When we have been successful in educating the public to the great importance of these matters —the danger to which they are exposing others, and the danger to which they are being exposed— I hope that the thinking portion will take an intelligent interest in the matter, and render us their earnest co-operation and assistance, and thus augment our powers to conserve the public health.

Mr. Kershaw's lectures on sanitary plumbing, that I have referred to in a previous portion of this report, have not been confined to Napier. The plumbers of some of the other towns have expressed a desire for instruction, and have benefited by Mr. Kershaw's ability to communicate it.

I have addressed the local bodies with reference to the appointment of sanitary inspectors. Dannevirke and Woodville have expressed themselves favourably towards the suggestion, and I have no doubt will soon have the matter *en train* for the appointment. Other local bodies have brought the matter up at their meetings, and shelved it for future discussion; and some others are silent upon the point. During the winter months I shall have more opportunities of meeting the various local bodies, discussing the matter with them, and pointing out the necessity of the appointments.

F. D. DE LISLE, L.R.C.P., D.P.H., F.R.I.P.H.,
District Health Officer, Hawke's Bay.

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## WELLINGTON DISTRICT.

Department of Public Health, Wellington, 24th August, 1903.

Dr. Mason, Chief Health Officer, Wellington.

WELLINGTON HEALTH DISTRICT.—Area, 12,696 square miles; population—white 183,170, Maori 7,162—190,332; dwellings, about 20,000; birth-rate, 28·4 per 1,000; death-rate, 9·8 per 1,000; infectious diseases notified (exclusive of measles), 1,526. *Local Authorities:* Boroughs, 21; County Councils, 21; town districts, 10; Road Boards, 40: total, 92.

In spite of many drawbacks, the work of the year 1902–3 has not been completely devoid of result. In last year's report our hopes for the coming year were duly set forth. Some of these hopes have been realised; but many, alas! must be served up as a *réchauffé* for 1903. We have, however, made some headway, and among our triumphs may be mentioned—(1.) The more or less successful organization of the district into sub-districts, each under the charge of a competent sanitary inspector, appointed by and under the control of the Department. (2.) The satisfactory arrangement that has been made with the Wellington Corporation as regards the inspection of the city. (3.) The fact that four boroughs have adopted water and drainage systems, one borough a public water-supply, and four boroughs have decided to extend their drainage systems. (4.) A general improvement in the sanitary condition of the whole district. (5.) The erection of three hospitals for the treatment of infectious cases.

It is obviously unwise to tabulate our failures, but chief among these has been our inability to cope with the epidemic of scarlet fever, which is even now in our midst.

### ANOMALIES OF "THE PUBLIC HEALTH ACT, 1900."

It has been noted by more than one competent authority that the New Zealand Health Act of 1900 is one of the most complete Acts on the subject in the English language. It certainly strikes the ordinary reader as such, and he probably would consider that it would carry a District Health Officer as far as he could wish to go. But the Act is neither so complete nor so far-reaching as it would at first sight appear to be. Sometimes it is actually bewildering. A District Health Officer may condemn a building in a borough as unfit for human habitation, but he cannot prevent it from being erected just outside the limits of the borough; consequently the suburbs of a large town are often made the dumping-ground for insanitary buildings. Power to condemn buildings in counties is urgently needed. It is not very long ago that we were prevented from officially condemning a very insanitary hospital, as it happened to be just outside a borough boundary. It is also unfortunate that in seizing unsound food the action can only be rendered legal by subsequently prosecuting the owner. This is apt to be rather hard on the owner who has purchased the noxious article in all good faith. Although sanitary inspectors may be appointed by local bodies, yet two local bodies may not combine for the purpose of paying the inspector's salary, despite the fact that by so doing money is saved and a better officer appointed. These are a few minor details. It is to be hoped that the larger question of quarantine will be dealt with by amendment during the ensuing session.

### LOCAL ADMINISTRATION OF THE PUBLIC HEALTH ACT.

One of the chief difficulties in the way of a successful administration of the Public Health Act is the number of local authorities, there being no less than ninety-two in the Wellington District. Speaking broadly, the Borough Councils, Town Boards, and County Councils are alive to their responsibilities under the Public Health Act; but not so the Road Boards, of which there are forty in the district. These, with two notable exceptions, have tried to shift all sanitary work on to the respective County Councils. It is difficult to see what particular gap in local government is filled by the Road Boards, especially the smaller ones.

Under the administration of some County Councils are certain small townships with populations varying from five to eight hundred inhabitants—too many for a county, too few for a borough. As many of these townships are far distant from their administrative centres, they therefore have no local governing body in the true sense of the word, and it is not to be wondered at that the elements of sanitation are neglected. For such townships the Town Districts Act of 1886 would be most useful, as it answers admirably in those townships where that Act is still in force.