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The shared history of public health and planning in New Zealand: A different colonial experience

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ABSTRACT

Historically, public health shared common concerns with town planning, as both sought to create healthy living environments. This article explores how the relationship between the two areas developed and changed in New Zealand and how this experience reflects New Zealand's colonial status and history and its bicultural character. It explores Māori experience of both areas in the period from 1840 to 1990 including how Māori concerns and interests were addressed and influenced public health and planning. The experience of Māori in these areas is also considered in terms of some of the experiences of First Nation people in Australia and Canada. It concludes that the shared history of planning and public health was not sustained beyond the 1940s.

1. Introduction

This seeds of this work grew out of research that was undertaken for the Public Health Advisory Committee (PHAC), which was seeking to better understand the historical roots of planning and public health in New Zealand as a precursor to reconnecting the two areas. PHAC is a sub-committee of the National Advisory Committee on Health and Disability which advises the Minster of Health on health issues and policies. This interest in examining the historic links between public health and planning was part of PHACs attempt to promote the relinking of these two expert areas, a linkage that has been promoted in a number of countries (Chapman, 2011; Corburn, 2005; Kidd, 2007; Harris, Harris-Roxas, Wise, & Harris, 2010). These attempts to better integrate health concerns into planning practice generally acknowledges that they shared a history derived from their 'view of the city as pathogenic and disorderly, requiring interventions to make urban areas more "regular" and "disciplined" (Corburn, 2007, p. 688). Meller confirms similar views existed in Victorian Britain where 'a civilised society was clean, educated and orderly' (Meller, 1997, 260), ideas that were in turn embedded in colonial practices.

An interest in this shared history usually begins with accounts of the uncontrolled growth of cities during the Industrial Revolution and the massive economic and social change that it created. Hall's (1996) 'City of Dreadful Night' with its 'urban ills' of disease, overcrowding and slums produced the need for amelioration, first provided by civil engineers and public health practitioners. The latters' role in Britain grew out of the issues revealed by Chadwick's 1842 '*Report on the Sanitary Conditions of the Labouring Population of Great Britain*'. It represented the growing concern that poor sanitary arrangements and lack of any oversight or control would lead to diseases that affected all city dwellers. Legislation starting with the *Public Health Act 1848* began to establish public health as an independent branch of medicine. After the Royal Sanitary Commission in 1871 'local authorities became responsible for public health and social welfare' (Cole, Sim, & Hogan, 2011, 89). Administrative structures for public health also emerged, with the first Medical Officer of Health being appointed in 1871. The *Public Health Act 1874* and later legislation further expanded the roles for public health and by 1919 'all publicly funded preventative activities and health care were unified into a single system at local authority level' (Cole et al., 2011, 89). Thus by the 1890s Manchester had twenty eight sanitary inspectors, four smoke inspectors, two food inspectors and six factory and workshop inspectors (Crook, 2007, 373).

Public health legislation also created the need for public health practitioners and in 1871 a Diploma of Public Health was established. In 1924 the London School of Hygiene and Tropical Medicine established the first School of Public Health (Cole et al., 2011). Public health practitioners began to organise themselves, with the Sanitary Institute (from 1904 the Royal Sanitary Institute) being founded in 1876. It advocated for public health, organised

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public health conferences from 1889, advocated for new qualifications and became the basis of a professional organisation. By 1900 in Britain public health was a well-established undertaking, with a career path for practitioners and a role in central and local government.

The origins of town planning are also usually presented as being derived from the ills of the Industrial Revolution as Cherry (1969), Corburn (2005), Hebbert (1999) posit and this is seen as the link between planning and public health. Freestone observes this means that 'the history of planning in Great Britain is dominated by public health reforms, the garden city movement, the passage of town planning legislation and countryside protection' (Freestone, 2007, 38). Thus the agenda for the emerging town planners focused on creating healthy and attractive living environments for everyone both now and in the future. This future orientation and their holistic approach helped to distinguish planning from other disciplines. Nevertheless, without Howard's seductive garden city/suburb paradigm (see Fishman, 1982; Hall & Ward, 1998; Miller, 1998b), providing a practical vision of the ideal city (Fishman, 1982) with international appeal, it is hard to see town planning having become as influential and widespread as it became. Like public health town planning ultimately required legislation, first achieved in 1909, to become a local government responsibility. British legislation in 1919 and 1932 in particular, expanded the role for planning and secured its role in directing new development. It took the uncontained growth of London and the extensive war damage in many cities after World War II to carry planning beyond plans into a premier role in the New Town movement and the development of the ultimately disastrous high rise housing estates.

Cherry notes that most of the high minded intervention to improve the ills of the city were meet 'with suspicion and hostility' (Cherry, 1996, 45) as the costs of those interventions were regarded as a burden by those who paid for them. Corburn suggests that both public health and city planning advocates believed that 'scientific rationality' and 'economic efficiency' would restore order to the chaotic cities as well as being underpinned by a 'moral environmentalism' (Corburn, 2007, 689). Corburn's moral environmentalism is essentially part of what Hebbert calls the 'sanitarianism/street-based sanitary paradigm' (Hebbert, 1999, 436–439) which claimed that narrow closed streets reduced air movement, concentrated filth and gave rise to the miasmas that created ill health. The solutions advocated by this group were based on better street layouts, public health engineering and the reduction of crowded buildings. Both sanitarianism and moral environmentalism assumed that scientifically and economically rational actions would positively change conditions for the urban poor. As Hebbert notes 'the sanitary street was a victim of its own inordinate success' (Hebbert, 1999, 437) and it took the garden city/city beautiful predilection for street trees, gardens, etc. to refashion them as part of urban amenity. Together, Corburn's (2007) account of developments in the United States and Hebbert's work emphasise that both public health and town planning had to constantly evolve if they were not to become victims of their own success.

Ward (2002) however sees the origins of planning in more complex terms and observes that 'modern planning embraced the new realities of the city as a dynamic and capitalistic centre of production, distribution, consumption and reproduction' (Ward, 2005, 11). In this conception the structural aspects of modern planning are emphasised and planning expresses 'newer functional priorities of land use, infrastructure, efficient circulation and, increasingly, social welfare' (Ward, 2005, 11). In this interpretation planning moves away from the traditional view of public health and planning as complementary responses to the ills of the Industrial Revolution. Instead planning is a future orientated activity, facilitating the capitalist city by ensuring it provides the structures from business zones to new roads that it needs to function. It also allows for the political–economy model of planning whereby planning arises out of the underlying conflicts within the capitalist city as the state's mechanism for resolving their resolution (Porter, 2010, 49–50). In either conception of the role of planning, as Sandercock (1998), Porter (2010) and other writers have highlighted, it is easy to overlook the 'other' planning histories of gender, race and sexual orientation. If these are neglected then any history of planning and presumably public health becomes 'self-justificatory' more concerned with legitimising the dominant view, excluding all others and building a foundation for the subsequent profession (Sandercock, 1998, 2). In the New Zealand context it is vital for both planning and public health address race given the original bicultural nature of New Zealand society and the move to multiculturalism from the 1960s onwards with the arrival of Pacifica[1] migrants.

This article builds on the original PHAC research to further explore the linked history of planning and public health in New Zealand. That research was based on both primary archival research undertaken primarily at National Archives in Wellington and a variety of secondary sources. The secondary sources include a range of my previous research which was largely based on archival research (see for instance Miller, 2002, 2004a, 2004b). This contextualising of the work provides some boundaries for this exploration and focuses it primarily on the British colonial experience which is likely to provide the best comparisons to New Zealand's developments. It also simultaneously provides a variety experiences that could only be drawn from such a geographically expansive empire. This historical overview allows the identification of how far New Zealand's experiences in establishing public health and planning in a self-governing colony with a Māori population, mimicked or diverged from colonial experiences elsewhere in the British empire. It will also allow an assessment of what that knowledge adds to our understanding of the development in both areas. This work commences extended discussion starts with a brief overview of the experience of public health and town planning in other British colonies.

2. Planning, public health and the colonies

Ward's concept of planning is one that can accommodate the planning that arises out of imperialism, the product of the expansion of capitalist economies into the so called 'empty lands'. The latter was a widely held view which ignores the existence of indigenous people in those empty lands (Havemann, 1999, 125–128). Britain was at its height the world's largest and most influential empire and dominated the world's political and economic life through most of the nineteenth century and the early decades of the twentieth century. Home in '*Of Planning and Planting*' (1997) provides a comprehensive account of the planting and planning of colonies from the first American settlements of the early seventeenth century to the extensive colonising of Africa and South East Asia, to the often unsuccessful attempts to leave a planning legacy in the colonies when the inevitable demands for independence become too great to resist. Colonialism that is 'the appropriation, occupation, and control of one territory by another' (Omolo-Okalebo, Tigran, Werner, & Segendo, 2010, 152) was the handmaiden of imperialism and 'the formation of cities was a key part of this process' (Home, 1997, 2). The need for cities, particularly port cities, to be rapidly established made them challenging locations for new ideas and methods. Colonies were where European ideas displaced the existing indigenous ideas

[1] Pacifica is an omnibus term which covers migrants predominantly from Samoa, Tonga, the Cook Islands, Niue, and Raratonga.