of Commons, May 15, 1928.
[4] The Right Hon. Neville Chamberlain in the House of Commons, May 15, 1928.

CHAPTER XXIII

SANITARY SUPPLIES AND SERVICES

THE Royal Sanitary Commission, in their second report (1871) includes, amongst other things comprising "the ordinary supply of what is necessary for civilized social life," a supply of wholesome and sufficient water for drinking and washing, provision of sewerage, and the utilization of sewage, removal of refuse, provision of burial for the dead without injury to the living, and regulation of markets. In so doing, they rightly recognized that the subdivision of local government which was referred to them was "generally designated in recent legislation as sanitary though it might be, in a wider sense, called economical."

It is important to press this point when considering public health efforts of all kinds. Looked at from a financial point of view, these efforts result on the whole, and usually in detail, in a loss; the balance is usually on the debit side. But, viewed as benefiting the community, as a provision of "collective goods"[1] which are enjoyed by all, and often to the greatest extent by the poorest members, the financial outlay is amply justified. It is these facts that have deterred private enterprise from any general attempt to provide the supplies and services enumerated above. The public interest and private interests clash; and to the growing recognition that, in matters of health at least, the interests of the community cannot be left to the mercies of private individuals, we owe the increasing extension of the public provision of these supplies and services.[2]

[1] Marshall, *Economics of Industry* (1893), p. 54.
[2] Compare Mill, *Representative Government*, Chapter XV.